POSITION STATEMENT

Very Early Medical Abortion (VEMA)

Children by Choice supports the provision of Very Early Medical Abortion (VEMA) by experienced MTOP providers in Queensland, based on global evidence and practice that indicates it is a safe and sometimes preferred alternative to current MTOP practice.

We use the terms 'termination of pregnancy' and 'abortion' interchangeably throughout this statement to acknowledge the preferences and norms of and among our diverse stakeholders. We also use the terms women and pregnant people, together and separately, depending on the context of a statement and/or specificities of the research being cited, and recognise that it is not only women who seek and have abortions.

Recommendations

- We recommend the expanded provision of VEMA by MTOP practitioners trained and experienced in screening for ectopic pregnancies.
- Further research into the acceptability and safety, and barriers to the provision and uptake of VEMA in Australian populations is needed, acknowledging the current clinical trial underway in NSW.
- Advocacy around VEMA should focus on its safety and benefits for abortion seekers, including minimised wait times, potential for reduced pain and bleeding, and an equity lens that acknowledges VEMA's potential to increase access for people who may not be able to access, for any reason, timely ultrasound.
- Existing networks of/for MTOP providers should work to incorporate support for VEMA into their informal and formal networks, conversations and education, including identifying, reporting and addressing (where possible) barriers to provision – systemic and individual.

Background

Very Early Medical Abortion (VEMA) refers to medical termination of a pregnancy (MTOP) in an undisclosed/unconfirmed location (PUL) with mifepristone and misoprostol, known in Australia as MS2Step. It is becoming increasingly recognised internationally as a safe alternative to current early medication abortion (EMA) practice, which requires an ultrasound to confirm a pregnancy location prior to the

administration of MS2Step, resulting in sometimes significant delays from the time a pregnancy is identified to when an abortion is accessible/undertaken.

In Queensland, similarly to around Australia, current MTOP practice includes waiting for identification of an intrauterine pregnancy via ultrasound, usually around 6 weeks gestation, before initiating an abortion. VEMA can be conducted as early as 1 day after a missed period, or as soon as pregnancy is confirmed[1]. The risk of missing an ectopic pregnancy is seen as the primary risk of not confirming pregnancy location prior to abortion.

While Australia's first clinical trial of VEMA outcomes is still underway, as is a Randomised Control Trial (RCT) in the UK[2], a suite of international research and clinical guidelines indicate that VEMA is acceptable to pregnant people and health professionals, and likely a safe and possibly less-painful alternative to MTOP after confirmed pregnancy location. In Australia and Sweden, Bisjak and colleagues[3] found that MTOP under 49 days gestation resulted in a rate of ongoing pregnancy and need for surgical follow-up that is similar (slightly lower) to that of MTOPs conducted at later gestations (at which ultrasound identification of pregnancy location is possible). The rate of incomplete abortion with VEMA was shown to be significantly lower than in later MTOPs[4].

VEMA in Practice

Clinical and organisational guidelines from the UK and Australia recommend VEMA/abortion before ultrasound evidence to be a safe alternative to ultrasound-informed MTOP if it is the pregnant person's preference, and recognise that it may reduce the risk of retained products, and reduce pain and bleeding when conducted earlier in pregnancy (NICE Guidelines Sept 2019; Therapeutic Guidelines Australia). VEMA has been found to have high levels of acceptability among MTOP providers across Europe[5].

In place of an ultrasound, or in cases where an ultrasound identifies an empty uterine cavity, serial serum beta-hCG tests are used to confirm pregnancy, exclude ectopic pregnancy and determine the efficacy of a VEMA. An unexpected beta-hCG result post-VEMA (including lack of the characteristic fall of beta-hCG to indicate a successful MTOP) along with screening by an experienced practitioner prior to VEMA are used to identify possible ectopic pregnancies[6]. This helps to address the primary concern of missed ectopic pregnancies from a lack of ultrasound prior to abortion. Studies have shown, however, that MTOP conducted on ectopic pregnancies don't produce harmful effects[7]. Ectopic pregnancies have been found to be rare among abortion seekers (.2-.3% of people presenting for MTOP)[8].

Accessibility and Equity

Minimising delays between the time of pregnancy confirmation to abortion has important implications for accessibility, choice, safety and wellbeing for abortion seekers.

Women and people who can become pregnant who experience family and domestic violence and/or sexual assault (FDVSA) are more likely to experience an unintended pregnancy, to have one or more abortion experiences[9] and to experience an abortion at later gestational age[10]. Reproductive Coercion and Abuse (RCA) (see Grace and Anderson 2016 for definition) can both increase the need for and limit access to abortion services for women and pregnant people.

People living outside of metropolitan areas in Australia face significant barriers to access to abortion care and related services[11], including ultrasound services. Furthermore, young people, people from migrant and refugee backgrounds, and people facing socio-economic disadvantage face increased barriers to SRH care, including abortion services, given the limited availability of services and frequent high out-of-pocket costs.

Eliminating delays, side-effects and the need for multiple appointments is likely to support abortion access for abortion seekers living with RCA, coercive control and/or FDVSA. Access to VEMA also has the potential to increase abortion accessibility for people living long distances from health services (including ultrasound services), or those who can't access multiple services for a range of other reasons. We note, for example, recent significant delays in access to and limited bulk billed/affordable ultrasound in some areas of Queensland, delays which could be circumvented through the implementation of VEMA. VEMA protocols can also enable easier access to MTOP via telehealth, provide increased privacy for patients and reduce delays caused by the need to mail 'hard copies' of request forms.

Feedback from stakeholders indicates that despite the potential of VEMA to improve accessibility for abortion seekers, it is important that VEMA patients reliably attend post-VEMA blood tests to ensure the effectiveness of the medications and to exclude continuing ectopic pregnancies. We acknowledge there are a range of personal, social, cultural and economic complexities and systemic barriers many abortion-seekers face which may impact their ability to reliably access abortion and related follow-up care. As such, ongoing advocacy and support – both systemic and with and for individual abortion seekers at the time of seeking care – to address barriers to engagement with follow-up care is needed. Where/when such advocacy isn't possible and barriers to follow-up blood-tests and care pervade, practitioners may not find it possible to safely provide VEMA to certain patients or populations.

Acknowledgments

Children by Choice wish to acknowledge the contributions and feedback offered by Dr Angela Smith. Dr Claire Mohr, our staff team and Advocacy working group.

About Children by Choice

Children by Choice is a non-profit organisation, committed to providing evidence-based information on all pregnancy options - abortion, adoption, alternative or kinship care and parenting.

Our pregnancy options counselling, information and referral service is Queensland-wide. Our education and training operate across Australia.

We also advocate for improvements to law and policy that would increase women's access to reproductive health services and information. We are recognised nationally and internationally as a key advocacy group for the needs and rights of women in relation to reproductive and sexual health.

We are funded by the Queensland Department of Justice and Attorney-General to provide our counselling and some of our community education services. We rely heavily on our members, supporters, and volunteers to assist us in our non-funded work, and are a registered charity with the Australian Charities and Not-For-Profits Commission.

Contact:

admin@childrenbychoice.org.au

References

- Bizjak I, Fiala C, Berggren L, Hognert H, Sääv I, Bring J, Gemzell-Danielsson K 2017, Efficacy and safety of very early medical termination of pregnancy: a cohort study, BJOG, Vol. 124, no.13, pp. 1993-1999, doi: 10.1111/1471-0528.14904

- Cameron S 2018, Recent advances in improving the effectiveness and reducing the complications of abortion, F1000Research, 7, F1000 Faculty Rev-1881, https://doi.org/10.12688/f1000research.15441.1

- Doran, F and Hornibrook, J 2016, Barriers around access to abortion experienced by rural women in New South Wales, Australia, Rural and Remote Health, vol. 16, no.1, 3538.

- eTG 2021, Very early medical abortion, Therapeutic Guidelines.

- Fiala, C, Bombas, T, Parachini, M, Agostini, A, Lertxundi, R, Lubusky, M, Saya, L, Danielsson, K G, 2020, Management of very early medical abortion—An international survey among providers, EJOG, Vol. 246, pp.169-176.

- Goldberg, A 2018, Safe medical abortion at very early gestation, The 13th FIAPAC Conference: Liberating women – removing barriers and increasing access to safe abortion care, Nantes, France, 14-15 september 2018, International Federation of Professional Abortion and Contraception Associates, available: file:///C:/Users/KariVallury/Desktop/Goldberg%20vemA.pdf

- Grace K T, Anderson J C 2018, Reproductive Coercion: A Systematic Review, Trauma, Violence, & Abuse, vol.19, no. 4, pp.371-390, doi:10.1177/1524838016663935

- Kapp, N, Baldwin, M K, Rodriguez, M I 2018, Efficacy of medical abortion prior to 6 gestational weeks: a systematic review, Contraception, Vol. 97, No.2, pp. 90-99, https://doi.org/10.1016/j.contraception.2017.09.006.

- Miller E, Decker M, McCauley H, Waldman J, Schoenwald P, Silverman J 2010, Pregnancy coercion, intimate partner violence and unintended pregnancy, Contraception, Vol. 81, no.4, pp. 316-322.

- NICE 2019, Abortion care. [F] Abortion before ultrasound evidence. NICE guideline NG140, Evidence reviews, National Guideline Alliance, Royal College of Obsetricians and Gynecologists, Available: https://www.nice.org.uk/guidance/ng140/evidence/f-abortion-before-ultrasound-evidence-pdf-6905052978

- Pallitto C, García-Moreno C, Jansen H, Heise L, Ellsberg,M & Watts C 2013, Intimate partner violence, abortion, and unintended pregnancy: Results from the WHO Multi-country Study on Women's Health and Domestic Violence, International Journal of Gynecology & Obstetrics, Vol. 120, No. 1, pp. 3-9, https://doi.org/10.1016/j.ijgo.2012.07.003

- Thakuri D S, GhimireP R, Poudel S & Khatri R B, 2020, Association between Intimate Partner Violence and Abortion in Nepal: A pooled analysis of Nepal demographic and health surveys (2011 and 2016), BioMed Research International, https://doi.org/10.1155/2020/5487164.

- The Gynae Centre UK, Very Early Medical Abortion (VEMA), 2021, The Gynae Centre UK, London, available: https://www.gynae-centre.co.uk/our-services/very-early-medical-abortion-vema/.

- WHO 2012, Understanding and addressing violence against women, World Health Organisation, available: http://apps.who.int/iris/bitstream/handle/10665/77432/WHO_RHR_12.36_eng.pdf;jsessionid=C99F2127AE852B5F8CFF2D13849DE72E?sequence=1.

- Wright, L 2019, Very Early medical Abortion (VEMASCOT), University of Edinburgh and NHS Lothian, Clinical trial identifier: NCT03989869, available: https://clinicaltrials.gov/ct2/show/NCT03989869.