Expanding access to safe abortion and/or post-abortion care (PAC) in South Asia: Is expanding the provider base a feasible option?

Introduction

A South Asia regional consultation, with representation from Bangladesh, India, Nepal and Pakistan, was held in New Delhi, in March 2011, to deliberate on ways of expanding the provider base for safe induced abortion, so as to overcome inadequate and inequitable access to safe abortion, as well as to services for the management of incomplete abortion and complications of unsafe abortion that persist in the region, and thereby to reduce morbidity and mortality from unsafe abortion. Specifically, deliberations focused on the feasibility of expanding the provider base for first trimester abortion services (including medical abortion (MA) and manual vacuum aspiration (MVA), menstrual regulation (MR) services), and post-abortion care services. More specifically, the consultation discussed the feasibility of including, over and above obstetricians-gynaecologists and allopathic physicians certified to provide abortion, other competent health care professionals as abortion providers. These other competent providers, identified somewhat differently in the four countries, include various categories of nurses and midwives, and physicians trained in alternative (non-allopathic) systems of medicine. The literature has, thus far, tended to refer to these other competent providers as “midlevel providers”; given the increasing recognition of the inadequacy of the term, this statement refers to these providers, more appropriately, as "other competent providers."

The consultation was attended by a range of stakeholders, including policy makers, programme managers, researchers, and representatives from non-governmental organizations and civil society, professional organisations, the private sector and development partners.

The regional consultation was preceded by country-level consultations in each of the four countries, with participants comprising policy makers, programme managers, researchers, and representatives from non-governmental organizations, professional organisations, the private sector and development partners from within each country.

This statement was informed by recommendations made at country-level consultations in the four countries, as well as by the deliberations made at this consultation by participants from the four countries.

Rationale

It is estimated that over half of all abortions conducted in developing countries are unsafe.[1] WHO's most recent estimates suggest that 21.6 million unsafe abortions take place worldwide, and of these, 21.2 million, or 98% take place annually in developing countries. South-Central Asia is the region with largest number of unsafe abortions, estimated at more than 6.8 million annually, despite the broad legal parameters for induced abortion in Nepal and India as well as a the widespread availability of MR services in Bangladesh. Deaths as a result of unsafe abortions in developing countries are estimated to be 47,000 annually, that is, 220 deaths per 100,000 abortions with South-Central Asia accounting for 200 deaths per 100,000 abortions[2]. Specifically, in the four countries represented at this consultation:

- In Bangladesh, about 800,000 women undergo menstrual regulation annually[3,4] mostly unreported (official estimates suggest a much lower number of 200,000)[5]. While MR is largely safe, evidence from the large number of post-abortion care admissions in facilities reiterates that large numbers of unsafe abortions -- estimated at another 150,000 to 200,000 -- do indeed take place in Bangladesh (Rob, personal communication).
- In India, more than 5.5 million of the 6.5 million abortions that take place annually are conducted by uncertified providers or in unregistered facilities[6;] unsafe abortion accounts for 8% of all maternal deaths[7.]

- Estimates suggest that, in total, approximately 890,000 abortions, both safe and unsafe, are conducted in Pakistan annually, with an estimated abortion ratio of 20 per 100 live births; about 197,000 women are treated for post-abortion complications annually[8].
- In Nepal, it is estimated that, in total, 165,000 abortions, both safe and unsafe, take place annually, and unsafe abortion is the third major cause of maternal death in the country[9].

In all these countries, poor women's access to safe abortion services remains, in practice, limited. A large percentage of rural women delay their abortions into the second trimester, seek abortion from untrained providers or in unregistered facilities, travel long distances to obtain abortion services, and risk abortion-related complications. In large part, unsafe abortion remains a problem because there are too few providers of abortion services in these countries. In view of the fact that other competent providers are generally more likely than physicians to work in remote and underserved areas of developing countries in Asia, enabling them to provide abortion services would go a long way in improving access to safe abortion.

Laws governing access to abortion in the four countries of South Asia represented at this consultation vary. For example, in Pakistan, abortion is permitted to save the life of the mother or in order to provide "necessary treatment"[10]. In Bangladesh, Menstrual Regulation (by vacuum aspiration, conducted to bring on menstruation and not as a method of pregnancy termination) is legally permitted within eight weeks of the last menstrual period by a paramedic and up to ten weeks by a physician[5,11] and abortion is legally permitted only to save the life of the mother[12]. India permits abortion for a range of social and physical reasons, including contraceptive failure, mental and physical health of the mother, foetal problems and rape; abortions are permitted up to 20 weeks of pregnancy and at any time during pregnancy to save a woman's life, but must have the consent of two providers if more than 12 weeks[13]. In Nepal, abortion is permitted up to 12 weeks on request, up to 18 weeks in the case of rape and incest, and at any time during pregnancy to save a woman's life, if the physical and mental health of the mother is affected and in case of foetal abnormalities[9,14]. All four countries provide services for post-abortion care in the context of the wider definition of reproductive health.

Laws governing who can provide abortion services also vary:

- In Bangladesh, aside from trained allopathic physicians, Family Welfare Visitors (FWVs), female sub-assistant medical community officers (SACMO) and paramedics, that is, those who have had at least 18 months of formal training, are permitted to provide MR (up to 8 weeks following the last menstrual period); only physicians are permitted to provide MR and abortion services beyond 8 weeks, as well as post-abortion care services. Physicians trained in non-allopathic systems of medicine (e.g. Ayurveda, Homoeopathy) are not permitted to provide menstrual regulation or abortion services[5].
- In India, abortions can be conducted by all obstetrician/gynaecologists, and by other physicians who have undergone abortion-related training and are certified to conduct abortions; nurses, midwives, physicians trained in non-allopathic systems of medicine (e.g. Ayurveda, Homoeopathy) are not permitted to provide abortion (although they may assist certified physicians in doing so)[13].
- In Nepal, aside from trained allopathic physicians, staff nurses, and ANMs with Skilled Birth Attendance (SBA) training are permitted to provide MA; staff nurses, in addition, are permitted to provide MVA. Homoeopaths and Ayurveds are not permitted to provide abortion services[9].
- In Pakistan, only trained allopathic physicians are permitted to provide abortion to save the life of the woman or in order to provide "necessary treatment."[15]

Task shifting from physicians to other competent health professionals and task sharing between these two categories of health care providers represents an important option in these circumstances, provided that safety and efficacy can be assured. In general, task shifting or sharing are clearly warranted in procedures in which required skills can be transferred to other competent providers and where trained other competent health care providers can deliver the services instead of relying on the skills of highly trained personnel who are in short supply. Experiences from both low and high income countries suggest that task shifting has been successful in both expanding services and improving outcomes for patients, without compromising on patient safety and satisfaction.

While governments may favour task shifting and expanding the provider base to include other competent providers, the need for evidence about the safety and efficacy of abortions provided by other competent providers has often been articulated by governments of the region.

Defining other competent providers
Participants agreed that other competent providers comprise, in general, a range of provider categories:

- ANMs/lady health visitors and/or community midwives with training in skilled birth attendance (SBA)
- Nurse-midwives, nurses holding diplomas or degrees and/or their equivalent
- Physicians trained in non-allopathic systems of medicine, including Ayurveds, Homoeopaths etc.

However, each country elected to encompass, in its definition of other competent providers, those best suiting each country's own context and legal situation, and pursue the expansion of the abortion provider base to include these providers only.

Recommendations
In order to provide women safe, accessible and acceptable abortion care services, participants at the regional consultation strongly recommended that other competent providers should be legally permitted, following due training, to independently provide comprehensive abortion care (CAC), including menstrual regulation (MR), first trimester abortion services (both Manual Vacuum Aspiration (MVA) and Medical Abortion (MA, that is, using mifepristone-misoprostol)), and/or post-abortion care (PAC), as appropriate within each country's legal context. Participants also agreed that other competent providers must have the responsibility of providing post-abortion contraceptive counselling. Participants representing medical and nursing associations in all four countries, further, endorsed the recommendation to expand the provider base.

Participants also noted that in order to expand access to safe abortion, several other complementary measures are necessary, as appropriate within each country's legal context. These include, for example, efforts to:

- Include specific drugs (mifepristone and misoprostol) in the essential drug list and MVA equipment in the essential equipment list;
- Equip facilities with infrastructure, equipment and regular supply of drugs, etc to ensure effective provision of abortion and post-abortion care services;
- Ensure a strong, effective, supportive and functional supervision and monitoring system;
- Support NGOs already providing abortion and post-abortion care services in terms of training, equipment and drugs;
- Ensure universal access to abortion and post-abortion care services, with special initiatives to reach the poorest; and raise community awareness about the legal aspects of abortion within each country's legal context, and dispel misperceptions that it is not legally available or that it is not accessible.

However, participants agreed that the main focus of the recommendations of the consultation would be on the provision of abortion and post-abortion care services by other competent providers.

Recommendations made at the consultation are listed below:

1. Act upon the evidence on the safety and efficacy of abortion

Evidence is now available from several countries in the region that confirms the safety, efficacy and acceptability of the provision of abortion and/or menstrual regulation by other competent providers. For example:

- Evidence from Nepal confirms that nurses and ANMs who have had SBA training can provide medical abortion up to 9 weeks of pregnancy as safely as doctors can[16].
- Evidence from India shows that nurses and Ayurveds can provide MA as safely and effectively as physicians can, among women with gestational ages up to 8 weeks[17].
- Evidence from India also shows that nurses can provide MVA as safely and effectively as physicians can for women with gestational ages up to 10 weeks[18].
- Evidence from Bangladesh highlights that FWVs can provide MR safely and effectively for women whose last menstrual period took place up to 8 weeks earlier[19].
- Experiences from all four countries, including Pakistan[15], highlight that other competent providers can provide post-abortion care and post-abortion contraceptive counselling.

Findings from these studies, as well as the study showing the safety of MVA conducted by nurse-midwives in Vietnam and South Africa[20], collectively and strongly confirm that abortion services given by other competent providers are as safe and effective as those given by physicians. The consultation recommended that:

- Available evidence on abortion, MR and/or PAC specific to the socio-legal context in each country is collated and updated.
- A coalition is established that works in conjunction with other partners working for women's health and rights to advocate for amendments and changes in the law, rules, regulations and policies to promote the provision of abortion, MR and/or PAC by other competent providers.

Participants highlighted the need for governments and country stakeholders to act upon this evidence and to take steps to include other competent providers among those legally permitted to provide abortion, MR and post-abortion care services.

2. National governments and ministries of health must amend laws, rules, regulations and policies for expanding the provider base

Safe abortion services and/or MR, as appropriate in each country's legal environment, and PAC services must be widely accessible, including to women in remote rural settings, and national laws and policies relating to the provision of abortion and post-abortion care services by other competent providers must be amended accordingly. Specifically Governments and Ministries of Health in each country must:

- Express commitment to expanding the provider base for abortion, MR and/or post-abortion care, review and/or amend laws, rules, regulations and/or policies for expanding the provider base to ensure widespread access and availability of safe abortion/MR and/or PAC as appropriate in each country's legal context.
- Take steps to amend existing laws, rules, regulations and/or policies so that appropriately trained other competent providers are permitted to independently provide abortion/MR and/or PAC services so as to ensure widespread access to these services as appropriate in each country's legal context

- Take steps to introduce and or make readily available medical abortion drugs for abortion, MR and PAC services as appropriate in each country's legal context
- Take steps to amend rules governing the prescription of allopathic drugs so that other competent providers are legally authorised to dispense drugs for abortion/MR and/or PAC services, as appropriate in each country's legal context, for medical abortion.

3. Enhancing the skills of other competent providers: addressing training needs and certification procedures

Participants acknowledged that expanding the skills of other competent providers to include first trimester abortion and post abortion care will require attention to training, both pre-service and in-service, and advised the following:

- Review and revise the pre service curriculum for all other competent providers to include competency based training on MVA, MA and/or MR, and CAC, as appropriate in each country's legal context and PAC; training in EMoC should include the use of MVA for post abortion care, with the objective of institutionalising the use of MVA for post-abortion care.
- Provide in-service and refresher training options to develop the skills of other competent providers in the provision of menstrual regulation, abortion and post-abortion care services as appropriate in each country's legal context, and encourage other competent providers to pursue such training.
- A large number of abortion seekers obtain their abortions from facilities in the private or NGO sector; it is important, therefore, to explore the feasibility of including other competent providers working in these sectors in training and certification procedures.
- Develop a pool of trainers to train MLPs in the provision of MVA, MA, MR, CAC and PAC services as appropriate in each country's legal context.
- Make arrangements for appropriate training facilities to be integrated into existing service systems, including arrangements for the provision of adequate mentoring and support.
- Outline certification and registration procedures for other competent providers. Set standards governing the certification or accreditation of providers, post-training follow-up and supportive supervision, documentation, M&E and audit, and ensure implementation.
- Ensure that job descriptions of certified other competent providers include the provision of MR, abortion (MVA/MA), CAC and/or PAC services as appropriate in each country's legal context.

4. **Reviewing the content of revised training programmes: Addressing the content of curricula, protocols, manual and guidelines**

- Prepare appropriate competency based training curricula, protocols, manuals and demonstration kits, as well as operational guidelines and materials MR, abortion (MVA/MA), CAC and/or PAC services as appropriate in each country's legal context); update national guidelines on a regular basis to reflect the latest evidence.
- Pre- and in-service training curricula content should be revised to include abortion service provision as appropriate, including training in pelvic examination, STI screening, gestation age estimation, assessment of abortion completion status, recognition and treatment of abortion related complications, as well as in pre-abortion and contraceptive counselling techniques, making appropriate referrals and a gender and rights perspective. Training should also cover accurate and complete reporting of abortion and post-abortion care services provided
- Ensure that the training of all other competent providers includes values clarification, along with sensitization on attitudes and behaviour towards all abortion clients, so that their right to confidential and caring services are respected.
- MVA is important for both CAC and PAC, and hence, training should be viewed as an essential aspect of all training programmes for other competent providers in all settings, including those in which abortion services are not legally permitted, because of its importance for PAC.

5. Establishment of appropriate guidelines for abortion service provision and referral

The consultation made a general recommendation that guidelines for abortion, MR, PAC service provision are prepared that are applicable to all abortion providers, that is including but not limited to other competent providers. Suggestions for inclusion in these guidelines are as follows:

- The minimum infrastructure required at facilities (government facilities, NGO facilities, private facilities) in which abortion providers are based.
- Identification of an appropriate backup facility, including a telephone referral system and transport services for easy referral in the event of serious adverse events, and the basic equipment required in these referral facilities.
- Links with other reproductive health services including family planning services.
- Provision for ensuring client privacy and confidentiality, including private post-abortion recovery facilities.
- Provision of contraception, basic medication, and pain control.
- Adequate systems for infection prevention and waste disposal.
- Inclusion, in the health management information system (HMIS), indicators to track abortion service provision.

6. Expand the evidence base

The group underscored the fact that available evidence is robust enough for governments to take immediate steps to enable the provision of first trimester abortion (MA and MVA) and/or post-abortion care by other competent providers. At the same time, the group recognised the need to build evidence on related matters to ensure that governments have the necessary evidence not only to bring about amendments to existing laws, rules and regulations, as relevant to each country setting, but also to enable a smooth transition to the provision of abortion by other competent providers, and to document implementation issues arising from their provision of abortion once initiated. The following issues were highlighted:

- Evidence is now available from India and Nepal that establishes the feasibility of the provision of MA [16,17]and MVA[18] by other competent providers, and from Bangladesh establishing the feasibility of provision of MR[19] by these categories of providers. Next steps with regard to research on the provision of abortion services by other competent providers need to fill country-specific gaps, including, for example, those relating to provider category, facility type and women's perspectives.
- Undertake a situation analysis to understand the positive or enabling factors that already exist within each country to support other competent providers in providing abortion/MR/PAC and learn from these on the ground experiences.
- Undertake operations research in different contexts in the region to understand various health system level implications for midlevel provision of abortion; acceptability and feasibility of abortion/MR/PAC service provision by other competent providers, including, for example, a comparison of: MR services provided by nurses versus physicians in Bangladesh, post-abortion care services provided by nurses versus community midwives in Pakistan, abortion services provided by nurses in the public sector compared to those in the NGO sector in Nepal, and services provided by different AYUSH doctors in India.
- Once systems are in place, undertake operations research to assess the provision of CAC and PAC. Topics may include such issues as: access (availability, affordability, inequity) and specifically how to operationalise service delivery in difficult to reach populations, quality of service provision and care, acceptability of the provision of services by other competent providers among women, especially poor women, costing and cost-effectiveness, counselling

practices, and post-abortion contraception uptake among clients of other competent providers, safety and acceptability of abortion provided by other competent providers in private and NGO versus public sector facilities.
- Undertake qualitative studies to better understand the experiences of other competent providers in providing abortion and post-abortion care services, and their perspectives on factors enabling them to sustain service provision (for example, monetary incentives, supportive supervision, job satisfaction).
- Assess the extent to which expanding the provider base to include other competent providers can increase the uptake of post-abortion contraception.
- Assess the feasibility of outreach or in-community provision of abortion/MR/PAC versus the provision of these services at facility level.
- Assess the role of "new providers", such as chemists or pharmacists and the role they can play in providing information, assessing gestation cut off points, or referring women to appropriate facilities.

7. Role of civil society and professional associations in enabling the expansion of the provider base for abortion and post-abortion care services

The consultation appreciated the role that civil society organisations, including abortion advocate groups, NGOs and professional associations have played and can play in expanding the provider base, and highlighted several areas in which further efforts are needed, as follows:
- Civil society groups can play an important role in advocating for changes in government policies relating to the provision of abortion and post-abortion care services by other competent providers.
- There is a need to build an alliance of different stakeholders to build a consensus with regard to ways of expanding access to safe abortion/MR/PAC (as appropriate in each country's legal context), including by other competent providers; such an alliance can play a key role in enabling countries of the region share experiences, emerging issues and new evidence on the one hand, and in mapping, at country level, the full range of stakeholders and including their perspectives in efforts to increase the provider base, on the other.
- There continues to be misgivings among some physicians and other health care professionals about the feasibility of the provision of abortion and post-abortion care services by other competent providers. There is a need to allay the fears of these groups, and convey to them that task sharing with regard to the provision of abortion and post-abortion services by other competent providers complements rather than competes with the responsibilities of physicians.
- There is a need for closer linkages between various professional bodies, notably physician and nursing-midwifery associations.
- Civil society groups can also play an important role in informing communities about the legal situation with regard to abortion and more specifically, about the importance of seeking early abortions and of seeking abortion from a qualified provider, the dangers of unsafe abortion and the conditions under which abortion services are available (where restricted) and the availability of post-abortion care services. At the same time, they can raise awareness of the role of other competent providers in providing (where already legal) or assisting (where it is not yet legal) in the provision of abortion and post-abortion care services.
- Civil society groups and health serving NGOs should contribute to efforts to train or orient other competent providers with regard to counselling techniques and respect for women's rights.
- There is concern about possible misgivings among some women's health advocates about the provision of abortion and post abortion care services by other competent providers. In this context, efforts are needed that apprise this important constituency about the feasibility of midlevel provision of these services. At the same time, it is important that the concerns of this important constituency are addressed, and that efforts are made to address their concerns about compromised quality of care or possible effect on the practice of sex selective abortion.

8. Until such time as legislation is passed, focus on involving other competent providers in abortion services within the current legal context

The consultation recognised that passing legislation may not take place with immediate effect, but stressed the need to immediately initiate other activities, within the scope of existing legislation that may smoothen the transition to independent provision of abortion services by other competent providers once legislation is passed. These activities may include, for example, the following:

- Other competent providers may be involved in all permissible roles in assisting the provision of abortion, for example pre- and post-abortion counselling, assessment of eligibility through pelvic examination, post-abortion care including treatment of incomplete abortion as part of the EMoC package.
- Efforts to revise pre- service training materials to include theory on MR, abortion (MVA/MA), CAC and/or PAC services, as appropriate in each country's legal context, for other competent providers, as described in point 2 above, should be put into practice in anticipation of eventual changes in laws, rules, regulations and/or policies.

9. Supporting and funding the shift to the provision of abortion services by other competent providers

Resources will need to be allocated for training and monitoring of service provision by other competent providers and conducting operations research, and the consultation recommended that participants and governments explore ways of raising the necessary resources. More specifically, the consultation recommended that governments:

- Allocate greater resources for training, supervision and monitoring of service provision and for operations research in priority areas.
- Make adequate preparations for the roll out of service provision of by other competent providers once appropriate modifications of laws and policies are made.

References

[1]Sedgh. G., S. Henshaw, S. Singh et al. 2007. Induced abortion: Estimated rates and trends worldwide. *Lancet:* 370(9595):1338-1345.

[2]World Health Organization (WHO). 2011. *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008, 6th edition*. Geneva: World Health Organization.

[3]Islam, M., U. Rob and N. Chakroborty. 2004. "Menstrual regulation practices in Bangladesh: An unrecognized form of contraception." *Asia-Pacific Population Journal* 19(4).

[4]Directorate General of Family Planning, Management Information System. 2010. *Monthly Progress Report on Performance of Family Planning, MCH and Reproductive Health Services*. Dhaka, Bangladesh: MIS, DGFP.

[5]Population Council. 2011. Expanding access to safe abortion and PAC in South Asia: Is provision of services by midlevel providers a feasible option? National level consultative meeting. Bangladesh: Population Council.

[6]Chhabra, N. and S. C. Nuna. 1994. *Abortion in India: an overview*. New Delhi: Ford Foundation.

[7]Office of the Registrar General, India (RGI). 2006. *Sample Registration System, Maternal Mortality in India: 1997-2003 Trends, Series I, Causes and Risk Factors.* New Delhi: RGI

[8]Population Council. 2004. Unwanted pregnancy and post-abortion complications in Pakistan. Findings from a National study, Islamabad. Pakistan: Population Council.

[9]CREHPA. 2011. Country Status Report, Nepal: Midlevel provision of abortion to expand safe abortion access. Nepal: CREPHA.

[10]Pakistan Penal Code 1860. *Act XLV of 1860 (Section 338).* Accessed on 28 March 2011 at http://www.pakistani.org/pakistan/legislation/1860/actXLVof1860.html.

[11]Piet-Pelon, N. J. 1998. "Menstrual Regulation Impact on Reproductive Health in Bangladesh: A Literature Review." *South and East Asia Regional Working Papers No. 14*. Bangladesh: Population Council.

[12]Bangladesh Penal Code 1860. *Act XLV of 1860 (Section 312).* Accessed on 28 March 2011 at http://bdlaws.minlaw.gov.bd/pdf_part.php?id=11.

[13]Government of India (GOI). 2003. *The Medical Termination of Pregnancy Rules (amendment)*. New Delhi: Government of India.

[14]Forum for Women, Law and Development, Kathmandu. n.d. *11th amendment to the Muluki Ain*. Accessed on 29 March 2011 at http://saathi.org.np/images/11th%20Amendment%20to%20the%20Muluki%20Ain.pdf

[15]Population Council. 2011. Consultation on midlevel provision of safe abortions and post abortion care. Islamabad: Population Council.

[16]Warriner, I. K., et al. 2011. Can midlevel health care providers administer medical abortion as safely and effectively as doctors – results from a randomised, controlled equivalence trial in Nepal. *Lancet:* 377 (9772):1155-1161.

[17]Jejeebhoy, S. J., S. Kalyanwala, S. Mundle et al. 2011. Feasibility of expanding the medical abortion provider base in India to include ayurved physicians and nurses India MA. (Unpublished paper).

[18]Jejeebhoy, S. J., S. Kalyanwala, S. Mundle et al. 2011. Expanding the provider base in India: The feasibility of MVA provision by non-MBBS providers. (Unpublished paper).

[19]Bhatia, S., A S G. Faruque and J. Chakraborty. 1980. Assessment of menstrual regulation performed by paramedics in rural Bangladesh. *Studies in Family Planning:* 11:23-27.

[20]Warriner, I. K., O. Meirik, M. Hoffman et al. 2006. Complication rates of first trimester manual vacuum aspiration abortion performed by physicians and midlevel providers (MLPs) in South Africa and Viet Nam: a randomised, controlled, equivalence trial. *Lancet:* 368 (9551):1965-72.