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(Room 6)

14:00 - 14:55 WS #34: Abortion - Where Are We Now?

15:05 - 16:00 WS #44: Abortion - Where Are We Now? (Repeated)

Abortion where are we now?

Helen Paterson

With thanks to Alison Knowles

Disclosures

- I am a certifying consultant
- I am an abortion provider
- I am an abortion receiver
- I am Chair of APGANZ
- I am a researcher in the area of abortion and LARC
- I am a woman

Abortion in NZ

- Needs to be in a licensed premise
- 2 certifying consultants
- In the crimes act
- Must fit the legal criteria
- “Mental health” is not defined in the Crimes Act. The ASC has, however, indicated it is comfortable with certifying consultants applying the World Health Organization (WHO) definition of health.
- WHO defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”
- After 20 weeks permanent risk to health

Conscientious objection

- Contraception Abortion and Sterilisation Act (S46)
- Bill of Rights Act 1990
- Human Rights Act 1993
- ***Health Practitioners Competence Assurance Act 2003***
- *174 Duty of health practitioners in respect of reproductive health services*
- *(1) This section applies whenever—*
- *(a) a person requests a health practitioner to provide a service (including, without limitation, advice) with respect to contraception, sterilisation, or other reproductive health services; and*
- *(b) the health practitioner objects on the ground of conscience to providing the service.*
- *(2) When this section applies, the health practitioner must inform the person who requests the service that he or she can obtain the service from another health practitioner or from a family planning clinic.*

Proposed law

- Health procedure
- <20 there would be no statutory test that the health practitioner needs to apply.
- Post 20 weeks

the statutory test would require the health practitioner to reasonably believe that abortion is appropriate with regard to the pregnant woman's physical and mental health, and wellbeing.

Both:

The practitioner would continue to be required to ensure that the woman makes an informed choice and gives informed consent.

- In all cases, existing health law continues to recognise the right of health care consumers to receive an appropriate standard of care by a suitably qualified and competent health practitioner

- A woman can self-refer to an abortion service provider

- The Bill makes it clear that health practitioners must advise women of the availability of counselling services if they are considering an abortion or have had an abortion, but that counselling is not mandatory.

- It clarifies that practitioners who object on grounds of conscience must disclose their objection to the pregnant woman at the earliest opportunity

- The requirement that a practitioner who objects on the grounds of conscience must tell the woman how she can access the contact details of a provider of the service requested.

- A regulation-making power to set up safe areas around specific abortion facilities, on a case-by-case basis

- The Bill retains important criminal offences, with necessary language changes to update and align the terminology with modern drafting.
- It retains the offences—
- • for unqualified people (ie, not health practitioners) who attempt to procure an abortion on a pregnant woman:
- • for unqualified people (ie, not health practitioners) supplying the means for procuring an abortion.

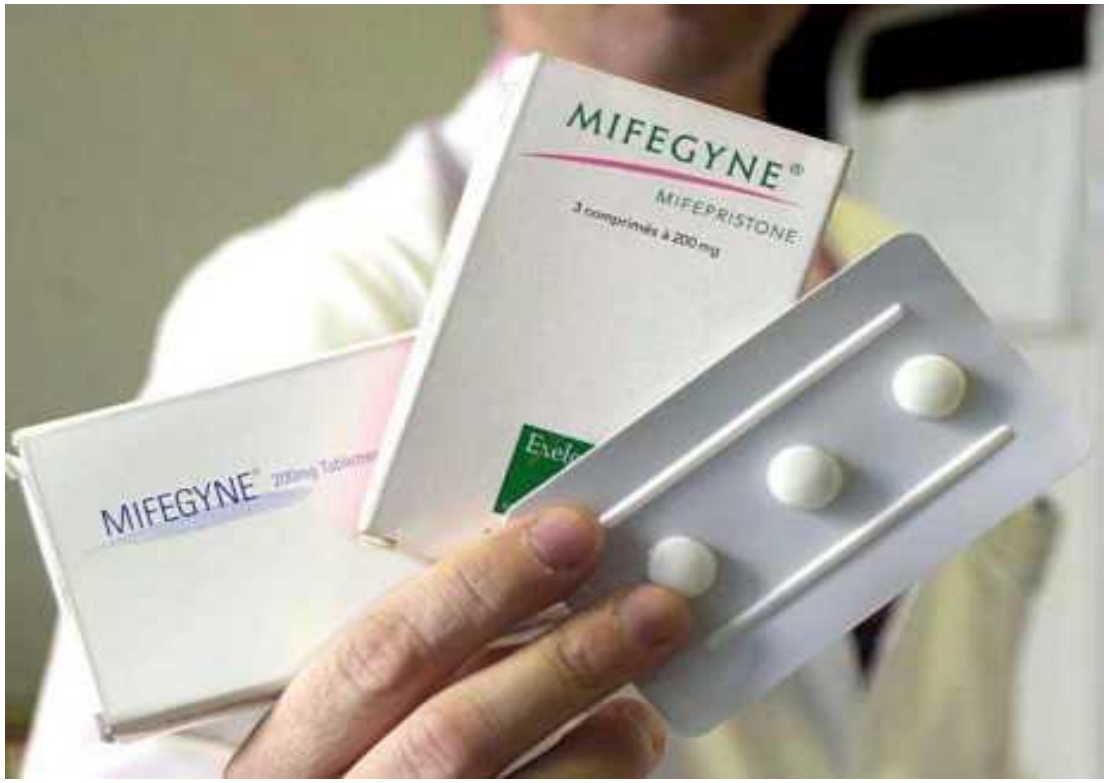
Early medical Abortion

THE LAW AND MEDICAL ABORTION IN NEW ZEALAND

Both Mifepristone and Misoprostol must be given on a licensed premise

Both Mifepristone and misoprostol as recommended by the ASC Standards Committee are being prescribed ‘off label’

WHAT IS MIFEPRISTONE AND HOW DOES A MEDICAL ABORTION WORK ?



MODE OF ACTION OF MIFEPRISTONE

- Detachment of the embryo, decrease HCG, luteolysis
- Increase in myometrial activity
- Opening and ripening of the cervix

MODE OF ACTION OF MISOPROSTOL

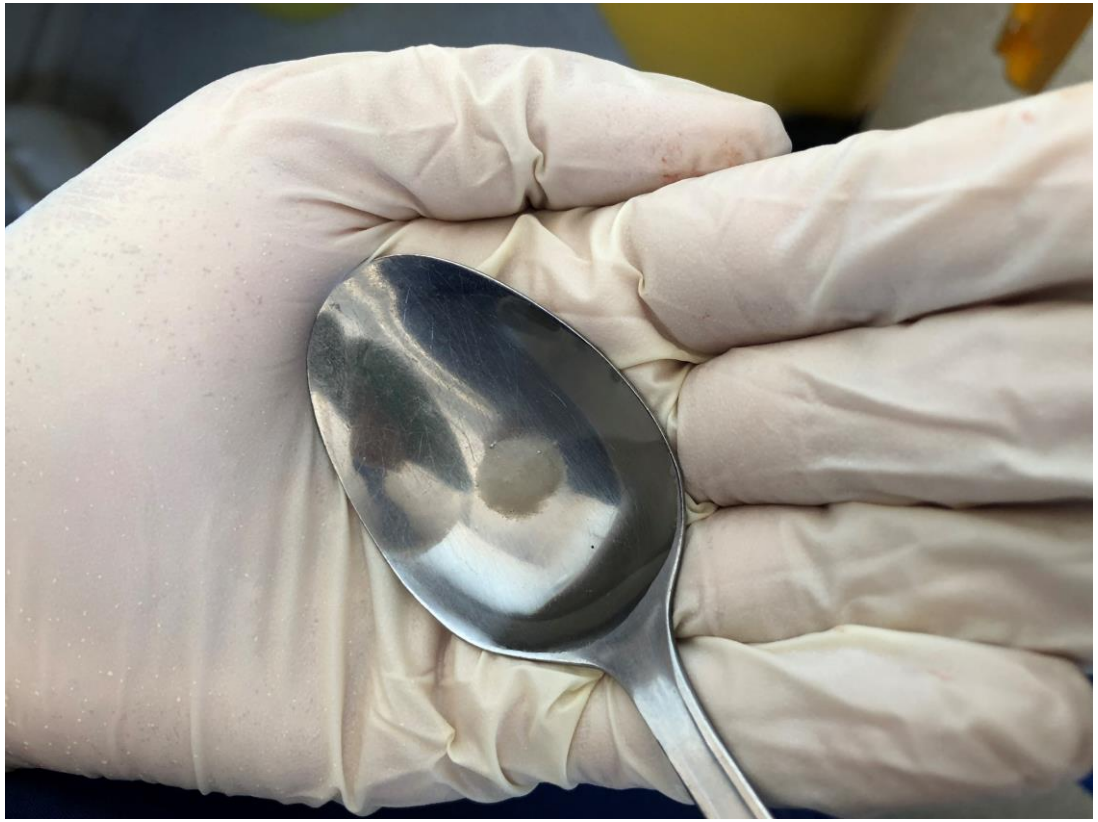
- Misoprostol is an analogue of prostaglandin E1

- Misoprostol causes myometrial contractility and opening and ripening of the cervix

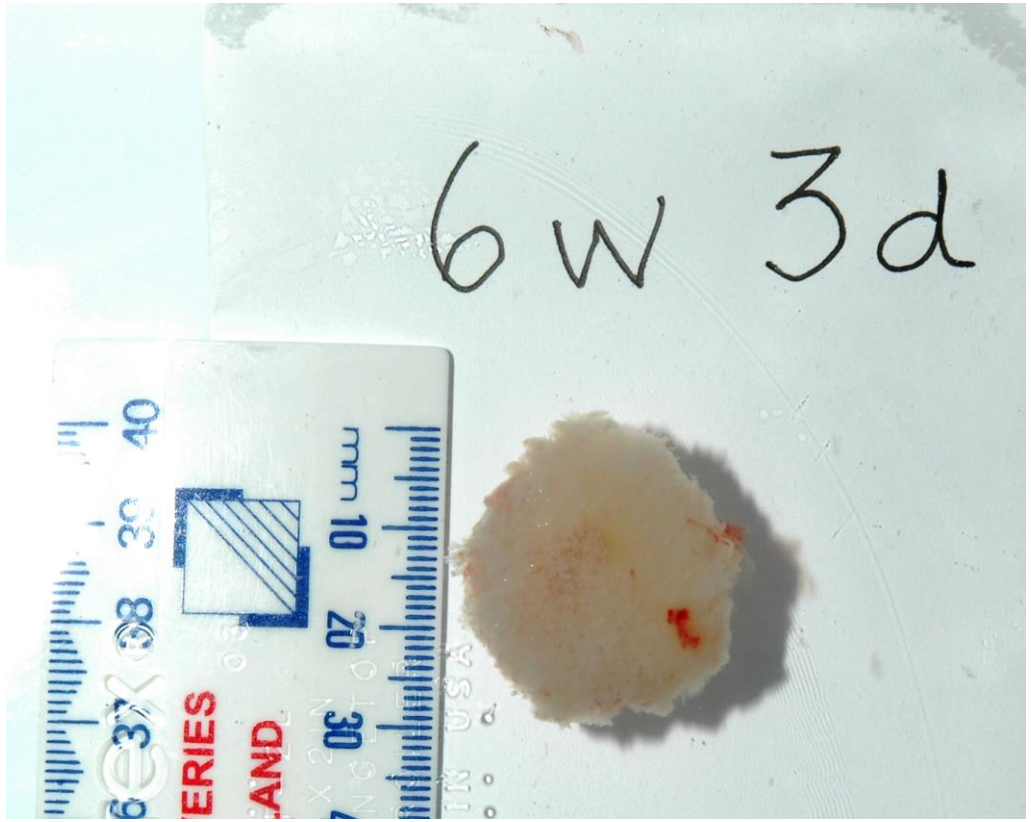
STANDARD REGIMEN

- DAY 1 : Mifepristone 200mg po in licensed clinic
- DAY 2-3 : Misoprostol 800mcg B/SL in licensed clinic
  1st serum HCG at clinic
- DAY 7-14 : 2nd serum HCG in community
- DAY 7-14 : Clinic notifies woman of HCG results

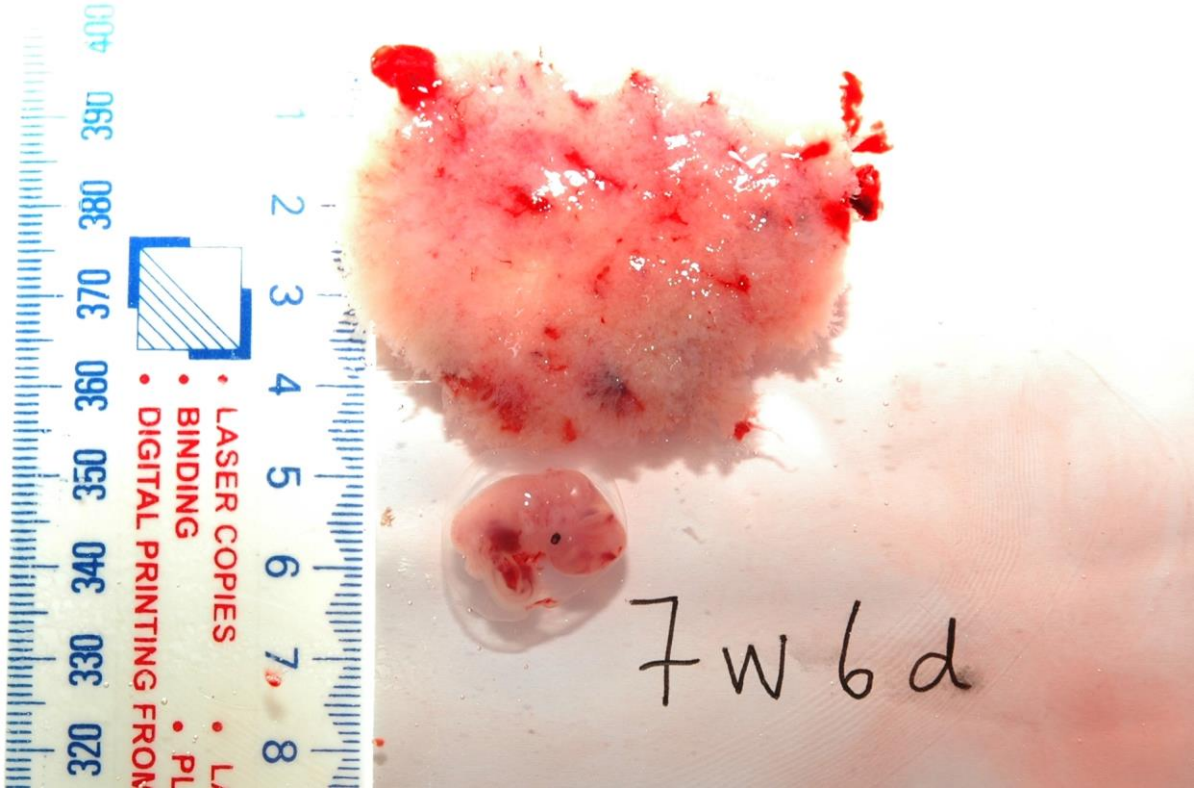
4-5 weeks



6 weeks 3 days



7 weeks 6 days



The effectiveness and safety of EMA is well documented.

Systematic review of 87 randomised trials, cohort or case studies with 47,283 participants < 63 days (9w) showed:

4.8% treatment failure (defined as need for surgical intervention)

1.1% continuing pregnancy

Nearly all studies have mife/miso interval of 36-48 hours because :

*peak effect on uterine contractility

*greatest myometrial sensitivity to prostaglandin

Negative consequences of 36-48 hour delay :

*reduces method choice if one desires short process

*increases likelihood of pain/bleeding before misoprostol

*cost and resource intensive in NZ because of NZ Abortion law (prevents home use of misoprostol)

(Swahn et al BJOG 1988,Creinin et al BJOG 2001,Spitz et al NEJM 2998, Schaff et al 1999)

THE DIFFERENCE A DAY MAKES

- 24 hour interval is

- Effective for abortion through 63 days
- More acceptable than waiting 48-72 hours
- Part of recommended regimens in RCOG, WHO, ACOG, ASC

CAN THIS INTERVAL BE REDUCED FURTHER TO OFFER MEDICAL ABORTION IN ONE DAY?

THE EVIDENCE
SAME TIME vs 24 HOUR

- Creinin MD Obstet Gynaecol 2007

	24 hours	Same time
	(n=546)	(n=554)
COMPLETE ABORTION		
TOTAL	97	95
With one dose misoprostol	94	91

THE EVIDENCE
SAME TIME vs 24-72 hour interval
bpas experience

	SAME TIME (n=683)	NOT SAME TIME (24-72 hours) (N=534)	ODD RATIO (95% CI)
COMPLETE ABORTION. NO SURGERY	92.4%	97.2%	0.3(0.2-0.6)
SURGICAL EVACUATION	7%	2.8%	2.6(1.5-4.8)
ONGOING PREGNANCY	2.1%	0.56%	3.7(1.1-13.0)
NONVIABLE PREGNANCY OR RETAINED GESTATIONAL SAC	2.8%	0.9%	3.4(1.1-0.2)

bpas CONCLUSIONS

SAME TIME HAS HIGHER FAILURE RATE THAN 24+ INTERVAL

- Surgical evacuation 7% vs 2.8%
- Continuing pregnancy 2.1% vs 0.56 %
- More second doses of misoprostol

EVEN WITH THIS KNOWLEDGE LOTS OF WOMEN CHOOSE SAME TIME EMA

- More intensive follow-up
- Experience is still acceptable and preferable to 24h interval

SUMMARY OF SAME TIME STUDIES

- OVERALL FAILURE RATE 5.5%
- OVERALL ONGOING PREGNANCY RATE 1.3%

(Raymond et al Contraception 2013)

HOW DO YOU DECIDE WHETHER TO HAVE A MEDICAL OR SURGICAL ABORTION?

- **Reasons to choose a SURGICAL abortion**
- The procedure takes a short amount of time
- It is more effective than medical abortion (less risk of needing readmission to hospital)
- Women usually do not have heavy bleeding at home
- An IUD or IUS can be fitted at the same time
- No follow-up tests required
- **Reasons to choose a MEDICAL abortion**
- It requires no surgery
- It requires no sedation or anaesthesia
- It has the potential for greater privacy
- Some women feel it gives them greater control over their bodies
- It may feel more "natural" for some women

COMMENTS FROM ACCEPTABILITY STUDIES

- **POSITIVES**
- *better, easier, more harmless than expected
- *felt good, convenient and safe
- *home more comfortable and private
- *partner support possible at home
- *less invasive
- *relieved, natural, safe, 96% recommend to a friend
- *liked awareness of process, greater control, avoidance of aneasthesia, more discreet,
- *women who chose their method were more positive than those who were assigned a method. (95% vs 74%)
- *63% wanted to see what was expelled
- **NEGATIVES**
- *more pain and bleeding than surgical
- *bled for too long, sad saw POC
- *medical abortion more painful than surgical abortion under GA
- *too time-consuming
- *not as quick and easy as expected

ELEGIBILITY CRITERIA FOR MEDICAL ABORTION
clinical criteria

no allergy to misoprostol or mifepristone

no confirmed or suspected ectopic pregnancy OR molar pregnancy

no history of bleeding disorder or on anticoagulants

Haemoglobin > 100g/L

no IUD in situ

no ischaemic heart disease

no renal failure

no liver failure

no chronic adrenal failure

no porphyrias

no severe uncontrolled asthma on steroids

no more than 63 days pregnant (9w0d LMP)

ELIGIBILITY CRITERIA FOR MEDICAL ABORTION personal and social criteria

Must be aware that she has a choice between a medical or surgical abortion

Must have a support person who can be with them throughout the medical abortion process.

Must have a cellphone which she agrees to keep with her and charged throughout the abortion process.

Must have access to transport

Must intend to stay at a place within 2 hours of a hospital which can offer back up surgical gynaecological support throughout the abortion process.

Must agree to attend the clinic on a second day for administration of misoprostol

Must be aware of failure / incomplete abortion rates of 5%.

Must agree that should EMA be unsuccessful/incomplete/complicated, surgical intervention may be necessary.

Must be able to communicate in English or have a support person who can translate for them who will be with them throughout the medical abortion process.

Must accept the possible complications/side effects which can occur during a medical abortion

Must agree to have follow up beta HCG blood tests to confirm completion of abortion

EARLY CARE
IS
BETTER CARE

Questions?

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