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Medical abortion practices: a survey of National Abortion Federation members in the United States

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Abstract

Background: Little is known about clinical implementation of medical abortion in the United States following approval of mifepristone as an abortifacient by the Food and Drug Administration (FDA) in 2000. We collected information regarding medical abortion practices of National Abortion Federation (NAF) members for the year 2001.
Methods: Questionnaires were mailed to 337 active US NAF member facilities.
Results: A total of 258 facilities responded (77%); 252 nonhospital facilities were included in the analysis. Most of these facilities (87%) offered medical abortion in 2001, providing an estimated 28,400 medical abortions, approximately 52% of medical abortions in the US that year. Over 75% began offering mifepristone/misoprostol abortions within 5 months of the start of mifepristone distribution. Almost all (99%) reported using mifepristone/misoprostol regimens, with most offering one or more evidence-based alternative regimens (83%); a few (4%) used the FDA-approved regimen.
Conclusion: After FDA approval of mifepristone, NAF member facilities rapidly adopted evidence-based mifepristone/misoprostol regimens.

Keywords: Abortion; First-trimester abortion; Medical abortion; Mifepristone; United States

1. Introduction

Abortion is one of the most common medical procedures obtained by women in the United States (US) [1], with most occurring in the first trimester. Vacuum aspiration abortion has been the method of choice for first-trimester pregnancy termination since the 1960s [2]. In September 2000, the US Food and Drug Administration (FDA) approved mifepristone, an antiprogestin, for use with misoprostol (a prostaglandin) in early medical abortion, providing a nonsurgical alternative to women seeking pregnancy termination [1,2]. Since the approval of mifepristone in France and China in 1988, 37 additional countries around the world have approved this alternative abortion method [3]. Studies by the Guttmacher Institute suggest that integration of mifepristone regimens into first-trimester abortion practice took a decade or longer to occur in several European countries [4,5]. Mifepristone is not available in Canada, where evidence-based use of methotrexate is still the most common method of medical abortion.

Understanding how US facilities incorporated mifepristone medical abortion into existing services has important implications, given the potential for medical abortion to improve access to abortion procedures. Few data exist on medical abortion provision in the US shortly after legalization of mifepristone. We therefore surveyed member facilities of the National Abortion Federation

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(NAF), the professional and educational organization of abortion providers in North America, on medical abortion practice in 2001.

2. Materials and methods

The methods of the study have been described previously [6]. Briefly, we mailed self-administered questionnaires about abortion practice, including medical abortion practice, to all active member facilities of NAF in 2002. A similar survey on first-trimester surgical abortion practices had been conducted in 1997 [7]; questions about medical abortion practice were added to the new survey. The total population of recipients consisted of 364 facilities in the US, Canada and Australia. Of those who responded and offered medical abortion in 2001, only six (3%) were non-US facilities (five in Canada and one in Australia); we therefore present data for US facilities only. Of the 337 facilities in the US, 77% returned the administrative survey. However, two were hospital based and four were missing data on the type of facility, leaving a total of 252 nonhospital US facilities. The majority (87%) of these facilities had medical abortion services available in 2001. Results are presented for the 218 nonhospital US facilities offering services.

We asked each clinic administrator to complete a questionnaire that covered four topics relevant to this analysis: facility characteristics, pre- and post-procedural requirements, patient eligibility criteria and medical abortion regimen protocols. We also sent separate questionnaires for up to five individual clinicians if they performed at least 15% of surgical abortions at the facility; 190 clinicians returned these forms, representing 123 of the 218 facilities. We asked only two questions of clinicians about medical abortion: whether they are ever consulted for medical abortion complications and practice regarding repeat dosing of misoprostol. The results from the clinician questionnaire are found in the clinicians' survey section of the results; all other results are derived from the administrators' form with the individual facility as the denominator. The Institutional Review Board of Northwestern University approved this study.

2.1. Statistical analysis

We present descriptive findings for facility characteristics, as well as medical abortion regimen protocols, patient eligibility criteria and administrators' opinions about medical abortion procedures. We explored associations between each of these outcomes and region, facility type, facility size and whether staff attended CME-accredited medical abortion training, using the Student's *t* test and chi-squared test to assess the statistical significance of differences in continuous and categorical outcomes, respectively.

Some administrators responded for more than one site within a network of facilities. We weighted their responses by the number of sites their questionnaire represents. Respondents reported the annual number of first-trimester medical abortions within predefined ranges (categories were none, less than 50, 50–200, 201–400, 401–600, 601–800, 801–1000, 1001–1300 and more than 1300). We calculated estimates of the total number of first-trimester medical abortions performed using the midpoints of these ranges. For facilities reporting more than 1300 medical abortions, the largest possible response, we used 1300 procedures. Similarly, respondents reported the annual number of first-trimester surgical abortions within predefined ranges (from less than 500 to more than 7500); we used the midpoints as estimates for the total number of first-trimester surgical abortions performed. We classified facilities by size, with small facilities defined as those that perform fewer than 1000 first-trimester medical and surgical abortions per year; medium between 1000 and 3000; and large more than 3000. We also explored the results for facility size defined by the number of medical abortions only. As we did not find trends by size of facility when measured by medical abortions alone, we present results using size of facility defined by first-trimester medical and surgical abortions combined.

3. Results

Eighty-three percent (208/218) of the facilities offering medical abortion reported actually providing medical abortions in 2001. These facilities provided an estimated total of 28,400 medical abortions in 2001.

3.1. Facility characteristics

As seen in Table 1, half (50%) of the facilities offering medical abortion were classified as small, 38% medium and

Table 1
Characteristics of nonhospital-based NAF facilities in the US that offered medical abortion services in 2001

Facility characteristics (*n*=218)	Percent
Size in terms of estimated number of first-trimester abortions in 2001[1]	
Small (<1000)	50
Medium (1000–3000)	38
Large (>3000)	12
Region where facility is located	
West	33
East	25
South	22
Midwest	20
Type of facility	
Clinic	71
Private office	12
Surgical center	17
Commercial status of facility	
For profit	48
Not-for-profit	52

[1] Eleven facilities were missing information on case number of first-trimester abortions, *n*=207.