Position Statement: Widening the Range of Providers and Settings for Abortions

Background

In the past, most abortions were done surgically and such surgery was the domain of gynaecologists. Neither of these situations now pertain; both medical and surgical abortion procedures can now be safely performed by a range of types of provider. This advance is constrained in a few countries in which the law specifies that abortions are carried out by gynaecologists and in many countries which specify that only physicians may perform abortions. This Statement sets out the evidence for widening the disciplines that can perform abortions and the settings in which they are done. In many settings services have not been modernised and there is scope for expansion of the provider pool.[1]

Task Shifting

Task shifting/sharing is supported by the World Health Organization because it optimises the roles of healthcare workers.[2] It is defined as a process of delegating tasks, where/when appropriate, to less specialised healthcare providers, and has been shown to increase productivity within healthcare systems.[3] Few abortions need the highest level of skills that necessitate gynaecologists to perform them. General practitioners (GPs) can safely and effectively play a major role in service delivery of medical abortion; this has been shown in Australia, Canada, France and the USA,[4–8] and is apparent in the Republic of Ireland since 1 January 2019. Such GP services are highly acceptable to women.[9–11]

Mid-Level Providers

Non-physician clinicians have been termed mid-level providers. Nurses, midwives and physicians' assistants have all been found in clinical studies to be able to provide both early medical and early surgical abortion with similar outcomes to doctors.[3,7,12–14] In South Africa and Vietnam, provision of surgical abortion by classes of healthcare providers other than doctors was shown to be highly acceptable.[15] In a Swedish study, medical abortion provided by midwives was shown to be as effective and safe as that provided by a physician.[16] In this study, although a majority of women were indifferent to who provided the service, those who expressed a preference chose midwives to a larger extent.

Non-Clinician Providers

It has been shown in Nepal that pharmacists and pharmacy workers can also safely provide medical abortion.[17]

Settings

In some countries, laws still specify that abortions are carried out only in hospitals. Progressive laws allow abortions, including surgical procedures, to be performed in community settings too.[a]

[a] This Statement does not cover self-managed abortion – refer to the British Society of Abortion Care Providers (BSACP) website (https://bsacp.org.uk/resources/other-position-statements/) for this topic.

Early surgical abortion in the form of manual vacuum aspiration (MVA) can be safely delivered in a community setting.[18,19]

The UK National Institute for Health and Care Excellence (NICE) recommends that abortion services are provided in a range of settings, including in the community.[20] NICE conducted a systematic review that showed a clinically important difference in patient satisfaction between community services and those delivered in hospital settings, with community services rated higher than hospital settings.[21] NICE concluded that community services should be provided because the evidence showed improved access to abortion services in this setting. There was good evidence that women[b] preferred nurse- or midwife-led services over doctor-led services, and that that there was a shorter time interval between referral and assessment in nurse-led services. NICE therefore recommended that "abortion providers should maximise the role of nurses and midwives in providing care".

Home is another valid setting for abortions. Administration of misoprostol at home has been practised in many countries for some years. The coronavirus (COVID-19) pandemic has triggered expansion of places allowed for abortions in the Republic of Ireland and Great Britain to include a woman's home for the mifepristone, as well as the misoprostol, administration. Home use of mifepristone has been shown to be safe and effective.[22]

BSACP Position

The provider pool can be expanded by using general practitioners and non-physician clinicians in abortion services, both medical and surgical. Pharmacists can provide medical abortion. Community settings are suitable for the majority of abortion services; widening the range of settings used improves accessibility and acceptability of services.

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[b] Within this Statement we use the term woman. However, it is important to acknowledge that it is not only people who identify as women for whom it is necessary to access women's health and reproductive services in order to maintain their health and wellbeing. Abortion services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

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