Who provides mifepristone for medical abortion?: An analysis after mifepristone's approval in Canada

Michelle Didero MSc[1,2], Wendy V. Norman MD, MHSc[2]

[1]David Geffen School of Medicine at UCLA, [2]London School of Hygiene & Tropical Medicine

BACKGROUND

- Mifepristone has long been used for first-trimester medical abortions in many countries around the globe
- Usually taken orally and followed by a drug called misoprostol, mifepristone has been shown to safely improve access to abortion in pregnancies up to 11 weeks of gestation
- In Canada in 2017, mifepristone became available by prescription for medical abortions
- Mifepristone-misoprostol is currently the only government-approved medical abortion regimen in Canada
- Despite the successful approval of mifepristone, little is known about health care provider characteristics that may contribute to mifepristone provision

OBJECTIVE

- Understand baseline physician characteristics associated with new or continued mifepristone provision

METHODS

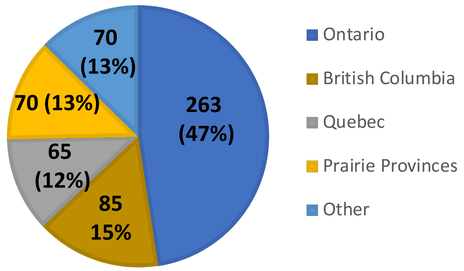
- Secondary analysis in a longitudinal study
- 554 participants recruited through multiple national level physician organizations
- A 61-item online Mifepristone Implementation Survey (MIS) was distributed at baseline and 12-months
- The survey used the Legare scale, 12 theory-based questions about likeliness to adopt a new behavior. Legare questions scored 1-6 (or -7), least likely to most likely
- Other characteristics analyzed: age, sex, specialty, providence/territory, previous abortion experience
- Analysis by X^2 test and logistic regression

RESULTS

Table 1: Characteristics of survey respondents measured at baseline

	Stratum per variable	Total at Baseline n (%)
Age	Ages 22-35	180 (32.8)
	Ages 36-48	187 (34.1)
	Ages 49-79	182 (33.2)
	Total	**549 (100.0)**
Sex	Female	452 (81.6)
	Male	99 (17.9)
	Other	3 (0.5)
	Total	**554 (100.0)**
Primary Specialty	Primary Care	380 (76.12)
	Specialty	128 (23.88)
	Total	**536 (100.0)**

PROVIDENCE/TERRITORY



PRIOR ABORTION PROVISION

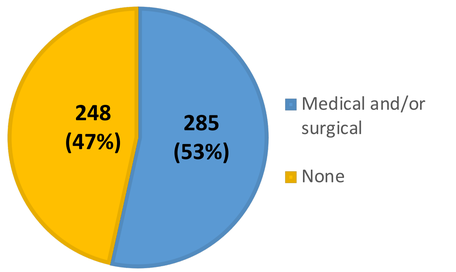


Table 2: Crude odds ratio for mifepristone provision at 12-months by baseline variable (n=194)

Variable (Baseline)	Crude OR (95% CI)	p-value
Intention to provide medical abortion	2.24 (0.92, 5.44)	0.086
Confidence in ability to provide medical abortion	**2.36 (1.02, 5.39)**	**0.005**
Belief that abortion provision is ethical	0.81 (0.22, 2.94)	0.735
Plan to provide medical abortion	**3.54 (1.52, 8.21)**	**0.004**
Belief that most people who are important to me in my profession would either refer for, or provide, medical abortion	1.01 (0.48, 2.13)	0.978
Belief of acceptability of medical abortion provision	1.59 (0.40, 6.28)	0.525
Ability to provide medical abortion	**2.77 (1.19, 6.44)**	**0.022**
Estimate of the percentage of my colleagues in this community who provide or will provide medical abortion	1.09 (0.50, 2.38)	0.826
Belief that for me, providing medical abortion would be extremely difficult (1) to extremely easy (7)	**3.02 (1.38, 6.65)**	**0.004**
Opinion on whether a respected co-worker would provide, or refer for, medical abortion?	1.32 (0.62, 2.82)	0.471
Opinion that for me, providing medical abortion would be useless (1) to useful (7)	1.03 (0.32, 3.28)	0.961
Opinion that for me, providing medical abortion would be (1) harmful to beneficial (7)	1.79 (0.75, 4.28)	0.199
Averaged Legare survey score at baseline using all 12 factors of likeliness grouped by score (<6 vs. ≥ 6)	**4.15 (1.92, 8.98)**	**<0.001**

CONCLUSION & DISCUSSION

Conclusions

- About half of survey participants had medical and/or surgical abortion experience at baseline and 12 months
- Providing mifepristone at 12-month follow-up was associated with:
  - Previous abortion provision experience
  - Confidence, plan, ability, and/or perceived easiness of providing medical abortion
- Providing mifepristone at 12-month follow-up was not associated with:
  - Physician age, sex, primary specialty, providence/territory
  - Personal belief regarding abortion ethics or peer acceptability

Limitations

- Survey length
  - Evidence of responder fatigue within baseline survey
  - Lower participation at follow-up
- As multiple barriers to mifepristone access still exist, selection bias may play a role

Next Steps

- Study with focused survey & larger sample size
- Consider physician training to improve confidence, ability and ease of mifepristone provision

REFERENCES

Norman WV, Guilbert ER, Okpaleke C, et al. Abortion health services in Canada: results of a 2012 national survey. *Can Fam Physician*. 2016;62(4):e209-e217.

Devane et al. Implementation of mifepristone medical abortion in Canada: pilot and feasibility testing of a survey to assess facilitators and barriers. *Pilot and Feasibility Studies* 2019;5:126.

Légaré, France et al. Responsiveness of a simple tool for assessing change in behavioral intention after continuing professional development activities. *PloS one*. 2017;12(5).