Who can provide abortion care?

Considerations for law and policy makers

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Summary

For women who want to end their pregnancies, laws that allow only medical doctors to provide abortion are real barriers. Abortion can safely be provided by nurses, midwives, paramedical personnel and other midlevel providers. Women who have correct information can take pills to end a pregnancy safely outside a health facility. However, many abortion laws require the involvement of one or more medical doctors. These laws criminalize women and other health professionals who end pregnancies safely without a doctor.

Under doctor-only laws, health systems—particularly in the global south—cannot train enough abortion providers to make abortion accessible to all women. Doctor-only laws discriminate against women who belong to vulnerable and disadvantaged groups and who are least likely to have access to medical doctors.

Lawmakers need not designate who can provide abortion in the law. Documents such as national health standards and guidelines are better suited to clarify who are authorized providers. Enacted by the Ministry of Health and ideally updated every few years, Standards and Guidelines can reflect the latest scientific evidence in abortion care.

Who is qualified to provide safe abortion?

The World Health Organization (WHO) states that abortion care can be safely provided by midlevel providers.[1] "Midlevel providers" is a term for non-physician clinicians that can include midwives, nurse practitioners, clinical officers, physician assistants, family welfare visitors, and others.*

Medical doctors are not always needed for abortion care, as medical technology has evolved and enables others to safely provide. WHO-recommended methods include vacuum aspiration and two regimens for medical abortion (abortion with pills): the drugs mifepristone followed by misoprostol or misoprostol alone.[2] Midlevel health providers often already have training in the skills needed for abortion care.[3]

Trained midlevel providers can provide first-trimester vacuum aspiration and medical abortion as safely and effectively as physicians. A systematic review of 8,908 first-trimester vacuum aspiration and medical abortions — with one group performed by midlevel providers and the other performed by physicians — concluded: "Safety and efficacy outcomes…did not differ significantly between providers."[4]

Women can take pills to end a pregnancy safely, outside the presence of a health professional. Women can take one or more of the medical abortion drugs at home, to improve privacy without compromising safety.[5] Around the world, women have been taking misoprostol for decades to end pregnancies and there are few known complications. They may receive information on medical abortion from a variety of sources—including hotlines, text messages, websites, health professionals, family or friends.[6] These same sources may provide misoprostol.

With the advent of pills for abortion, we can no longer easily categorize abortion as safe or unsafe. Risk runs along a spectrum and is highest, for example, when a clandestine provider uses a dangerous method such as putting sticks into the uterus. Risk is lower when a woman with correct information takes misoprostol, even without a health professional present.[7]

The questions of who is a safe abortion provider and what are the appropriate skills continue to evolve with a growing body of evidence. WHO recognizes that these questions are not static and their recommendations will change periodically to reflect the latest evidence.[8]

* Ipas is aware of the tension associated with using "midlevel provider" or "MLP" to collectively refer to the various cadres of health-care providers which may include nurses, midwives, nurse practitioners, physician assistants, clinical officers and others. This term implies that these clinicians provide care that is of a lower standard or of less quality than the care rendered by physicians. Multiple studies have shown that the safety and effectiveness of care provided by these cadres is equivalent and sometimes better than that provided by their professional counterparts. The value of these cadres and their potential contributions toward achieving the health Millennium Development goals is well recognized.

The need for task-sharing

A major barrier to access to health care is a serious shortage of health care workers. At least 57 countries face a crisis shortage of health workers; 36 of those are in Africa.[9] National-level governments, global health authorities and regional bodies have promoted task-sharing to improve health system performance and health outcomes. Task-sharing (also known as task-shifting) means redistributing tasks traditionally performed by doctors to nurses, midwives and community health workers.

Task-sharing can increase the availability of healthcare services in a cost-effective manner. Regional bodies, including the West African Health Organization,[10] East African Community,[11] and the Pan American Health Organization[12] have recommended that governments expand access to health-care service by training lower-level health-care workers.

Punishing quacks

Lawmakers may want to criminalize unskilled abortion providers who injure and kill woman. Prosecutors and health authorities can deter and punish unsafe, clandestine abortion providers through existing laws and regulations that apply to all health care services. Across the globe, the health-care profession is regulated through three primary vehicles: professional councils or health boards, civil law or tort liability, and criminal law. In many common law countries, individuals who endanger women seeking abortion could be charged with common law battery,[13] inflicting bodily injury,[14] assault occasioning actual bodily harm,[15] maliciously administering poison,[16] or (should death result) manslaughter. These approaches are more appropriate vehicles than the abortion law for deterring unsafe providers.

Doctor-only laws can violate women's human rights

In many settings, governments must train midlevel providers in abortion care to fulfill the right to health. The right to health under the Convention on Economic, Social and Cultural Rights (CESCR) requires that governments ensure health services are accessible to all, especially for the most marginalized groups. As a health-care service, abortion must be within physical reach of everyone. Governments must ensure appropriate training of health personnel.[17] Under the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), governments must ensure universal access for all women to a full range of high-quality sexual and reproductive health services.[18]

Committees overseeing CEDAW, CESCR and the Convention on the Rights of the Child have recommended that States Parties recruit and train lower cadre health workers to fulfill the right to health. The CEDAW Committee has urged government to decentralize the health-care system and train community health workers to improve maternal health.[19] The CESCR Committee has instructed governments to train health extension workers, highlighting lack of access to health-care providers.[20] Committees overseeing all three treaties have stressed that the right to health depends on the availability of skilled providers, particularly in rural areas.[21]

How to draft laws for abortion access

Midlevel providers and women with accurate information can end pregnancies safely. With evidence currently available, WHO now recommends that midlevel providers can provide abortion care. Future evidence or technological developments may lead health experts to recommend abortion without a health professional.

To allow for the development of abortion technologies and new evidence, abortion laws should avoid authorizing only health professionals as providers. Such laws can criminalize a woman's safe use of medical abortion on her own, even when she takes abortion pills at home under the care of a health professional

By conditioning legal abortion on the presence of a provider, lawmakers limit access and may criminalize safe abortion care.** If abortion laws authorize providers based on current recommendations, they may contain barriers to methods recommended in the future. Instead, lawmakers can draft abortion laws that begin with clauses such as, "abortion may be performed if…" or "abortion is not punishable if…"

Example laws that enable task-sharing

SWEDEN

The Abortion Act, Act No. 595/1974, as amended through Act No. 998/2007.

On a woman requesting the termination of her pregnancy, an abortion may be performed if the measure is taken before the expiry of the 18th week of pregnancy and cannot be presumed, on account of illness on the woman's part, to entail any serious danger to her life or health….

FINLAND

Law No. 239 of 24 March 1970 on the interruption of pregnancy, as amended through Law No. 374 of 29 May 2009.

1. A pregnancy may be interrupted at the request of the woman and in conformity with the provisions of this Law:..

SOUTH AFRICA

Choice on Termination of Pregnancy Act, 1996. as amended by the Choice on Termination of Pregnancy Amendment Act, 2008 (Act No. 1 of 2008), 17 February 2008.

2(1) A pregnancy may be terminated-…

** The abortion laws of many commonwealth countries begin with clauses that criminalize women and health professionals who are not doctors. For example: UNITED KINGDOM. The Abortion Act 1967 (as amended through 2008): "A person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner of two registered medical practitioners are of the opinion, formed in good faith..."

In the last decade, several laws have been updated to allow midlevel providers to provide abortion:

- South Africa's 1996 law and 2008 amendments authorize a "registered midwife" or "registered nurse" who has the required skills to perform an abortion.

- Nepal's law was changed in 2002 to allow abortion for any reason up to 12 weeks, if abortion has been done "by a licensed health practitioner who has acquired the prescribed qualifications according to the procedure prescribed" by the government.

Laws passed after a national abortion law can allow for new interpretations of doctor-only requirements. For example, Zambia's Health Professions Act of 2009 expanded the types of health practitioners that could be certified to provide basic health care. This 2009 law can be used to interpret Zambia's 1972 abortion law, which requires the involvement of three "registered medical practitioners". Under the 2009 Act, "registered medical practitioner" can be interpreted to include midlevel providers.

Ministries of health can authorize abortion providers

Lawmakers in Ethiopia did not authorize providers in the abortion law, in order to allow the Ministry of Health to do so. The Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia state, "In order to make safe abortion services as permitted by law accessible to all eligible women, the role of midlevel providers such as health officers, nurses and midwives should be expanded to provide comprehensive abortion services including uterine evacuation using MVA and medical abortion."

Ministries of health can authorize nurses, midwives, or other provider cadres to perform abortion by interpreting older laws through Standards and Guidelines. For example, Ghana's 1985 law allows abortion when provided in certain circumstances by a "registered medical practitioner." Under Ghana's Standards and Protocols, the law on abortion providers is interpreted to include midwives, community health officers, and medical assistants trained in midwifery.

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