

**14 January 2006**

**Submission to the Senate Community Affairs Legislation Committee**

**Re: Therapeutic Goods Amendment (Repeal of Ministerial responsibility for approval of RU486) Bill 2005**

**Submission from Dr Margaret Sparrow representing Istar Ltd, Wellington, New Zealand**

**Introducing Istar Ltd:**

Istar is a not-for-profit company incorporated under the Companies Act 1993 on the 22 February 1999. All five Directors are specialist medical practitioners experienced in abortion care. The company was formed specifically to import mifepristone into New Zealand, no other pharmaceutical firm wishing to be involved because of the sensitive nature of abortion. The Directors were familiar with international developments and recognised the desirability of introducing medical abortion as an option for New Zealand women.

**Reasons for making a submission:**

**(1) Close links between Australia and New Zealand therapeutic regulators:**

While acknowledging and respecting differences between the two countries Istar is aware of the close cooperation of the Therapeutic Goods Administration (TGA) in Australia and Medsafe (NZ) since the signing of a Memorandum of Understanding between the two regulators in May 1993. This process of harmonisation culminated in the signing of an agreement on 10 December 2003 by the two Governments for the establishment of a joint scheme for the regulation of therapeutic products.<sup>1</sup> The primary objective of this agreement is to safeguard public health and safety in Australia and New Zealand by establishing and maintaining a joint scheme consistent with international best practice for the regulation of the quality, safety and efficacy or performance of therapeutic products, and of their manufacture, supply, import, export and promotion. Article 12 makes allowance for departures from the scheme by one party in exceptional circumstances.

**(2) Close links between Australian and New Zealand professional organisations:**

There is extensive interchange between health professionals in both countries. Four of the Directors of Istar are Fellows of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) and three are Fellows of the Chapter of Sexual Health Medicine of the Royal Australasian College of Physicians (RACP). Dr Margaret Sparrow was a member of the Termination of Pregnancy working party for RANZCOG which published a resource for health professionals in November 2005.<sup>2</sup> Colleagues in Australia have expressed their frustration at not being able to provide mifepristone for medical abortion or for other indications.<sup>3-5</sup>

### **(3) To provide background on the New Zealand situation:**

Istar has followed the debate on the approval process for mifepristone in Australia and has noted in the Senate committee hearing in Canberra on 15 December 2005 several references to the use of mifepristone in New Zealand. One of these was not accurate. On Pg CA39 of the Hansard transcript Dr Tippett states “In the New Zealand context, a woman might be given the drug to take at home.....” This is not possible because the law in New Zealand requires that both the mifepristone and the misoprostol must be taken in a licensed institution. A brief description of the New Zealand situation has recently been published<sup>6</sup> and further details are offered to assist the committee in its deliberations. This is not to suggest that the New Zealand model should be adopted in Australia. This submission will not deal with more general information which is available from other sources.

### **The New Zealand approval process:**

- May 2000 Istar signed an agreement with the French manufacturer Exelgyn to import Mifegyne® (mifepristone). Other sources from China and the USA were considered but rejected in favour of the French manufacturer which already supplied France (since 1988), the United Kingdom (since 1991), Sweden (since 1992) and 18 other countries. The agreement restricts use to within New Zealand (not Australia) and only for abortion. The agreement does not include other uses of mifepristone e.g. for emergency contraception or for the treatment of other medical conditions. Practitioners wishing to use mifepristone for other conditions must obtain supplies direct from Exelgyn under special authority.
- June 2000 Istar submitted an application to Medsafe, the New Zealand equivalent of the TGA for approval of Mifegyne® as a new higher-risk medicine. The comprehensive dossier including clinical trials was provided by Exelgyn. The packaging was the same as that supplied to the United Kingdom. The usual procedures were adopted as for any other application and the process took 14 months. This included an assessment by the independent Medicines Assessment Advisory Committee. All applications in New Zealand require the approval of the Minister of Health before being gazetted and this approval is usually forthcoming on the advice of Medsafe. The Minister of Health Annette King was kept informed of the process throughout.
- August 2001 On 30 August 2001 the official notice of approval was published in the *Gazette*. Mifegyne® is only available on a restricted basis from Istar and it is only supplied to institutions licensed under the Contraception Sterilisation and Abortion Act. It is not available through pharmacies. The introduction of mifepristone has been documented more fully in journal articles.<sup>7,8</sup>

Following approval there is ongoing monitoring by Medsafe with annual inspection of premises and a review of safety reports with modifications by Istar to the data sheet as required.

### **Abortion legislation in New Zealand:**

In New Zealand the grounds for having a legal abortion are in the Crimes Act 1961 and Amendments and the procedures to be followed are in the Contraception Sterilisation and Abortion Act 1977 and Amendments. All legal abortions must be *performed* in a licensed institution. Initially this requirement presented difficulties for clinics wishing to provide an early medical abortion service. Having an early medical abortion is a two-stage process with the mifepristone given on the first day followed by a prostaglandin, misoprostol, given 36-48 hours later. This second drug causes the expulsion of the uterine contents usually within the next few hours.

Did this mean that both drugs had to be given in a licensed institution and did women need to stay in a licensed institution until the abortion was complete? Because differing legal opinions were obtained Istar requested that the Abortion Supervisory Committee seek a judicial review. The case was heard before a judge of the High Court and his ruling in April 2003 was that both drugs must be taken in a licensed institution but the woman did not need to stay there between taking the drugs nor did she need to stay in the clinic until the process was complete.

Because of this legal problem the first use of Mifegyne® in New Zealand was in October 2001 for a second trimester abortion in a hospital setting. Clinicians report favourably on the use of mifepristone for these later abortions as there is a significant reduction in the time required in hospital.

Between April 2002 and April 2003 (when the law was clarified) Level J Unit at Wellington Hospital was the only clinic offering an early medical abortion service under a very strict protocol that required the woman to undergo a surgical procedure if she had not aborted within 6-8 hours. The protocol was adapted from the published findings and personal communication with Professor Templeton's Unit in Aberdeen, Scotland. An audit of this first year's experience was recently published.<sup>9</sup>

### **Standard protocol for early medical abortion at the Auckland Medical Aid Centre:**

Since July 2003 the Auckland Medical Aid Centre has also offered an early medical abortion service and it is now the largest provider of medical abortions in New Zealand. The protocol used in Auckland is similar to that used in Wellington but with an upper gestational age of 8 weeks. In the first year of use in Wellington the upper gestational limit was 7 weeks but after April 2003 this was increased to 9 weeks. Another difference between the two services is the option for women in Wellington to return home soon after the administration of the vaginal misoprostol. In other countries not restricted by legislation as in New Zealand, it is not unusual for the entire second stage to take place in the woman's own home.

Cases are referred by their primary care physician in the same manner as for a surgical termination but it is essential that an ultrasound scan is carried out to confirm the gestational age and to exclude an ectopic pregnancy.

Other tests are routine antenatal blood tests and screening tests for sexually transmitted infections. Women are seen by a nurse/counsellor and two certifying consultants who must certify that they have legal grounds for an abortion. Because of the risk of fetal abnormality the method is not recommended for those who are unsure about the decision.

Exclusion criteria include having an intrauterine device in place (it must be removed first), chronic renal failure, long term corticosteroid therapy, history of allergy to mifepristone or prostaglandins, haemorrhagic disorders or current anticoagulant therapy. It is not recommended for smokers over the age of 35 years and may be unsuitable for those with heart disease, high blood pressure or diabetes.

Social contraindications include language difficulties, immaturity, lack of support, lack of telephone or transport should an emergency arise. Patients are warned about not taking alcohol or smoking for two days after taking the vaginal tablets. They are also warned not to use illicit drugs. Breast feeding mothers are advised to stop for at least 14 days after taking Mifegyne®.

A choice of medical or surgical procedure is discussed with patients under the gestational age of 8 weeks. Sufficient information on the advantages and disadvantages of both methods is provided to allow for informed consent to be given. The risks and complications of both methods are explained.

One tablet of Mifegyne® is given by mouth on the first day and the woman is allowed to go home after 30-60 minutes. This is to ensure that she does not vomit the tablets. She is given instructions on what to expect and a 24 hour telephone number to ring if assistance is required. In about half the cases there is little or no bleeding but occasionally (3-5%) there is a heavier bleed with pregnancy loss. The woman is advised not to use anti-inflammatory drugs or aspirin which might increase bleeding.

She returns to the clinic after 36-48 hours and is given four tablets of misoprostol inserted vaginally. This usually causes cramping pain and the woman may need pain relief. After four hours a second oral dose of misoprostol is given if there is no progress.

In the majority of cases the pregnancy is expelled after a few hours and the products are examined in water with light projected from underneath to confirm the successful completion of the abortion. At this early stage of pregnancy the most prominent part is not the tiny embryo but the fetal sac and the placenta. Some women ask to see the products and occasionally women ask to take them home for disposal.

The woman is observed for as long as required after the passage of the uterine contents with most being discharged home within an hour to the care of the referring doctor. Verbal and written aftercare information is provided and the woman is advised to have a check up in 10-14 days. Contraception is reviewed. The possibility of heavy bleeding is discussed with all women.

If the abortion has not taken place after 6 hours the woman is offered the choice of a surgical procedure that same day or she can go home to complete the abortion which may take several days. If she decides to go home without a surgical evacuation she is then followed with serial blood tests (beta chorionic gonadotrophin) and daily telephone contact. Follow-up is essential and an appointment is given for 1 week's time to ensure that the abortion is complete. Extra counselling is available if needed.

### **New Zealand Statistics and Guidelines:**

The Abortion Supervisory Committee oversees the implementation of the abortion procedures in New Zealand and presents an annual report to Parliament with statistics on the abortions performed.<sup>10-12</sup> The numbers for Mifegyne® abortions in New Zealand has increased each year and are reported as follows:

2002	203
2003	440
2004	698 (approximately 4% of the total abortions)

Since the introduction of medical abortion there has not been an increase in the number of abortions, in fact in 2004 there was a small decrease for the first time in seven years. The figures from the annual reports of the Abortion Supervisory Committee are as follows:

2002	17,380
2003	18,511
2004	18,211

In September 2004 the Abortion Supervisory Committee issued a report of a technical committee covering all aspects of abortion care using mifepristone.<sup>13</sup>

### **Recommendation:**

Istar supports the Bill which removes responsibility for approval of RU486 from the Minister of Health and Ageing and provides responsibility for approval of mifepristone to the TGA. This would be in keeping with the agreement between Australia and New Zealand for close cooperation as regards the regulation of therapeutic products. In New Zealand mifepristone has been assessed and its use monitored by Medsafe, the New Zealand equivalent of the TGA. The drug has been satisfactorily regulated using the same procedures and controls that are available for other prescription medicines.

## References:

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