

Editorial

Happy anniversary mifepristone: a decade of promise and challenges

September 29, 2010, marks the 10th anniversary of Food and Drug Administration's approval of Mifeprex (mifepristone) in the United States. That moment 10 years ago brought women the promise of increased access to early, safe, noninvasive abortion and the potential mainstreaming of abortion services into the larger scope of routine comprehensive women's health care [1,2]. The arduous 12-year path to approval required an intensive level of collaboration among key professional, advocacy and research organizations, working closely to navigate abortion-related politics and meet the natural challenges of introducing a new medical option to women and their health care providers.

The motivation for working with such purpose was the potential to improve access to abortion and improve health care for women and families. Mifepristone can increase access to abortion for three compelling reasons: women can choose this method at earlier gestational ages than is typical for suction procedures; it can be obtained from primary care physicians (and advanced practice clinicians in some states) without the need for surgical facilities; and it can be completed in the privacy of the woman's home. Mifepristone promises to expand abortion services by going outside the domain of a typical abortion clinic. It has the potential to increase the number and types of abortion providers while expanding access to care. Ideally, mifepristone can become a ubiquitous and essential component of women's health care practice, embraced not just by obstetrician/gynecologists but by all primary care clinicians.

Mifepristone use has steadily increased over the past decade and is a likely factor in the trend toward very early abortions [2,3]. Since FDA approval, more than 1.3 million US women have chosen this method (personal communication with manufacturer, 2010). And the number of mifepristone abortions and abortion providers has increased significantly, even as the number of abortions and providers has decreased during the same period [2]. According to the latest Guttmacher data, the proportion of abortions performed in the US at less than 9 weeks of gestation increased 5% in just 4 years, from 58% in 2000 to 63% in 2004 (the most recent available data) [2]. Preliminary estimates indicate that mifepristone accounted for roughly 27% of eligible abortions in 2009 in the United States compared to 22% in 2005 [3].

But mifepristone has yet to achieve its potential for expanding access to abortion services and rectifying inequities in abortion care in the United States. There are a number of barriers to enhanced access. First, there is a geographical divide regarding abortion services: 35% of US women live in counties where there is no abortion provider and 99% of all abortion facilities providing more than 400 terminations annually are concentrated in metropolitan areas. Many states have "physician-only" laws mandating that abortion provision be limited to MDs, limiting the potential pool of clinicians [3]. Also, the cost of medical liability insurance for clinicians who provide medical abortion can be prohibitive [4]. Finally, primary care and advanced practice clinicians, in particular, have not usually been trained in the use of this method.

Mifepristone use in the United States is concentrated in urban areas, which can leave rural women without access to early abortion. In 2005, Guttmacher researchers found that mifepristone-only and vacuum aspiration providers are located overwhelmingly in metropolitan areas — approximately 95% for both [2]. The same study also found that 84% of mifepristone abortions were performed in only 93 US counties, a mere 3% of all US counties [2]. Compounding this issue, close to 40% of US women age 15–44 years still live in counties without an abortion provider [2].

In addition to enhancing efforts designed to increase the geographical distribution of mifepristone, expanding the type of provider offering this service remains a ripe area of future focus. Most obstetrician–gynecologists have incorporated mifepristone provision into their practices. But expectations that primary care providers would offer the drug have yet to be realized, and family medicine doctors provide only a small percentage of mifepristone abortions [2]. Lack of training and malpractice insurance barriers may be sizable issues preventing incorporation of this service. Nurse practitioners, physician assistants and certified nurse midwives remain an excellent and relatively untapped pool of providers who can help increase access to early medication abortion services.

As our community celebrates a decade of women's expanded access of safe and early abortion options in the United States, we must invest some time and energy into

developing and promoting further expansion of mifepristone use. While the medication regimen has evolved to help improve efficacy, shorten the process, decrease costs, promote flexibility and reduce side effects and complications, other developments need to take place to help ensure wider access of mifepristone to women in US counties without an abortion provider. Efforts to expand the number and type of abortion provider remain fertile ground for expanding access. We must concentrate on access to early abortion services to women in rural areas and focus on training all appropriate members of the clinical team in its use.

The availability of this noninvasive, safe and effective medication abortion method has had a profound effect on the lives of American women. This significant milestone for women's reproductive health highlights the collective accomplishments of health care providers, researchers and women's reproductive rights advocacy groups, and it also demonstrates the desire of women to have access to a safe, nonaspiration abortion option.

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