Are we prepared for change? The need for evidence on healthcare practitioner readiness for current and future trends in abortion provision in the UK

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Significant changes are occurring in the landscape of abortion provision in the UK. More women are having medical abortions and self-managing these at home, resulting in an increase in the proportion of abortions performed before 10 weeks' gestation.[1] Since 2018, women in Britain have been able to take misoprostol, the second medication for medical abortion, at home provided they have attended a clinic to have it prescribed. The COVID-19 pandemic has accelerated the trend towards self-management. As an emergency and temporary measure due to concerns about reduced health service access for women with unwanted pregnancies during the pandemic, consultations about pregnancy options have occurred by telephone or video and, if women wish and are deemed clinically appropriate, a medical abortion pack of both mifepristone and misoprostol can be posted to their home (up to 9 weeks, 6 days' gestation in England and Wales, and no restriction in Scotland, but clinical guidelines state up to 11 weeks, 6 days). Laws prohibiting abortion have been repealed in Northern Ireland, effectively decriminalising most abortions, and pressure for decriminalisation has been mounting in the rest of the UK. The changes are taking place alongside shifts in thinking about healthcare generally. Recognition of patient-centred approaches and supported self-management, alongside enhancement of activities that complement clinical care in sexual and reproductive health, has gained more prominence.

The changes have significant implications for all methods of abortion delivery and care. The roles and scope of non-abortion specialist healthcare practitioners, such as pharmacists, general practitioners (GPs), nurses and midwives, in administering and supporting abortion procedures (including medical abortion and vacuum aspiration) are being reconsidered. The location and staffing of abortion services has a major role in normalising abortion and removing stigma. Abortion is a common procedure, but its 'separateness' can isolate it from mainstream services and marginalise those providing abortion services. Changes to the legal framework of abortion provision alone will remove some, but not all, barriers to access – for either women or practitioners. Where decriminalisation has occurred elsewhere, as in Australia, stigma and negative attitudes toward abortion among some health practitioners have persisted.[2] A GP survey in Northern Ireland examining the effect of recent decriminalisation found only around 40% felt abortion services should be part of general practice, and only half would be willing to prescribe abortion pills.[3] No relevant data are available on the inclination of healthcare practitioners in other parts of the UK to expand their role in abortion provision. In Canada, however, where training has been provided, more doctors have been willing to undertake abortions.[4] Medical abortion delivery and care provided by nurses, midwives and pharmacists have been found to be effective, safe and acceptable to women. Evidence from low- and middle-income countries, where task-shifting and sharing is more widespread, illustrates trained nurses and midwives can safely and effectively provide vacuum aspirations,[5] and

within National Health Service (NHS) early pregnancy units, nurses have long performed the same procedure where pregnancy is non-viable. In UK primary care, the development of new clinical roles such as Advanced Clinical Practitioners and General Practice Assistants provides expanded opportunities for multidisciplinary service provision. A systematic review has highlighted lessons to be learned about abortion provision in these settings for the UK context.[6] While rates of effectiveness and safety outcomes were comparable between specialist and non-specialist abortion providers, job satisfaction increased among midwives and nurses, and abortion specialists were freer to manage more complex cases. However, potential negative consequences of transferring more early medical abortion to primary care settings included the imposition of a greater burden on GPs and longer patient waiting times.

Self- and home administration of medications for abortion are effective and acceptable for women, for many even preferable particularly where decision-making is made jointly with the healthcare provider.[7] Telemedicine consultations for those having early medical abortions at home have also been reported to be safe, acceptable and effective.[8] Additional benefits include reduced waiting times and gestation age at abortion and greater privacy and convenience for many patients. Yet, the appropriate balance of e-health delivery and face-to-face contact clearly depends on context and patient preference.

A consultation conducted by the Scottish Government in June 2021 on continuing permission for mifepristone at home found much of the opposition was driven by pro-life campaigners and faith groups.[9] For the benefits of recent trends to be enhanced, and any costs diminished, a robust evidence base is needed to inform and underpin programmatic action and policy. Evidence necessary to understand and support workforce willingness and preparedness for changes in abortion care and provision in the UK is scant. Provider education for non-abortion specialist healthcare practitioners is not yet in place in the UK and little is known about the level of training required and what the demand would be. Research is needed on optimal ways of increasing non-specialist practitioner confidence and competence to support women both in face-to-face and remote consultations with self- and home management and to understand potential barriers, such as concerns around financing and medicolegal factors.

The SACHA (Shaping Abortion for Change) Study, funded by the National Institute for Health Research, aims to provide an evidence base to inform optimal configuration of health services and systems for abortion provision in the UK. We will collate and synthesise existing research findings on novel models of care, draw lessons from countries spearheading reforms in abortion provision, and consult women, practitioners and key stakeholders on approaches likely to be most feasible and acceptable in the UK context. An important component of this work is a national survey to assess healthcare practitioners' views on the desirability and perceived consequences of decriminalisation and demedicalisation of abortion. A comprehensive understanding of UK healthcare practitioners' attitudes, current practices and future intentions will help identify and address challenges and opportunities for future provision of high-quality abortion care. The COVID-19 pandemic has acted as a catalyst for innovation in some European countries, but in others inequalities in abortion access have widened.[10] The SACHA Study is timely and will provide essential evidence for future abortion provision in the UK and elsewhere.

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Contributors RSF drafted the article and JS, MJP, JR and KW contributed to subsequent drafts. All members of the SACHA Study Team were sent the final draft and provided comments.

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