The Political Challenges And Educational Opportunities Around Very Early Abortion

By Rebekah Saul

Public attention to congressional action on abortion last year was focused almost exclusively on the Partial-Birth Abortion Ban Act—an antiabortion initiative designed to capitalize on Americans' concern over "late" pregnancy termination (*TGR*, Vol. 1, No. 6, December 1998). Meanwhile, in the shadow of the "partial-birth" debate, a congressional move that could have greatly impacted the other end of the abortion spectrum received very little attention: Last summer, the House endorsed a provision that effectively would have barred Food and Drug Administration (FDA) approval of very early, nonsurgical methods of abortion, such as mifepristone (commonly known as RU-486).

In the end, the provision failed to become law. The brief debate over the measure, however, focused less on abortion than on "science"—on the contention that congressional intervention in FDA's review of any one category of drugs (in this case, abortion-inducing drugs) would constitute an egregious and inappropriate interference with accepted scientific processes, one that could have negative consequences for a range of health conditions. During the fight, the reproductive rights community largely laid low, ceding to these more "mainstream" concerns.

With mifepristone's final FDA approval still in the offing, reproductive health supporters almost certainly will face further attempts by antiabortion lawmakers to prevent its progress—which, in turn, may yield additional opportunities to rethink legislative and public education strategies around this and other newly available methods of very early abortion. While last year's strategy, in the short term, clearly worked to sow doubts in the minds of key legislators about the wisdom of congressional meddling in the FDA drug-approval process, it did little to advance the abortion debate by increasing public understanding about very early abortion methods. It, therefore, also did little to close a troubling gap between longstanding public support for abortion as early in pregnancy as possible and the lack of congressional support for a range of new technologies that promise a potential shift in that very direction. As a long-term strategy, closing this gap, while a significant challenge, may prove critical for both reproductive health politics and the availability of reproductive health services.

Outlawing RU-486...

In an unforeseen move last June, Rep. Tom Coburn (R-OK) offered an amendment to a spending bill to prohibit the use of funds by FDA "for the testing, development or approval...of any drug for the chemical inducement of abortion." After the briefest of debates, the House approved the amendment, 223-202. The Senate declined to include a similar provision in its version of the appropriations measure, so the fate of the FDA restriction ultimately was decided by a House-Senate conference committee, which rejected it.

Though it clearly would have much broader implications, both sides of the abortion divide recognized the Coburn amendment's fundamental purpose—to derail mifepristone's long-awaited entrance into the United States. In combination with the prostaglandin misoprostol, the compound was first approved as an abortion method in France in 1988. Because the mifepristone/misoprostol regimen is a "medical"—that is to say, nonsurgical—form of abortion, and because it is effective at stages of pregnancy traditionally considered too early for effective surgical abortion, its development was considered a major reproductive health breakthrough.

Ever since mifepristone's debut in Europe, reproductive health proponents have looked forward to its advent in the United States. The drug's introduction into this country was stalled by various political maneuvers until 1993, when President Clinton effectively directed FDA to review it. In 1994, the Population Council began a year of clinical trials in the United States, which ultimately affirmed the French experience—that the drug regimen is a safe and effective method of abortion in the first seven weeks of pregnancy (measured from the beginning of a woman's last menstrual period). In 1996, the Council submitted a New Drug Application to FDA, which in turn deemed the drug "approvable," pending final information on manufacturing and labeling. Taking advantage of the delay regarding these final details, Coburn and like-minded members of Congress—who believe that abortion is murder at any stage in pregnancy—clearly aimed to stop mifepristone in its tracks.

New technologies that enable women to have abortions in the earliest stages of pregnancy could affect reproductive health politics *and* service delivery.

NEW AND RE-EMERGING VERY EARLY ABORTION TECHNOLOGIES

***Mifepristone/Misoprostol Regimen*–Mifepristone blocks the hormone progesterone, which is needed to maintain a pregnancy. Misoprostol, an already marketed protaglandin, causes uterine contractions. The combined regimen has demonstrated effectiveness roughly comparable to surgical abortion, and can be used as soon as a pregnancy is detected up to 49 days from a woman's last menstrual period (LMP). Barring congressional action to the contrary, final FDA approval of the regimen is anticipated later this year.**

***Methotrexate/Misoprostol Regimen*–Methotrexate blocks folic acid and prevents cell division; already marketed as a cancer-fighting drug, its use as an abortifacient is legal but technically "off-label." This regimen is also being used from the detection of pregnancy up to 49 days LMP.**

***Manual Vacuum Aspiration (MVA)*–A surgical procedure that utilizes a non-electrical suction instrument to evacuate the contents of the uterus, MVA may be used throughout the first 12 weeks of pregnancy. Use of MVA was fairly widespread in the early 1970s, but technology limited early pregnancy detection, as well as detection of incomplete abortion. Improved pregnancy tests and ultrasound equipment have facilitated MVA's re-emergence as a surgical method of very early abortion.**

...Or Hampering Science?

In support of the funding ban, Coburn and other congressional opponents of abortion rights maintained that approving abortion technologies is not an appropriate function for a federal agency whose mission is to promote health. Reproductive rights advocates countered that because abortion is legal in the United States, it is wholly appropriate that medical methods of abortion be considered on an equal basis with drugs used for other legal purposes.

Notwithstanding these arguments, however, a major component of the prochoice strategy was to allow questions about the appropriateness of congressional intervention in complicated scientific processes and protocols, namely, the long-established FDA drug-approval process, to dominate the debate. Indeed, a large and diverse coalition of organizations promoting biomedical research was amassed to oppose the provision on the grounds that it could have far-reaching, negative consequences on a range of health technologies, not just those relating to pregnancy termination.

While mifepristone is being reviewed by FDA in light of its efficacy as an abortifacient, these organizations pointed out, the drug also has shown promise in treating other conditions, such as Cushing's syndrome and endometriosis. Barring mifepristone's approval, then, also would slow research on alternative uses, they said. In addition, research advocates cautioned that the Coburn amendment could implicate *any* drug that causes an abortion (as a side effect, not just as its primary purpose)—for example, drugs used in chemotherapy. Fearing the Coburn amendment would effectively bar a range of important therapies, the National Coalition for Cancer Research went on record opposing it.

If Timing Matters

Downplaying the abortion issue *per se* while highlighting "larger" questions has been considered the safest, if not only, way to prevail in an antiabortion Congress on a matter impinging on reproductive choice—especially in recent years, when antiabortion advocates have focused on restrictions that are largely backed by the public. In the case of efforts to prohibit the approval of mifepristone, however, at least the *potential* for galvanizing widespread public and political support certainly exists. The drug is most effective in the first half of the first trimester and, therefore, offers women a new option for the earliest possible termination of pregnancy. Moreover, it is just one of a number of emerging technologies—surgical as well as nonsurgical—that allow women to obtain an abortion at stages traditionally considered too early for effective surgical abortion (see box).

Public opinion in the United States is highly supportive of early abortion. According to a *New York Times*/CBS poll conducted in early 1998 at the time of the 25th anniversary of the Supreme Court's *Roe v. Wade* decision, almost two-thirds of American adults believe that abortion should be legal in the first three months of pregnancy. Support for legal abortion drops precipitously after the first trimester, however. Abortion practice largely mirrors public opinion. American women overwhelmingly have abortions early in pregnancy—approximately half of all abortions occur within the first eight weeks and almost nine in 10 by the end of the first trimester. The newly emerging abortion technologies, taken together and coupled with advancements in pregnancy detection, have the potential to shift the timing of abortion in the United States even more in that direction, by increasing the percentage performed in the first half of the first trimester.

Fiction and Fact

According to the Kaiser Family Foundation, however, the American public is largely ignorant about these methods. In 1997, according to a Foundation poll, only 43% of women and 51% of men had even heard of either mifepristone or methotrexate, a long-marketed cancer-fighting drug also being used "off-label" as an abortifacient; moreover, only seven in 10 of the women who had heard of these drugs knew that they could be used as a method of pregnancy termination. It is likely that recently available *surgical* techniques of very early abortion are similarly unknown. (New data from The Alan Guttmacher Institute [AGI] indicate medical abortions constitute a small but rapidly growing fraction of all abortions; AGI estimates that, in 1996, 4,200 medical abortions were performed in the United States and that 4,300 such abortions were provided *in the first half* of 1997. No comparable information is available on the extent to which MVA is being used.)

There is also some evidence, at least in the public debate, that support for very early abortion methods, especially medical methods, may be tempered by confusion about how the methods work and, consequently, how they might affect the incidence of abortion. One myth, in the words of

Rep. Joseph Pitts (R-PA), is that they would make unwanted pregnancy "the medical equivalent of a headache: pop a pill and it will go away." The implication is that mifepristone or methotrexate, by making the procedure "easier," would diminish the seriousness with which women treat abortion.

A concerted public education campaign may be necessary to engage the public and build the bridge between theoretical support and public activism.

In reality, medical abortion is comparable to a miscarriage, but it can take considerably longer; the process can span several days and, though extremely safe, involves significant medical supervision. In terms of what's involved in the actual procedures, medical abortions and surgical abortions each have relative advantages and disadvantages from the viewpoint of the women undergoing them; experience in Europe shows that some women prefer one and some the other. In countries where it has been available, however, there is no evidence to support the notion that the availability of mifepristone increases the overall incidence of abortion; in fact, the abortion rate in France has declined more or less steadily since mifepristone's advent in 1988.

From Theory to Practice

Clearly, there is much work to be done to educate the public about the new abortion methods—how they work and how they may, and may not, impact the overall provision of abortion services—so that future attempts to restrict very early abortion methods can be fought head-on. Indeed, a concerted public education campaign may be necessary to engage the public and build the bridge between theoretical support and public activism.

Increased activism around very early abortion could have a positive, multiplier effect on reproductive health policy debates. Beyond staving off further damaging congressional action, it also could help add a new "winner" to the reproductive rights political agenda. That, in turn, could re-engage policymakers and the public in the basic right to abortion. As a bonus, prevailing on the issue of FDA approval of new abortion technologies, specifically mifepristone, could prove beneficial for a broad array of medical conditions—safeguarding, at the same time, the independence and integrity of the FDA drug-approval process itself.