



Summary of the 4th congress of FIPAPAC

Paris 24 and 25 November 2000

INTRODUCTION

The fourth congress of FIAPAC took place in the Georges Pompidou European Hospital in Paris.

250 professionals attended the congress from over 17 nations, Europe was strongly represented, and participants came from as far as U.S.A., Canada, Mexico, Australia and South Africa. This reflects the steady growth of attendance at our congresses, from 50 in Amsterdam, 100 in Brussels and 120 in Maastricht.

The conference, which lasted for two days, consisted of 5 round tables, 2 workshops and a session for open discussion. Simultaneous translation was provided for French, English and German throughout the congress.

Debates, discussions and exchanges of views between members were very numerous and highly productive. They were of great benefit to everyone, and created an atmosphere of warmth and friendliness among all present.

The congress concluded with a memorable dinner at the French Senate in the Palais du Luxembourg, where the FIAPAC was cordially welcomed by the French State, a strong indication of the political will in France to open the debate on abortion.

First round table: Who is entitled to carry out 1st trimester abortions?

- **From the point of view of a gynaecologist**
- **From the point of view of a general practitioner**
- **From the point of view of a womens right activist**
- **From the point of view of a midwife**

(no abstract available)

Second round table: Medical abortions. Chair. E. Aubeny

Two techniques are currently in use:

1. abortion using mifepristone (RU 486) + misoprostol,

2. abortion using misoprostol alone.

1. Abortion using mifepristone (RU 486) + misoprostol

I. DAGOUSSET gave a report on the technique of abortion using mifepristone + misoprostol, practised at the Orthogenic Centre at BROUSSAIS Hospital in Paris.

Using this method, this centre has performed 15,000 terminations up to 49 days of amenorrhoea, using 600 mg mifepristone + 400 µg misoprostol. An additional dose of 400 µg of misoprostol would be administered, if the first procedure shows no sign of success within 3 hours after the first dose. This has increased the success rate to 98.6%.

Concerning the psychological indications and contra-indications of this procedure, C. FIALA (Austria) pointed out that this method, which lasts 48 hours, is conducted in a way which calls for some degree of participation by the patient. Appropriate counselling is therefore required.

D. PLATEAUX (France) raised the question of whether patients should stay in hospital after taking misoprostol. A survey of 199 French women shows that most women prefer this.

E. SCHAFF (U.S.A.) gave a report on the results of 7,000 terminations using 200 mg of mifepristone + 800 µg of misoprostol, performed without hospitalisation, with misoprostol taken by the woman herself at home. Two transfusions and 8 hospitalisations occurred in this group. Most women preferred taking misoprostol at home instead of being hospitalised. But this requires extra counselling before the termination.

Who should control the effectiveness of the procedure? I. BANGOU (Guadeloupe) maintained that it should be the specialist and the general practitioner who started the treatment.

How should it be controlled? T. HUSSON (France) indicated that a good way of ensuring the success of the method is to measure hCG 10 days after misoprostol. It should be below 75% of the initial value before the abortion. An ultra-sound at follow-up is also an excellent method.

During the discussion, C. GEMZELL reported that Sweden has excellent results

using mifepristone 600 mg + gemeprost 1 mg, administered vaginally. Some centres perform 70% of their abortions in this way.

Many speakers from the floor suggested that the method should be made easier, with the misoprostol being taken at home.

2. Abortion using misoprostol alone

J. CARBONEL (Spain) uses this method, with 3 doses of 800 µg misoprostol alone. The rate of success ranges from 90 to 92% in pregnancies up to 63 days of amenorrhoea (LMP). This technique is less expensive than that using mifepristone.

Emergency contraception:

- **Can it be carried out without a medical prescription?**
- **Does emergency contraception cause ordinary contraception to be neglected?**

(no abstracts available)

Third round table: Risks in abortion - how to detect them?

- **The point of the operating physician**
- **The point of view of the anaesthetist**
- **The point of view of the counselling personal**
(no abstracts available)

Workshops:

- **The dilatation of the cervix by drugs vs mechanical**
- **Echography prior to abortion**
(no abstracts available)

Fourth round table: Post abortum Contraception - practices to be revised

(no abstract available)

Fifth round table: The law controlling abortion in different countries

Chair: D, Roynet

Germany

Abortion is allowed up to 14 weeks of amenorrhoea.

A session of counselling must take place at least 3 days before the procedure.

A woman who is doing an abortion abroad, without prior counselling risks a legal procedure.

Minors need parental consent from their parents for an abortion. The Courts can oppose abortions for minors.

Establishments performing abortions are under the jurisdiction of the regional government. The price of an abortion is reimbursed by the state in most cases, depending on the income of the women.

All publicity concerning abortion is forbidden.

Belgium

Termination has been legal since 1990.

It is authorised on the demand of the woman and on medical grounds up to 14 weeks of amenorrhoea.

The woman has to declare that she is in a situation of distress, and must make her request in written form.

Beyond 14 weeks of amenorrhoea, termination is possible only after the consent of two doctors, provided that there is a serious health risk to the woman, or if there is an abnormality of the foetus.

There is a mandatory waiting period after the first counselling of 6 days.

Denmark

Since 1973, termination has been authorised up to 14 weeks of amenorrhoea.

Beyond 14 weeks a woman must apply to a committee, though these take very liberal views.

For minors under 18 years of age, the authorisation of the parents or of the committee is necessary.

Spain

Termination is allowed up to 22 weeks of amenorrhoea, with no requirement for a waiting period. 97.3% of terminations are done for psychological reasons; 15% concern adolescents.

The private sector performs 97% of terminations. Although the law is restrictive, access to termination is good. There is a need, however, for fairer legislation.

The present reporting system is insufficient.

France

Termination is allowed up to 14 weeks of amenorrhoea, on demand by the woman.

A waiting period of 7 days for reconsideration is required between the first counselling and the abortion procedure.

Counselling is offered but not obligatory.

Minors need the consent of their parents. If that is not possible, they can choose a responsible adult, who will accompany them.

Great Britain

The law is strict in theory but flexible in its application. Two doctors must assess the physical or mental risk to the patient, and give their consent.

Termination is allowed up to the 24th week of amenorrhoea.

Holland

Since 1984, termination has been authorised on the decision of the woman alone. No time limit is specified, but it is rare for 22 weeks of amenorrhoea to be passed. The procedures are carried out in private, non-profit-making centres, and are strictly registered.

Ireland

Abortion is illegal; as a consequence women go secretly to Great Britain.

Until 1981, contraception has also been illegal. Since family planning centres exist. The free sale of condoms began only in 1986.


Emergency contraception is considered as an abortive practice and consequently not available.

Italy

The law legalising abortion came into force in 1978, the limit is 12 weeks of amenorrhoea. A medical certificate is necessary, and a waiting period of 7 days has to be respected. Terminations are performed in the public sector. Access varies from one region to another.

Quebec

The law on abortion has been deleted in 1988. Since, there is no law governing abortion. The procedure is therefore subject to an agreement between the



women and her doctor, as with any other medical treatment. The availability of terminations depends on the good will of the doctors. There are 30,000 terminations in Quebec; 125.000 for the whole of Canada.

Sweden

Since 1975, abortion has been authorised up to 18 weeks of amenorrhoea. There are 30,000 terminations a year.

Switzerland

Since 1942, abortion has been authorised if the woman's life is in danger. A certificate signed by 2 doctors is required. The law is strict in theory, but very flexible in its application. Terminations are performed in hospitals, in clinics and private practice.

USA

Since 1973, throughout the country, abortion is legal on the demand of the woman alone, during the first trimester of pregnancy. For the second trimester of pregnancy, laws vary in different states. For the third trimester of pregnancy, throughout the entire USA, abortion is authorised only to save the life of the woman.

The PROLIFE movement is very powerful, and access to the centres is difficult. There is a serious shortage of trained staff.