Shorter waiting time due to abortion pill

Nearly all abortions in Norway today are performed with the abortion pill Mifepristone. This has resulted in shorter waiting time, earlier abortions, and the possibility to have abortions at home.

“It’s a success story,” says Mette Løkeland, who has done research on medical abortion in Norway between 1998 and 2013.

In 1998, the waiting time for abortion was just over eleven days. Today the waiting time has decreased to just over seven days. According to Løkeland, this is the result of the abortion pill.

The opportunity of taking pills instead of surgery has also resulted in earlier abortions. In 1998, less than half of the abortions were performed by the end of week nine of the pregnancy, whereas in 2013 the figures had increased to almost eighty per cent.

“For women who wants to have the abortion as early as possible this is more easily accessible today. This is also in line with the preliminary work related to the Termination of Pregnancy Act, which states that it is both desirable and beneficial to have the abortion as early as possible,” says Løkeland.

More than ninety per cent of her interviewees have told Løkeland that they are satisfied with the medical abortion procedure.

Complete shift in the Norwegian treatment of abortion

The abortion pill, whose official medical term is Mifepristone and is taken in combination with the pill Misoprostol, was developed in the early 1980s, but it wasn’t available in Norway until 1998.

Norway has now some of the highest numbers in the world when it comes to the use of the abortion pill. The Scandinavian countries and Scotland have the largest percentage of medical abortions in the world.

In 1998 only about six per cent of the abortions carried out in Norway were performed with the abortion pill. In 2013, the figures are above eighty per cent.

“We have witnessed an almost complete shift in the treatment of abortion from surgical to medical abortion,” says Løkeland, who normally works as a gynaecologist in Bergen and as chief physician at the Abortion Register at the Norwegian Institute of Public Health.

“The nurses have increasingly taken over the responsibility for the treatment, which has resulted in increased capacity and availability for the doctors to perform other tasks for other patient groups.”

Satisfied with home abortions

While European countries have been restrictive in terms of allowing women access to home abortions, this
practice has been the norm in the U.S. since 2000. Haukeland University Hospital started to offer home abortions in 2006, and it quickly became the preferred abortion procedure among the women who were offered the choice.

Home abortion means that the woman takes a Mifepristone, the abortion pill, at the hospital, and is given a Misoprostol to bring home. Thus, the actual termination of the pregnancy happens at home.

Critics have worried that having an abortion at home may be lonely and traumatic, and that the women don’t receive the necessary health aid.

As part of her study, Løkeland has therefore asked 1018 women whether they were satisfied with their home abortions.

Of the women who had their home abortion by the end of week nine, more than ninety-five per cent replied that they were satisfied.

The women who were asked chose to participate in the study and chose to have a medical abortion.

“For those who chose this procedure themselves, medical abortion appeared as an acceptable and preferred procedure that they were satisfied with,” says Løkeland.

Possible to choose surgical abortion

Although medical abortion is the recommended procedure at Norwegian hospitals today, Løkeland emphasises that no one should be forced to choose medical abortion, or so-called home abortion.

“Medical abortion is absolutely the recommended procedure, since it is regarded as more gentle to the body. We have similar preferred methods for a number of other procedures as well, and the preferred method is the one we recommend first.”

“But it’s important to note that surgical abortion should also be available if someone prefers that instead.”

From mild pains to extremely painful

Løkeland also asked about pain in relation to the abortions. Some women had very painful experiences with medical abortions, while others just experienced mild pain.

“But people are still satisfied, even those who experience moderate to strong pain,” says Løkeland.

“There is not necessarily any connection between the degree of pain and the degree of satisfaction.”

Løkeland also found that women who have not given birth before find medical abortion more painful than women who have given birth.

“Either, this might imply that a body which has already given birth has a higher physical pain threshold, or women who have given birth may have other expectations when it comes to pain, since they’ve already experienced a pain which is much worse,” says Løkeland.

The study has not shown any connection between the length of pregnancy and the degree of pain.

Pioneering work related to the abortion pill procedure
Many countries only offer medical abortion until the end of week nine of the pregnancy. At Haukeland University Hospital, however, Løkeland and her colleagues have carried out pioneering work by performing medical abortions in weeks nine to twelve. These abortions are performed at the hospital, not at home.

254 women participated in the study. For approximately ninety-two per cent of the women, medical abortion was sufficient to complete the abortion. Eight per cent of the women needed to undergo a surgical procedure in order to complete the abortion.

“Is the number of failed abortions high or low?”

“No procedure is flawless, and both a surgical and a medical abortion may fail. When we summed up a larger set of data based on 700 patients, the number of successful abortions was approximately ninety-five per cent. The more we work on this, the more we learn, and the number of surgical procedures decreases accordingly. We’re learning how to interpret when an abortion is incomplete and we become more patient, thinking that this will sort itself out. We’re to a larger extent using Misoprostol again now, rather than going for surgery straight away,” says Løkeland.

Must prepare the women for pain

Seven out of the 254 women experienced bleeding that had to be stopped by the use of surgery, and most of the women felt the need for painkillers during the abortion.

Several of the women responded that they did not expect the abortion to be as painful as it was. But even among these women, who had their abortion between weeks nine and twelve, nine out of ten responded that they were satisfied with the procedure.

“It became clear from the follow-up study of the women who had their medical abortion during weeks nine to twelve that it is important not to underestimate the pain. If the hospital underestimates how painful it might be, the women may be frightened and experience a stronger sense of pain.”

Many have several abortions

Løkeland has also done research on the Abortion Register, where she has studied the registered women’s level of education, their connection to the job market, and how many abortions they’ve had.

She was surprised to find that in 2013, almost 50 per cent of the women who had an abortion had gone through one or several abortions before. They are called “repeat abortions”, and the rate in Norway is higher than that of our neighbouring countries and higher than any previous Norwegian figures.

This may have several explanations.

“This is either an actual increase, or it shows that women talk about this more freely today since it is regarded as less of a stigma. The information in the Abortion Register is based on the women’s own accounts,” says Løkeland.

According to her, however, the most likely explanation is that the Abortion Register has improved, partly due to the introduction of electronic patient journals.

Neither do the figures show whether someone has had more than two abortions. Women who have had three or more abortions are counted as repeat cases every time they are registered, since the Abortion Register is anonymous.
Calls for involvement from the authorities

According to the study, the education level of those who have more than one abortion is slightly lower than the level of those who have had only one abortion. Moreover, their connection to the job market is also somewhat lower.

“Studies from the United Kingdom show the same tendency. It is these women who need the most support from society,” says Løkeland.

“Norway has a high degree of repeat abortions. This is something that the authorities should look into, in the same way as the health authorities made a major effort in order to decrease the number of teenage abortions. One suggestion would be to subsidise long-term effect hormonal contraception.”

“How significant is this find? Isn’t it stigmatising to claim that those who have more than one abortion come from the lower classes of society?”

“These data are significant, and they are based on a huge amount of people,” says Løkeland.

“But we also have to keep in mind that this is statistics. Even though those who have little education and struggle on the job market are overrepresented among those who have more than one abortion, this does not mean that well educated and resourceful women aren’t among them too.”

Within 16 years, the abortion pill has led to a complete shift in the abortion procedures in Norway. And the women who have abortions are satisfied. (Illustration: Colourbox) [8]
Mette Løkeland recently defended her PhD thesis on the use of medical abortion in Norway from 1998-2013. (Photo: Ida Irene Bergstrøm) [9]

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