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Abortion care in BC: Evolving practice and next steps

Abortion care improved dramatically in Canada with the introduction of mifepristone in 2017. To continue to improve access to abortion in BC, more practitioners are needed, and they should be listed on confidential services. Legislative change is required to allow midwives to provide abortion care, and Ministry of Education and Child Care funding is needed to support training in surgical abortion.

ABSTRACT: Abortion has been legal in Canada since 1969 and is governed as usual reproductive health care. Before the medical abortion pill mifepristone became available in British Columbia in 2017, more than 90% of abortions in the province were provided in purpose-specific high-volume clinics located in densely populated urban areas. The availability of mifepristone increased the potential for primary care providers to offer abortion care because provision of this medication is a safe, simple service that is easily managed in a routine primary care visit. Since 1997, the BC Women's Hospital and Health Centre's Pregnancy Options Service has supported BC physicians who provide abortion care by confidentially connecting patients who are seeking abortion to their closest appropriate provider. Similar services are also provided by Options for Sexual Health BC. Family physicians are the main providers of medical abortion. Primary care physicians, nurse practitioners, and gynecologists offer service in rural and urban areas, in person or by telemedicine. Providing accessible abortion care currently has three challenges: (1) more practitioners are needed to reduce travel and wait times for services, (2) to assist people seeking an abortion to find a service provider, practitioners who provide abortions should become listed with a confidential abortion service directory, and (3) enhanced training and distribution of services for second-trimester surgical abortion are needed. The time for a small handful of health care workers to provide all aspects of abortion care is over.

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Abortion has been legal, safe, and common in Canada since 1969. Since Canada became one of the first countries to completely decriminalize abortion in 1988, abortion has been regulated as a normal health service through standards set by clinical guidelines, facility accreditation, and health professional licensing. Abortion is a normal component of usual reproductive health care and is a publicly funded service. It is a common procedure undergone by nearly one-third of Canadian women during their reproductive years. Due to the introduction of the medical abortion pill mifepristone in 2017, most abortion providers are now family physicians, who typically offer medical abortion within a wide range of primary care services. Approximately 95% of abortion care is delivered during the first trimester, but there is an ongoing need for second-trimester abortion for both fetal and maternal indications.

Evolution of abortion services in British Columbia

Before 1969, abortion in Canada was illegal, underreported, and a high cause of morbidity and mortality in women of reproductive age. In BC, between 1963 and 1970, up to 27% of direct obstetric deaths were related to unsafe abortion.[1-3] In 1969, the Criminal Code was amended to make contraception

legal, and to make abortion legal if provided in hospital under certain conditions. Due to a 1988 Supreme Court decision, Canada became one of the first countries in the world to completely decriminalize abortion.[4] Over the years, there have been several political attempts to recriminalize abortion care, but all have been unsuccessful.[5] The Society of Obstetricians and Gynaecologists of Canada and the Canadian Medical Association are strong supporters of reproductive choice and high-quality abortion for all people in Canada.[6,7]

From 1969 to 1988, abortion care was legally restricted to provision in a hospital setting and required approval of a committee.[8] These restrictions were removed in 1988, and over the following 30 years, the provision of abortion shifted away from hospitals to mainly purpose-specific high-volume clinics, which are typically available in the most densely populated urban areas.[5,9] In 2010, a BC study noted that urban abortion care was offered by seven purpose-specific clinics.[10] Since 1997, BC Women's Hospital and Health Centre in Vancouver has provided provincial leadership in supporting rural abortion services by integrating a network of care through the Pregnancy Options Service.[11] This confidential provincial database of abortion care providers offers a toll-free phone line to help people in BC who are seeking abortion care connect with their closest appropriate provider.[11] More recently, a similar service has been provided by Options for Sexual Health through its Sex Sense line.

In BC, prior to 2017, only physicians were licensed to provide abortion; approximately half were specialists and half were family physicians.[12] Most abortions were surgical, and more than 90% were conducted during the first trimester.[12,13]

Before 2017, outside of large urban areas in BC, abortion services were available in 17 hospitals, and a small proportion of medical abortion services were available from rural physicians, who used methotrexate and misoprostol.[10,12] However, these operating room–based and medical abortions accounted for less than 10% of all BC abortions, even though 43% of reproductive-aged women lived in rural areas.[10] Most patients living outside of major cities had to travel unreasonable distances to access abortion care and faced multiple barriers, such as justifying absence from work, time and costs related to travel, and replacing their caregiver or work responsibilities at home.[14,15] BC rural providers also faced challenges related to providing abortion services in the hospital operating rooms of their communities.[10,16] From 1998 to 2010, the rural abortion workforce declined by more than 60%.[10,17] These challenges to providing abortion care in rural areas were reflected across Canada.[12] The provision of highly effective first-trimester mifepristone medical abortion in primary care settings was postulated as a possible solution to increase equity in access to abortion.[18]

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Importance of primary care providers

In 2017, mifepristone, the gold standard for medical abortion, became available in Canada.[19-21] This primary care–supportable practice of providing medical abortion has not been associated with any increase in the overall rate of abortion or related complications, but the proportion of abortion care provided as medical abortion has increased compared with surgical abortion.[22] The availability of mifepristone as a regular prescription has also been associated with an increase in the number of providers, particularly in rural areas, and the distribution of providers.[23] According to a national qualitative study conducted in 2020, many family physicians became motivated to provide mifepristone after one of their patients requested an abortion, or after hearing a colleague's highly positive experience of prescribing the medication.[24,25] Many potential new or inexperienced medical abortion providers sought support or mentorship after mifepristone was introduced. The Society of Obstetricians and Gynaecologists of Canada, College of Family Physicians of Canada, Canadian Nurses Association, and Canadian Pharmacists Association provided expert advice to Canada's Contraception and Abortion Research Team[26] to create the Canadian Abortion Providers Support virtual community of practice site (https://caps-cpca.ubc.ca).[27] This secure resource platform provides access to information, practice and patient resources, clinical support such as the popular "10-minute checklist" for a mifepristone clinical encounter (downloaded more than 2000 times), and discussion forums on mifepristone abortion.[27] Polls of community of practice members in 2018 engaged interested clinicians from all regions of the country.[27,28] Seventy percent were primary care providers, 55% practised outside of metropolitan areas, 35% had no prior abortion experience before registration, and 6.8% practised in regions that had no abortion services before mifepristone became available.[27] A 2019 national survey showed there had been a shift in the disciplines and locations of the workforce that provided abortion care: primary care providers now provided 71% of the reported first-trimester medical abortions.[24] Responses to that survey indicated that 61% of medical abortion providers had less than 5 years' experience, and 67% practised outside of hospital.[29] As a result, approximately 30% more communities had local abortion services than prior to mifepristone release.[29] Most survey respondents, in both rural and urban areas, provided a low volume of abortions per survey respondent.[29] Similar results were found in a health administrative data study conducted in Ontario between 2017 and 2020, which showed that the number of abortion providers tripled after mifepristone was available, but most providers individually provided fewer than 10

abortions per year (i.e., offering abortion care as part of a wide range of services in primary care practice).[23]

Improved confidentiality and privacy

Medical abortion is becoming widely available across the country in a variety of health care settings. While rural communities initially reported a proportion of staff and physicians who would avoid participating in surgical abortion cases due to conflict of personal values, the shift to medical abortion increases the potential for confidentiality and equitable access and decreases reliance on an extended interdisciplinary team to provide each procedure. Similarly, this shift reduces both the potential for patients and primary care providers to face interactions with protesters and the potential for logistical and stigma barriers, as previously reported by abortion providers working in operating room settings. Physicians and nurse practitioners can now competently and safely treat patients who are seeking abortion with confidentiality in a usual office visit setting. The Society of Obstetricians and Gynaecologists of Canada's Sexual Health and Reproductive Equity committee recently released guidance on providing abortion care via telemedicine and access to abortion care during the pandemic **[Box 1]**.[19] According to these guidelines, medical abortion may be provided by telemedicine, with limited or no laboratory or imaging visits required.[30] This new guidance enables primary care providers to assess and manage abortion care for their patients more easily. Also, this care option is now available to those seeking abortion in rural or remote areas that have access to pharmacy services but that previously had no local abortion care. In 2020, 90% of Canadian practitioner respondents to a national poll indicated that they provided some components of abortion care via telemedicine.[31]

The demand for second-trimester abortion and highly skilled care is increasing due to . . . increases in maternal age, multimorbidity, and their associated risks.

Skills training

In Canada, family physicians and general obstetricians and gynecologists have the required skills to provide first-trimester surgical or medical abortion. Routine training in abortion care is variably offered by Canadian family medicine residency programs.[32] Medical abortion may also be provided by nurse practitioners and, in Quebec, also by midwives. Since 2017 in BC, nurse practitioners have been authorized to provide first-trimester medical abortion, for which training programs have been launched.[33-36] Better access to abortion care could also safely and effectively be supported by a range of primary care providers, including midwives.[37,38] In many jurisdictions, the provision of medical and surgical abortion by allied health professionals has been associated with high-quality care and high patient satisfaction.[37] Provision of this urgently needed update to midwifery health professional licensing legislation has the potential to improve access to abortion in BC.

As medical abortion increasingly becomes the first-choice method for first-trimester abortion, BC must consider the ongoing and perhaps even more pressing need to maintain surgical skills to ensure a trained workforce is available and capable of providing second-trimester surgical abortion. Training for procedures such as cervical dilation and uterine evacuation under sedation in outpatient settings can easily be integrated into standard obstetrics/gynecology residencies. This skill is an asset not only for managing severe and fatal fetal anomalies, which is increasingly in demand as maternal age at delivery is increasing in BC, but also when delivering a person who is presenting with other complications of pregnancy, such as previable rupture of membranes with infection or with a placental abruption with hemorrhage, either of which presents potential harm to the mother's health. Currently, our pregnant population is facing increasing challenges due to a greater chance of genetic diagnosis and to comorbidities such as high body mass index, diabetes, hypertension, and prior cardiac surgeries. The demand for second-trimester abortion and highly skilled care is increasing due to these increases in maternal age, multimorbidity, and their associated risks. To build and maintain the skills needed to perform these complex and advanced procedures, Ministry of Education and Child Care funding and education support are required to ensure surgical skill training programs are available within family practice and obstetrics/gynecology residencies and to create expertise through advanced training in family planning for fellows in obstetrics and gynecology.[13]

Finding an abortion provider

The switch toward medical abortion offered by primary care providers allows patients to manage their abortion in their own home at their convenience, which reduces wait

BOX 1. Resources for primary care providers who wish to provide abortions.

Society of Obstetricians and Gynaecologists of Canada guidelines
https://sogc.org/en/en/content/guidelines-jogc/guidelines-and-jogc-new.aspx

Canadian Abortion Providers Support virtual community of practice
www.caps-cpca.ubc.ca, including links to the:

- **Medical Abortion Prescriber Checklist Resource Guide**
  https://caps-cpca.ubc.ca/index.php/File:Medical_Abortion_Prescriber_Checklist_Resource_Guide.pdf
- **Medical Abortion Prescriber Checklist**
  https://caps-cpca.ubc.ca/index.php/File:Medical_Abortion_Prescriber_Checklist.pdf)

times, the need for referrals and travel, and the potential of facing protestors at an urban facility. In Canada and throughout BC, people who are seeking abortion may have difficulty finding a provider. Many primary care providers are now offering abortion care; however, few are listed in any of the services that patients can access to find their nearest provider. In BC, these services have had confidential lists of abortion providers for more than three decades, including the BC Women's Hospital and Health Centre's Pregnancy Options Service and the Options for Sexual Health Sex Sense line **[Box 2]**. To assist British Columbians who are seeking abortion, those who offer surgical and medical abortion are urged to list with BC's confidential abortion provider services. **Box 1** lists resources for primary care providers who wish to provide abortions or refer for abortion service. Identification of community allies will strengthen referrals for those who do not provide abortion directly but will facilitate their patient's care and support their colleagues who provide abortions.

Conclusions

Canada decriminalized abortion in 1988, and the rate of abortion has remained stable since then, although access to abortion care, particularly in rural areas and for second-trimester care, remains a concern in BC. Mifepristone medical abortion has had a rapid uptake in primary care since its introduction in 2017 and appears to offer a solution to urban–rural abortion access disparities. We hope that the need to provide medical abortion may convince more family physicians to incorporate the use of mifepristone as a small part of their standard practice.

Legislative change to approve the provision of midwifery abortion care and Ministry of Education and Child Care funding and infrastructure to ensure training in medical abortion care is included in training programs for midwives, nurse practitioners, and family physicians have the potential to improve access to essential abortion services in BC. The time for a minority of health care workers to provide all aspects of abortion care is over. Now is the time for nurse practitioners, family physicians, and obstetricians/gynecologists to consider meeting the needs of their patients for abortion care.

Family physicians and general obstetricians and gynecologists have the required skills to provide first-trimester surgical or medical abortion.

Primary care providers should talk with their patients and colleagues and consider what service they could offer to improve access to abortion care in BC. An important next step will be to improve and ensure equitably distributed access to second-trimester abortion. The key missing piece is Ministry of Education and Child Care funding to support surgical abortion training in both family practice and obstetrics/gynecology residencies and to support training for complex care through the advanced training fellowship. Equitably accessible abortion care in BC requires our provincial government and health professionals to take these next steps. ■

BOX 2. Where primary care providers can be listed as providers of abortion in BC.

BC Women's Hospital and Health Centre Pregnancy Options Service
- 1 888 875-3163
- www.bcwomens.ca/health-professionals/professional-resources/abortion-contraception-resources

Options for Sexual Health Sex Sense line
- 1 800 739-7367
- www.optionsforsexualhealth.org/sex-sense

Competing interests

In the past 36 months Dr Norman has held a number of federal grants to conduct a program of abortion health policy and services research highly related to the content of this article. As well, she received payment for expert testimony and consultancy advice to the Ontario Government, Office of the Attorney General, in a case related to access to abortion care. She has also served as a member of the Board of Directors of the Society of Family Planning, a professional academic organization for health care and research professionals engaged in abortion care provision, training, and research.

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