SPHERE
NHMRC Centre of Research Excellence in Sexual and Reproductive Health for Women in Primary Care

Women's Sexual and Reproductive Health COVID-19 Coalition

Nurse and midwife-led provision of mifepristone and misoprostol for the purposes of early medical abortion: a consensus statement

The Coalition supports nurse and midwifery-led provision of mifepristone and misoprostol for the purposes of early medical abortion (EMA) and:

1. *Recommends reforms to state-based legislation to:*
    a. *enable nurse practitioners (NPs) and endorsed midwives (EMWs) to prescribe mifepristone and misoprostol as MS-2 Step (Appendix 1)*
    b. *Allow suitably trained and endorsed/authorised registered nurses and midwives to be able to obtain /supply and administer mifepristone and misoprostol for the purposes of EMA under a scheduled medical authorisation, standing order or state approved Drug Therapy Protocol (Appendix 2)*
2. *Supports amendments to the TGA conditions of approval to include NPs and EMWs to be able to prescribe MS-2 Step (Appendix 1)*
3. *Supports an application to the PBAC to include NPs and EMWs to be able to prescribe MS-2 Step (Appendix 1)*
4. *Calls for the Nursing and Midwifery Board to expand the scope of practice of NPs and EMWs to include EMA (Appendix 1)*
5. *Calls for individual employers to allow Registered Nurses (RNs) and Registered Midwives (RMs) to administer mifepristone and misoprostol for the purposes of EMA through the use of standing orders and amendments to practice policy and procedures (Appendix 2)*
6. *Calls for increased training in EMA for all RNs and RMs (Appendix 2) to support:*
    a. *streamlined, efficient task-sharing models in which nurses and midwives lead the service and work alongside or via telehealth a prescribing medical officer or nurse practitioner*
    b. *supply and administration of mifepristone and misoprostol for the purposes of EMA via a scheduled medical authorisation or health management protocol*
    c. *Supply and administration of mifepristone and misoprostol for the purposes of EMA from standing orders, protocols and policy*

The need for affordable and accessible early medical abortion (EMA) services during the COVID-19 pandemic is currently amplified due to women* suffering financial duress and increased rates of family violence.

The lack of EMA providers is a major barrier to women accessing timely and safe abortions in Australia, especially in regional and remote areas[1-3]. Innovative models of access that take into account the individual, social, structural and geographical factors influencing access are required to ensure

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equitable access to EMA services for all Australian women. Remote and isolated geographical areas require special consideration distinct from regional areas, with access to healthcare even more difficult in these areas. Equity of access and choice of provider, where options are limited, are important considerations for women in these areas.

The number and distribution of EMA providers can be increased by task-shifting abortion provision from doctors to appropriately trained nurses and midwives[1]. Provision of EMA by nurses is as effective and safe as physician provision[4] and is supported by the World Health Organization (WHO)[5].

Both nurse-led & midwife-led models and nurse delivered team-based models of EMA provision have the potential to reduce associated costs at a health-system level. These include shorter time spent in the clinic, reduced waiting time to appointment, a cost-efficient workforce and reduced cost for treatment of complications[1]. Increasing provision of nurse-led models of EMA could not only increase access to abortion for women in regional and remote areas due to greater reach of services, but also for disadvantaged and vulnerable women[2] in all settings.

However, several barriers to nurse and midwifery-led EMA provision currently exist. Firstly, nurse practitioners, registered nurses and midwives, practice in accordance with federal, state and territorial legislation and professional regulation governing their practice. Their scope of practice with regard to the authority to obtain, administer, supply and/ or prescribe medication is dependent on their training, role and authorisation with the Nursing and Midwifery Board of Australia, and local jurisdictional guidelines. EMA provision is currently not included in any nursing or midwifery scope of practice or authority to obtain, administer, supply and or prescribe.

Secondly, under the current TGA approved conditions for MS-2 Step, only medical practitioners are able to complete the online training required to prescribe. In addition, the PBS listing of MS-2 Step (available at http://www.pbs.gov.au/medicine/item/10211K) restricts prescribing to medical practitioners and the treatment criteria 'must be treated by a prescriber who is registered with the MS-2 Step prescribing program'. In order for this to change MS Health would be required to submit a revised proposal to the TGA to amend the condition of approval in order for health practitioners other than medical practitioners are to be able to prescribe.

Thirdly there is a lack of adequate and appropriate training opportunities for nurse practitioners, registered nurses and midwives with regards to EMA provision.

Fourthly, for primary health care and practice nurses (PHCNs and PNs) the traditional distribution of labour between doctors and nurses together with a lack of support by some GPs and stakeholders; apprehension about scope creep and abortion stigma are all barriers to nurse-led models of EMA care[6].

Finally, current funding arrangements do not support the independent provision of nurse-led EMA as the MBS requires GP involvement to enable payment for consultations involving EMA[2,6].

To overcome some of these barriers, existing models of nurse and midwife-led care which include the authority to obtain, administer, supply and or prescribe medication could be extended to include EMA provision if the necessary legislative changes are made at federal and state level. For example:

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- NPs and EMWs are already authorised PBS prescribers for some medications, limited by the NPs/EMWs scope of practice and state and territory prescribing rights. For example, authorised nurse practitioners are able to prescribe morphine and S100 medication for the treatment of HIV and viral hepatitis, but they are not currently able to prescribe mifepristone and misoprostol for the purposes of EMA[7].
- EMWs can prescribe medication such as Morphine, amoxicillin and levonorgestrel within state and territory prescribing rights[7].
- Suitably trained and endorsed/authorised registered nurses and midwives can administer and supply a range of medicines, according to a scheduled medical authorisation, standing orders or in the case of Queensland state approved Drug Therapy Protocols that authorise a sexual and reproductive health program nurse to independently administer or supply a range of restricted and S3 drugs or S2 poisons[8].
- In some jurisdictions such as Victoria and the Northern Territory, the law stipulates that RNs can administer mifepristone and misoprostol for the purposes of EMA under the supervision of a medical officer[9].

In addition to more training and education about early medical abortion, changes are also required to TGA and PBAC approvals, state-based legislation and to the accepted nursing and midwifery scope of practice in order to enable suitably trained and endorsed/authorised registered NPs, RNs and RMs to register to obtain/supply and/or administer mifepristone and misoprostol for the purposes of EMA in all jurisdictions in Australia (see Appendix 1 and Appendix 2).

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Appendix 1: Points of action for Nurse Practitioner and Endorsed Midwife prescribing of mifepristone and misoprostol for the purposes of EMA

State Legislation	TGA	PBAC	Scope of Practice	Training for NPs and EMWs
•Reforms to state-based legislation to allow NPs and EMWs to prescribe	•Amendments to the TGA conditions of approval to include nurse practitioners and endorsed midwives to be able to prescribe MS-2 Step	•Apply to PBAC to include nurse practitioners and endorsed midwives to be able to prescribe MS-2 Step	•Nursing and Midwifery Board to expand the scope of practice of NPs and EMWs to include EMA	•Increased training in EMA for all NPs and EMWs

TGA – Therapeutic Goods Administration; PBAC – Pharmaceutical Benefits Advisory Committee; NPs – Nurse Practitioners; EMWs – Endorsed Midwives; EMA – Early Medical Abortion

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Appendix 2: Points of action for Registered Nurse and Midwife administering of mifepristone and misoprostol for the purposes of EMA

State legislation	Employment arrangements	Training for RNs and RMs
•Reforms to state-based legislation to allow suitably trained and endorsed/authorised registered nurses and midwives to be able to obtain /supply and administer mifepristone and misoprostol for the purposes of EMA under a scheduled medical authorisation, standing order or state approved Drug Therapy Protocol	•Individual employers to allow RNs and RMs to administer EMA through the use of standing orders and amendments to practice policy and procedures	•Increased training in EMA for all RNs and RMs

RNs – Registered Nurses; RMs – Registered Midwives; EMA – Early Medical Abortion

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