DECENTRALIZING ABORTION SERVICES IN VICTORIA: OPPORTUNITIES AND CHALLENGES

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Royal Women’s Hospital: Choices/PAS
OVERVIEW

• The context: access to family planning services in Victoria post abortion law reform
  • Findings of Victorian Women’s Health survey
  • Experience of service provision: public providers

• What models exist
  • Challenges
  • Opportunities

• Medical termination of pregnancy
  • A viable alternative
VICTORIAN ABORTION LAW REFORM 2008

- Removed abortion from the criminal code
- Abortion in Victoria Legal on patient request for all indications up to 24 weeks gestation
- For gestations greater than 24 weeks the opinion of two doctors is required
- Regulates health practitioners performing abortion
- Amends the crimes act of 1958 repealing provisions relating to abortion
- Abolishes common law offence of abortion
  - Creates new offences
ABORTION LAW REFORM

• Section 8
• Obligates practitioners who had a personal/cultural/religious objection to abortion to refer women to a colleague or service that would provide the information/services

• If consulted for info or request for Abortion service
• Must
  • Inform patient regarding conscientious objection
  • Refer the woman to another service
  • If life of woman threatened by pregnancy must perform abortion.
HOW HAS THIS CHANGED PRACTICE?

• For the patient
  • No longer has to demonstrate psychological/physical imperative
  • Does not have to request that abortion be "granted"
  • No mandatory counselling

• For the practitioner
  • Less emphasis on documentation and exploration of “Grounds For Abortion”
  • Assessment of competency/consent/coercion/decision making /risks remain the same but within a closer partnership
  • i.e The ethical issues remain as previously
ABORTION SERVICES IN VICTORIA

- Vast majority are First trimester > 85%
- 90 % in Private service
- Surgical continues to be predominant mode
- Cost approx. similar within private sector
  - This may change with PBS listing of Mifepristone this month
- Surgical second trimester services extremely limited
  - Public RWH /Austin Health
  - Private Variable (1 provider 18 +) costly
- Medical termination for maternal medical or fetal abnormality
  - limited by maternity service providers/hospital resources and staffing
  - Initially tertiary care but increasing confidence in secondary providers
ACCESS TO ABORTION VICTORIA 2013: A METROPOLITAN SERVICE BASE

Public

- Majority Melbourne Based
- RWH largest provider
  - 3 public lists plus 1 partially subsidized per week
- MMC 1 List per week
  - 90 min weekly phone intake
- Austin Health 1 list per fortnight
  - Reduced from weekly in 2010 as result of hospital cuts
- Very sporadic availability in some rural larger towns, not within a dedicated service

Private

- Fertility Control
- Marie Stopes 3 sites
  - E Melb, E St Kilda, Maroondah
- Limited services:
  - Monash
  - some availability triaged through public intake
  - Hampton Park
  - Women’s clinic in Dandenong
PAS AT THE WOMEN’S

• De facto state wide service

• Inability to deal with huge no. of enquires every day

• Accommodates 1/3 of all requests heard

• Actively manages intake by means testing
  • Health care card holders 30 / week
  • Partial Medicare subsidy approx. 12
  • Ability to provide MTOP increasing
25 participants all rural regions

- Highly variable access to family planning services/ pregnancy advice locally.
- Paucity of providers of MAP in small towns
- School based adol nurses limited ++ in options may provide
- Confidentiality/ lack of anonymity seen as biggest barrier to access
- Cost and need to travel major impact

Loddon Mallee, Goulburn NE, Gippsland Barwon West, Grampians

- majority aware of Vic Law reform
  - 90% reported no change to their practice of referral/availability
  - Vast majority referred out of town / Melbourne
  - 3.5% stated a local option for abortion<12 weeks
RURAL BASED ABORTION SERVICES

• PUBLIC
  • Ballarat
    • Limited availability on general gynaecology lists minority of gynaecologists
  • Bendigo
    • Fledgling service intermittent
    • Reestablished in 2013 fortnightly list <13 weeks
  • Shepparton  ? Limited availability
  • ? Echuca
  • ? Other

• PRIVATE
  • No data available
  • Anecdotal evidence of occasional referrals possible in some areas
BARRIERS FOR PROVISION OF SERVICES

• Surgeon individual decision
  • Conscientious objection,
  • fear of public response, reaction in small centres
  • Lack of privacy
  • Peer group pressure
  • Employment consequences at private/religiously funded institutions

• Availability of other willing staff
  • Anaesthetists
  • Nursing
  • Administrative
  • Lack of training/support for GP providers
  • And UNTIL RECENTLY..... Lack of access to medical options
POSSIBLE MODELS

• Hub and Spoke
  • Central provider with training, research protocol development roles providing range of sexual health services including contraception and abortion care
  • Secondary providers in an arc providing some of services with direct referral pathways, using same care guidelines
  • Examples: Scotland, Canada
• **DRIVE IN DRIVE OUT**

• Regional centres contract services, surgical, anaesthetic, medical while providing physical facilities and back up
  • May or may not have centrally or locally developed management guidelines
  • May also include MTOP clinic services

• Examples New Zealand Scotland
LOCAL BASED AND STAFFED SERVICES AS PART OF LOCAL SEXUAL HEALTH STRATEGY

- Surgical services
- Locally staffed and run service with referrals from local providers
- Able to respond to local need
- Less travel time
- Privacy / anonymity issues

- MTOP service
- Either run from 1 specific clinic with on site or off site pharmacy/ USS services
- Group of collaborating prescribers working from their individual clinics
- Early and rapid response required
  - Essential that women have awareness of the how and where of such a system
SURGICAL OR MEDICAL? FACTORS RELEVANT

Ideal situation
- Personal preference
  - Method
  - Length of procedure
  - No of appointments
  - Contraception provision/convenience
- Medical indications
- Timing/convenience

Current climate
- What is available in my region
- Cost/Distance/time off work/family responsibilities
- Confidentiality issues
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MIFEPRISTONE WHAT IS IT?

- Developed France
  1980s ru486
- Antiprogestagen
- Induces
  - abortion in 60%
  - pregnancies<7w
  - With misoprostol over 90%
USES OF MIFEPRISTONE

• Emergency contraception
• Induction of menses
• Induction of abortion
  • 1st trimester
  • 2nd trimester
  • Labour in management of FDIU
AUSTRALIA: MIFEPRISTONE ELIGIBILITY TGA

- Pregnancy < 49 days TGA approval and PBS listing criteria
  - (data on <63 days is reassuring)
- Role in 2nd and 3rd trimester MTOP and mx of fetal loss

- Contraindications
  - Bleeding disorder, ectopic, adrenal failure cortico steroid dependent, porphyria, iucd in situ
  - Hypertension, cardiac, hepatic or liver disease, severe anaemia
MIFEPRISTONE/MISOPROSTOL REGIMEN
GENERAL PROTOCOL

• Day 1 (Clinic)
  • Clinician counsels the woman, takes a medical history and performs an exam and lab tests
  • USS to confirm intrauterine site and gestational age
  • Mifepristone is orally administered

• Day 2-4 (Home or clinic)
  • Misoprostol is administered

• Day 7-14 (Clinic)
  • Patient returns to the clinic for follow-up /phone contact and bhcg
  • Clinician assesses for the completion of the abortion
    • Including Clinical History, Repeat BHCG (quantitative, urine) +/- USS
### MIFEPRISTONE/MISOPROSTOL REGIMENS COMPARISON OF PROTOCOLS

<table>
<thead>
<tr>
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<th>French Regimen</th>
<th>US: FDA Regimen</th>
<th>Evidence-Based Regimen</th>
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<tbody>
<tr>
<td><strong>Mifepristone Dosage</strong></td>
<td>600 mg (Day 1)</td>
<td>600 mg (Day 1)</td>
<td>200 mg (Day 1)</td>
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<tr>
<td><strong>Misoprostol Dosage</strong></td>
<td>400 µg, PO</td>
<td>400 µg, PO</td>
<td>400 µg, PO or 800 µg, PV</td>
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<tr>
<td>Or 1mg gemeprost, PV</td>
<td></td>
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<tr>
<td><strong>Gestational Limit</strong></td>
<td>≤ 49 days</td>
<td>≤ 49 days</td>
<td>≤ 63 days</td>
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<td><strong>Location of misoprostol</strong></td>
<td>At medical office/clinic</td>
<td>At medical office/clinic</td>
<td>At medical office/clinic or at home</td>
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<tr>
<td><strong>administration</strong></td>
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<tr>
<td><strong>Timing of misoprostol</strong></td>
<td>Day 2 or 3</td>
<td>Day 3</td>
<td>Day 2, 3, or 4</td>
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<td><strong>administration</strong></td>
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<tr>
<td><strong>Timing of initial follow-up</strong></td>
<td>Day 10 to 14</td>
<td>Day 14</td>
<td>Day 4 to 14</td>
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<td><strong>examination</strong></td>
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<tr>
<td><strong>Number of clinic visits</strong></td>
<td>Three or more</td>
<td>Three or more</td>
<td>Two or more</td>
</tr>
<tr>
<td><strong>required</strong></td>
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</table>
SUCCESS RATES

• 93-98% leads to complete abortion

• In the remainder curettage necessary to evacuate the uterus
MIFEPRISTONE/MISOPROSTOL REGIMEN
SIDE EFFECTS

Effects of abortion process

- Cramping
  - Often described as similar to menstrual cramps
- Vaginal bleeding
  - Median bleeding time 9-13 days
  - Often described as similar to a heavy period or spontaneous miscarriage

Common side effects

- Nausea
- Vomiting
- Diarrhea
- Headache
- Dizziness
- Fever, chills, hot flashes, warmth
COMPLICATIONS

• Pain and bleeding
  • Usually NSAIDS effective
  • Bleeding heavier than a period
    • Occasionally greater than 1 soaked pad per hour
    • Usually self limiting once products have been passed

• Infection
  • Rarely severe
  • As significant as for surgical procedures
  • Warrants “screen and treat” or prophylactic antibiotics at time of misoprostol admin.
COMPLICATIONS CONTINUED

• ? teratogenicity
  • Several reports misoprostol and limb defects, Mobius syndrome

• Severe bleeding requiring curette 1%

• Transfusion rate 0.1%

• 2-5% require aspiration of retained products of conception
  • similar to outcomes in expectant Management of miscarriage
6w 3d
PATIENT ACCEPTABILITY APPROX. 90%

• +ve
  • Choice
  • Ability to avoid anaesthesia
  • Privacy
  • Convenience

• -ve
  • Prolonged bleeding
  • No of clinic/Dr visits
  • Uncertainty as to whether complete
  • Timing of contraception
OPPORTUNITIES AND CHALLENGES

Opportunities
• Under new and innovative service models
  • Provides a real alternative to surgical procedure and attendant barriers to access i.e. rural and remote women
  • Rural services greatly enhanced if workable model developed

Challenges
• Identification, education, support of service providers/hospital based care if necessary prescribers and dispensers.
• Development of standardized models of care to avoid confusion and allow appropriate audit and research
• Developing information and referral pathways so women meet the early gestational criteria
• Follow up and contraception / Timing of Long acting reversible Contraception
MTOP SERVICE : KEY CONSIDERATIONS

Organisational
- Training and support of staff
- Establish Collegial links
- What model of service delivery
- Community awareness of service

Clinical
- Rapid appointment response needed
- Recourse to early USS
- Relationship with pharmacy
- Relationship with local services for clinical complications
- Clear follow up / on call advice service essential.
HOW TO BECOME A PRESCRIBER

• On line training and testing via Marie Stopes international MS2 website

• Approx 3-4 hrs.

• FRANZCOG members upload qualification

• Monitoring of prescriptions continues by dispensers

• Emergency MS 24 hr. advice line offered
KEY ISSUES

- Access to early detection of pregnancy, information and advice
- Provision of counselling services as needed/requested
- Efficacy and safety is greatest for earlier gestations < 7 weeks

- Coordinated care with
  - Standardised protocols
  - Clear follow up
  - Access to 24 hr advice
  - Availability of emergency services if necessary
  - Engagement of agreement with other service providers
WHAT CAN WE OFFER

• Advice re clinical set up
• Guideline development to fit local situation
• Mentorship/support
• Referral pathway
• Local service providers can contract personnel and skills.

• ALL Require LOCAL partnerships.