Incomplete abortion is defined as the presence of retained products of conception with no well-defined gestation sac. It is a potentially life-threatening condition that without well-timed and proper treatment can lead to severe complications such as haemorrhagic shock, sepsis, and death. Abortion-related complications still contribute substantially to maternal morbidity and mortality in sub-Saharan Africa. Backup treatment of complications from unsafe abortion and spontaneous abortion (post-abortion care) is an effective intervention to reduce maternal mortality. The post-abortion care model consists of emergency treatment of abortion-related complications, post-abortion contraceptive counselling, and free contraception.

The lack of physicians in many low-income countries restricts women’s access to post-abortion care. In Africa, the shortage of trained health-care providers is greatest in rural and remote areas where maternal mortality and morbidity is highest. In The Lancet, Marie Klingberg-Allvin and colleagues report the results of a multicentre equivalence randomised controlled trial to examine the efficacy and safety of misoprostol for treating incomplete abortion provided by midwives compared with standard care with the same treatment provided by physicians. The study was done in six health centres in rural, peri-urban, and urban areas of central Uganda. The results show both midwives and physicians achieved equal success rates for complete abortion within 14–28 days of the treatment. Midwives with a standardised training programme can independently diagnose incomplete abortion and successfully treat women with misoprostol at district level in a low-resource setting. The overall complete abortion rate in this study (96·2%) is comparable with results in previous studies (range 94·4–99·0).

Apart from physicians, nurse-midwives, physician assistants, and nurse practitioners have the clinical and counselling skills needed to provide first-trimester medical abortion. Involvement of midwives in treatment of incomplete abortion with misoprostol in low-resource locations has been assessed in other observational studies. In a randomised controlled trial, women who were randomised to have medical abortion under the care of a staff nurse in Nepal had a statistically comparable rate of complete abortion to those under the care of a physician, and reported no serious adverse events. In the Nepal study, women were examined and diagnosed by a physician and then treated by a nurse-midwife. A Swedish randomised controlled trial assessed nurse-midwife provision of early medical termination of pregnancy in a high-resource setting where ultrasound examination for dating of pregnancy is part of the protocol. Nurse-midwives involvement in determination of gestational age (using vaginal ultrasound) and full responsibility for providing medical abortion showed no significant differences compared with doctors.

Optimisation of the use of midwives would be a practical response to the lack of physicians at district level and a strategy to decrease maternal mortality. At home, women can self-administer misoprostol and manage the abortion themselves without expected side-effects. There were no reported differences in effectiveness or satisfaction between home-based or clinic-based misoprostol management of incomplete abortion according to a systematic review of prospective cohort studies.

WHO has updated its 2003 publication Safe abortion: technical and policy guidance for health systems. A range of safe options are available to women who seek an elective abortion and the woman can select not only the method but also pain control and post-abortion contraception. It is recommended to adopt the policy for expectant management as the primary
Comment

We declare no competing interests.