



Children by Choice
Association Incorporated

Providing pro-choice
counselling, information
and education services on
all unplanned pregnancy
options – abortion, adoption
and parenting

Contact Details...

phone 07 3357 5570
or free call 1800 177 725
(within Queensland)

fax 07 3857 6246

postal address
PO Box 2005
Windsor QLD 4030

street address
237 Lutwyche Road
Windsor QLD
Australia

info@childrenbychoice.org.au

www.childrenbychoice.org.au

Medical abortion – is it a reality for Australian women?

In 2006, thanks to the efforts of persistent politicians and dedicated groups such as CbyC, the Australian Government voted to remove the Federal Health Minister's veto on the importation of the medical abortion drug Mifepristone (RU 486). This decision paved the way for medical abortion to become a choice for Australian women. However Mifepristone continues to be almost inaccessible for some women considering abortion with an unwanted pregnancy.

Queensland obstetrician and gynaecologist, Dr Caroline de Costa and a Cairns colleague were the first to obtain permission to prescribe Mifepristone in Australia. Since gaining import permission in June 2006, Caroline de Costa and her colleagues have successfully treated a small number of women.

After June 1st 2007, more Australian women have had access to medical abortion, with *Marie Stopes International* (MSI) clinics introducing a Methotrexate-Misoprostol regimen. This was a win for woman's access to medical abortion, however MSI and other experts agreed that while Methotrexate is highly effective in pregnancy termination, its use is necessitated by the difficulty in accessing Mifepristone, which is the ideal drug for use in medical abortions¹.

Other doctors have since followed in gaining approval to prescribe the drug, mostly in the last 12 months, with the result that Mifepristone is now available as a choice for women through some clinics in Australia.

Why is Mifepristone difficult to access?

The Therapeutic Goods Administration (TGA) is responsible for assessing applications from medical practitioners who wish to become 'Authorised Prescribers' of Mifepristone, because it is currently a restricted drug. Detailed legal requirements may be a deterrent to applicants, who are required, among other things, to gain approval from an 'appropriate ethics committee'².

Medical practitioners outside the hospital system must exhaust a number of avenues before seeking endorsement from an appropriate College. Within the hospital system, medical practitioners may be inhibited by an ethics committee which does not support an application, or dictates rigid treatment conditions,

or does not see such support as their responsibility (for example taking a view that the drug should be subject to *medical* rather than *ethical* grounds for prescription).

Also hindering the availability of Mifepristone is the absence of any Australian-based pharmaceutical companies electing to apply to the TGA to manufacture and market the drug. Nor has a foreign-based pharmaceutical company applied to import and distribute the medication. It is hoped that this unusual situation will soon be remedied, though it is unclear if there are any applications being prepared.

The import problem could also be solved by following New Zealand's example, where after their own lengthy legal and political battles, a group of doctors founded the non-profit company *Istar* to import Mifepristone to their country³.

Our Vision ...

All women have the knowledge and power to take control of their sexual health and reproductive choices.

Mifepristone vs Methotrexate

While Mifepristone is the ideal drug for use in medical abortion, international research indicates that Methotrexate is also highly effective.

Methotrexate has traditionally been used in the treatment of some cancers and other conditions. While Methotrexate acts to stop fast growing cells (such as embryonic cells), and consequently inhibits progesterone levels, Mifepristone directly blocks the action of the hormone progesterone that is needed to sustain a pregnancy. This results in changes to the lining of the uterus, detachment of the pregnancy and softening of the cervix.

For most medical abortions to be complete, a second drug called Misoprostol is given at a later stage. Misoprostol causes the uterus to contract, and helps the pregnancy tissue to pass (similar to a miscarriage).

Support us ...

Make a donation today and ensure that we can continue to make a positive difference for women.

Membership of the association is open to all who agree with our aims.

Call us to explore opportunities to volunteer.

Misoprostol and Methotrexate are used 'off-label' in abortion procedures, which is a common practice where drugs are licensed for particular purposes but have evidence-based acceptance for other purposes (and where patients are informed of this status).

Useful Resources...

See references below &:

www.arha.org.au
www.childrenbychoice.org.au
www.maristopes.com.au
www.reproductivechoiceaustralia.org.au

© Children by Choice 2007

Disclaimer:
This information is intended as a general guide only. Whilst every effort has been made to ensure the accuracy of this information, we accept no responsibility for errors or omissions. This information is no substitute for independent professional advice.

The table below illustrates a comparison of Mifepristone and Methotrexate.

	Mifepristone	Methotrexate
The drug	Also known as RU 486. A synthetic antiprogesterone which blocks the action of progesterone.	A folic acid antagonist. Relies on its 'ability to inhibit trophoblast growth and consequently progesterone levels'.
Licensing	Restricted by TGA for abortions: Doctor requires 'Authorised Prescriber' approval.	Used 'off-label' for abortions and other OBGYN procedures. Registered for use in cancer treatment.
Treatment	Misoprostol given 1-3 days later.	Misoprostol given 5-7 days later.
Timing until complete	90% complete abortion within 4-6 hours of first Misoprostol dose ⁴ . 2% may take longer. 3% will 'miscarry' with Mifepristone alone.	60% complete within 24 hours of first Misoprostol dose. May take 3-4 weeks to reach 90% thus 30% require additional time/doses.
Side-effects	'Pain, cramping and vaginal bleeding (usually 9-15 days) result from the abortion process itself and are expected'. Other side-effects include diarrhoea (10-30%), vomiting (10-45%), and nausea (40-70%). Dizziness, headache, chills, shivering and fever are also reported ⁵ .	Similar effects as noted for Mifepristone.
Complications	5% require surgical termination, usually for incomplete or missed abortion	10% require surgical termination, usually for incomplete or missed abortion.
Effectiveness	95% up to 63 days gestation.	90% up to 49 days gestation.
Other facts	Registered for use in 33 countries around the world for safe abortion ⁶ .	Considered acceptable in countries where Mifepristone is unavailable.

Medical abortion and the law

At present, sections of the *Queensland Criminal Code (1899)* (Sections 224, 225 and 226) may be read to apply criminality to abortion. The usual defenses which make surgical abortion legal and accessible were, until September 2009, specific to 'surgical operations' so were not directly relevant for medical abortions. This has now been remedied by amendments passed in Queensland Parliament but it remains unclear whether these changes will provide enough certainty for more doctors to become involved in medical abortion provision. Medical abortion is available in some areas of Queensland but access remains patchy across the state.

However, in the instance of Mifepristone the TGA has approved use by Authorised Prescribers. Such prescription is lawful, in

compliance with the *Health (Drug and Poisons) Regulation 1996 (Qld)*, so it is often argued that the laws do not need to change to allow for legal medical abortions⁷. It is assumed that this also applies legality to the off-label prescription of Methotrexate and Misoprostol for use in abortions.

With both medical and surgical abortion, a difference still exists between legal and illegal treatments, based on the doctor's assessment of the woman's health and the doctor's actions in treatment protocols.

¹ Marie Stopes International, 2007 'Medical Abortion Now an Option for Women in NSW, QLD and WA', 30/05/07, Online: http://www.mariestopes.com.au/news/media_releases/medical_abortion_now_an_option_for_women_in_nsw_qld_and_wa Accessed 05/06/07.

² Therapeutic Goods Administration, 2006 'Frequently asked questions – Authorised Prescribers', Online: <http://www.tga.gov.au/unapp/apfaq.htm> Accessed 05/06/07.

³ Sparrow, M. 2004 'Introducing mifepristone into New Zealand', Online: http://www.arha.org.au/e-newsletter/ARHA%20documents/IntroducingMifepristoneNZ_June_2004.pdf Accessed 05/06/07.

⁴ World Health Organisation, 2003. 'Safe Abortion: Technical and Policy Guidance for Health Systems', Geneva, Switzerland. Online: http://www.who.int/reproductive-health/publications/safe_abortion/safe_abortion.pdf Accessed: 02/10/2006.

⁵ Royal Australian and New Zealand College of Obstetricians and Gynaecologists, 2005. 'Termination of Pregnancy: A Resource for Health Professionals', RANZCOG, Melbourne, Australia. Available online: www.ranzcog.edu.au/womenshealth/pdfs/Termination-of-pregnancy.pdf

⁶ Australian Reproductive Health Alliance, 2005, 'Fact Sheet: Mifepristone (RU 486)', Online: <http://www.arha.org.au/factSheets/mifepristone.pdf> Accessed 05/06/07.

⁷ De Costa, C. & de Costa, N. 2006. *Medical Abortion and the Law*, 'The University of New South Wales Law Journal: Forum: Reproductive Rights and the Law', Vol.12, No.1, pp.13-16.