The Abortion Provider Workforce in Canada

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Introduction

Annually, 80,000 abortions are reported in Canada[1]. Results of a 2012 survey showed:

1. <300 clinicians provided abortion services[2], mostly high volume providers located in specialized clinics;
2. Only ~4% of reported procedures were first trimester medical abortions (MA)[3];
3. And vast rural/urban access disparities, with services concentrated in urban areas[2].

Changes to abortion provision since 2012 include:

1. Health Canada approved mifepristone;
2. Restrictive regulations on mifepristone were removed;
3. Clinical practice guidelines for abortions were updated;
4. And nurse practitioners (NPs) began to provide first trimester MA.

We hypothesize that these described changes to abortion provision could positively impact abortion care.

Objectives

Generate the demographic profile of Canadian abortion providers in 2019. This poster focuses on first trimester MA providers and their care.

Methods

- We conducted an online, national, cross-sectional survey of physicians and NPs who independently provided abortion care in 2019.
- This anonymized, self-administered survey, available in French and English, collected participant demographics, including profession, specialty, location, age, and gender.
- The survey was distributed through health care organizations and networks using a modified Dillman technique.
- Descriptive statistics were generated through R Statistical Software.

Results.

- After data cleaning, we included 388 respondents who reported providing first trimester MA (including 30 NPs). 172 of them also provided first trimester surgical abortion.
- 99.4% used mifepristone
- 70.9% of first trimester MA respondents were primary care providers (family physicians, emergency medicine physicians, and NPs) and were women (86.9%). Median age was 41 years. About half (43.1%) were located rurally. 61% reported having less than 5 years experience (Table 1).
- Respondents were from across Canada (Fig.1).
- 27.7% (13,429) of all reported abortions (48,509) were first trimester MA. They represented 44.4% of all abortions in rural areas, as opposed to 25.6% in urban areas.
- 66.5% provided first trimester MA outside of the hospital, 97.4% in locations that provided other reproductive or general health care (Fig. 2).

Table 1: Demographics of First Trimester MA Respondents by Specialty

	Primary Care Providers[1], n (%) n=275	Specialists[2], n (%) n=113	Total, n (%) n=388
Urban vs Rural[3]			
Urban	146 (53.7)	72 (69.4)	218 (56.9)
Rural	126 (46.3)	39 (35.1)	165 (43.1)
Age			
<40	123 (46.8)	50 (46.7)	171 (46.5)
40-49	76 (28.9)	28 (26.2)	104 (28.3)
≥50	64 (24.3)	29 (27.1)	93 (25.3)
Gender			
Woman	241 (87.6)	96 (85.0)	337 (86.9)
Man	34 (12.4)	17 (15.0)	51 (13.1)
Years of experience			
<5	171 (64.5)	52 (52.5)	223 (61.3)
5-10	40 (17.0)	20 (20.2)	60 (16.5)
11-15	28 (11.9)	15 (15.2)	43 (11.8)
≥16	26 (11.1)	12 (12.1)	38 (10.4)

[1]Primary care providers includes family physicians, nurse practitioners, and emergency medicine physicians
[2]Specialists includes obstetricians and gynaecologists as well as maternal-fetal-medicine subspecialists
[3]We defined urban providers and facilities as those located within Statistics Canada's defined census metropolitan areas (CMA). All other providers and facilities were classified as rural.
Percentages were calculated based on the total number of respondents for the individual variable (based on skip pattern logic and non-mandatory questions).

Fig. 1 Province and Territories of Respondents

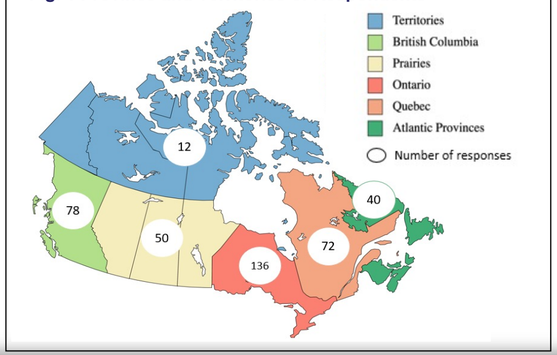
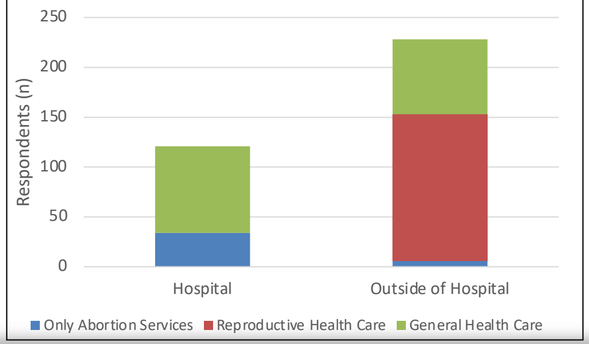


Fig. 2 Location of Practice for First Trimester MA Respondents



Discussion

Our results suggest, that following recent abortion provision changes:

1. There are many new providers, many who are located in a primary care setting;
2. The proportion of first trimester MA has substantially increased and a mifepristone regimen has been implemented;
3. Availability of mifepristone abortion from rural primary care providers may have lessened disparities in rural/urban access to abortion care.

Strengths of this survey: (1) The national sample, (2) the extensive recruitment method, and (3) we recruited more respondents than in the 2012 survey, consistent with the anticipated increase in the workforce.

Limitations of this survey: We cannot determine the representativeness of our sample as the true number of abortion providers in Canada is unknown.

Conclusion

The first trimester abortion workforce is a multidisciplinary group of health care professionals. Many are new to first trimester MA. Our survey results will inform policy makers, future clinical care guideline development, and are relevant to other countries aiming to improve access to first trimester MA, given that Canada is leading in the evidence-based removal of restrictive regulations surrounding mifepristone.

References

[1]CIHI 2019; [2]Norman et al. 2016. Can Fam Physician. [3]Guilbert et al. 2016. Can Fam Physician.

Acknowledgement

We would like to thank Canadian Institutes of Health Research (CIHR) for funding this study. Additionally, in kind support was provided by the Women's Health Research Institute of the British Columbia Women's Hospital, British Columbia Women's Hospital, the Society of Obstetricians and Gynecologists of Canada and the Canadian Nurses Association.