

Issues in
Abortion
Care 7

Deciding Women's Lives Are Worth Saving:

Expanding the Role of Midlevel Providers in Safe Abortion Care



IHCAR,
Karolinska Institutet



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Prepared by: Merrill Wolf

This document is based in part on presentations and discussions at an international conference titled "Expanding Access: Advancing the Role of Midlevel Providers in Menstrual Regulation and Elective Abortion Care," December 2-6, 2001, in South Africa.



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About Ipas and IHCAR

Ipas works globally to improve women's lives through a focus on reproductive health. Ipas's work is based on the principle that every woman has a right to the highest attainable standard of health care. Ipas concentrates on preventing unsafe abortion, improving treatment of its complications and reducing its consequences. Ipas strives to empower women by increasing access to services that enhance their reproductive and sexual health. Ipas technologies, training, research and technical assistance:

- support the development of women-centered health policies;
- improve the quality and sustainability of services;
- ensure the long-term availability of reproductive health technologies;
- promote women's active involvement in improving health care.

IHCAR, the Division of International Health of the Department of Public Health Sciences at Karolinska Institutet in Stockholm, conducts research and training in the field of international health with emphasis on low- and middle-income countries. IHCAR is currently active in approximately 25 countries, mostly in Africa but also in southern Asia and Latin America. A significant proportion of researchers and research students are involved in sexual and reproductive health projects, with emphasis on health systems and health policy. The focus of such research currently includes maternal morbidity and mortality, maternal and perinatal care, perinatal infections, fetal growth, appropriate technology in pregnancy termination, complications of unsafe abortion, midwifery care, sexually transmitted diseases including HIV/AIDS, childlessness, and delegation of responsibility to midlevel providers. IHCAR has a multidisciplinary character involving senior scientists from medicine, caring sciences and social sciences.

About the “Expanding Access” conference

With support from the Swedish International Development Agency (Sida), the Norwegian Agency for Development Cooperation (NORAD), the Ministry of Foreign Affairs of Denmark (Danida), the David and Lucile Packard Foundation and the Swedish Foreign Office, Ipas and IHCAR collaborated closely to organize the world's first-ever international meeting to promote the roles of midlevel health professionals in abortion-related care. The meeting — “Expanding Access: Advancing the Role of Midlevel Providers in Menstrual Regulation and Elective Abortion Care” — took place December 2-6, 2001, at Pilanesberg National Park in South Africa and was attended by 50 reproductive health professionals from 17 countries. This report is based largely on presentations and discussions at this conference.

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Glossary

Abortion: termination of pregnancy before the fetus is capable of extra-uterine life

Abortion care: counseling and clinical services for postabortion care, induced abortion and/or related needs that are appropriate in a given situation

Incomplete abortion: retention of a portion of the fetal or placental material within the uterus after spontaneous or induced abortion (retained products of conception)

Medical methods of abortion: use of pharmacological drugs to induce abortion

Menstrual regulation, MR: early uterine evacuation often without laboratory confirmation of pregnancy for women who report delayed menses

Midlevel providers in sexual and reproductive health: a range of non-physician health care providers — midwives, nurse practitioners, clinical officers, physician assistants and others — whose training and responsibilities differ among countries but who are trained in a range of clinical procedures related to reproductive health and who can be trained to provide early abortion

Postabortion care (PAC): a package of critical reproductive health services consisting of:

- community and service provider partnerships for prevention of unwanted pregnancy and unsafe abortion, mobilization of resources to help women receive appropriate and timely care for abortion complications, and ensuring that health services reflect and meet community expectations and needs
- treatment of incomplete and unsafe abortion and complications that are potentially life-threatening
- counseling to identify and respond to women's emotional and physical health needs and other concerns
- contraceptive and family planning services to help women prevent an unwanted pregnancy or practice birth spacing
- reproductive and other health services that are preferably provided on-site or via referrals to other facilities in providers' networks and accessible to women

Spontaneous abortion (miscarriage): unanticipated loss of pregnancy

Surgical methods of abortion: transcervical procedures for terminating pregnancy, including vacuum aspiration (electric vacuum or manual vacuum aspiration), dilation and curettage (D&C), and dilation and evacuation (D&E)

Unsafe abortion: a procedure for terminating an unwanted pregnancy either by a person lacking the necessary skills, or in an environment lacking the minimal medical standards, or both

If women's lives are to be saved, women's right to appropriate reproductive health services, including abortion care, must be secured by ensuring that women have access to these services in their communities.



Access to safe abortion care can be — and often is — a life or death issue for women. History shows that when women are determined to terminate an unintended pregnancy, if necessary, they will risk their lives to do so. Every year nearly 70,000 women die and millions more are injured because they lack access not only to safe, legal abortion services but even to humane and prompt treatment for complications of spontaneous or unsafely induced abortion (World Health Organization, 1998).

These deaths and injuries represent a social injustice of tragic proportions, particularly because they are almost entirely preventable. When properly performed, abortion is one of the safest medical procedures. Similarly, prompt access to care for treatment of abortion complications virtually guarantees a good outcome.

Abortion deaths contribute significantly to the greatest health disparity between rich and poor countries — deaths of women related to pregnancy. Women in wealthy industrialized countries face only a 1 in 4,100 chance of dying from pregnancy-related causes, while women in the world's poorest countries run a lifetime risk of 1 in 16 (World Health Organization, 2001). These deaths also represent significant gender inequity in access to health services. As Dr. Mahmoud Fathalla, former president of the International Federation of Gynecology and Obstetrics (FIGO), has said, “Women are not dying because of diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving” (Fathalla, 1997).

Progress in reducing deaths and injuries of women from abortion — a clear goal of numerous international initiatives — has been woefully inadequate, hampered primarily by a lack of political will. If women's lives are to be saved, women's right to appropriate reproductive health services, including abortion care, must be secured by ensuring that women have access to these services in their communities.

Globally, there simply are not enough health care providers trained and authorized to offer abortion care where and when women need it, especially in poor countries. Health system policymakers need to take much better advantage of the enormous untapped potential of health care professionals such as nurses, midwives, clinical officers, physician assistants and others. Midlevel health care providers are significantly more numerous and more geographically dispersed than physicians. Given appropriate training and supervision, they are well qualified to offer abortion-related care, particularly at the primary-care level. In many places, if they do not provide this essential care, no one will.

This report identifies challenges and opportunities for increasing the range of providers trained and allowed to offer abortion care, focusing on strategies related to midlevel providers. We hope it will galvanize interest and action among health care professionals and others in support of improving women's ability to exercise their sexual and reproductive rights and ending deaths and injuries of women from unsafe abortion.



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Foreword

*“Women ... are dying
because societies have
yet to make the decision
that their lives are
worth saving.”*

— Mahmoud Fathalla, M.D., Ph.D.
Former President, the
International Federation of
Gynecology and Obstetrics (FIGO)

Executive Summary

Women worldwide need access to safe abortion care — including treatment for potentially life-threatening abortion complications, postabortion contraceptive counseling and services, and induced abortion, in circumstances in which it is not against the law. Making these critical reproductive health services available to women in their communities can have a significant impact in reducing deaths and injuries from unsafe abortion, which accounts for at least 13 percent of global deaths of women related to pregnancy.

Empowering, training and supporting the vast numbers of midlevel health care providers to deliver abortion care is a crucial but often overlooked strategy. Nurses, midwives, clinical officers, physician assistants and other midlevel providers have solid clinical and other reproductive health skills on which to build, and the skills required to provide safe abortion care are well within the scope of their abilities. Experience from numerous countries demonstrates that, with appropriate training, supervision and support, many such providers can safely and effectively offer abortion-related care that is both accessible and highly acceptable to women. Significantly, midlevel providers are much more numerous, more geographically dispersed and more likely to work at the community level than physicians.

Mobilizing this cadre of health care personnel to offer abortion care may also have important cost benefits for both health systems and women. It may be a cost-effective strategy for health systems, since it costs less to train and employ midlevel providers than doctors. In addition, women are more likely to be able to afford health services that are available at the community or primary-care level.

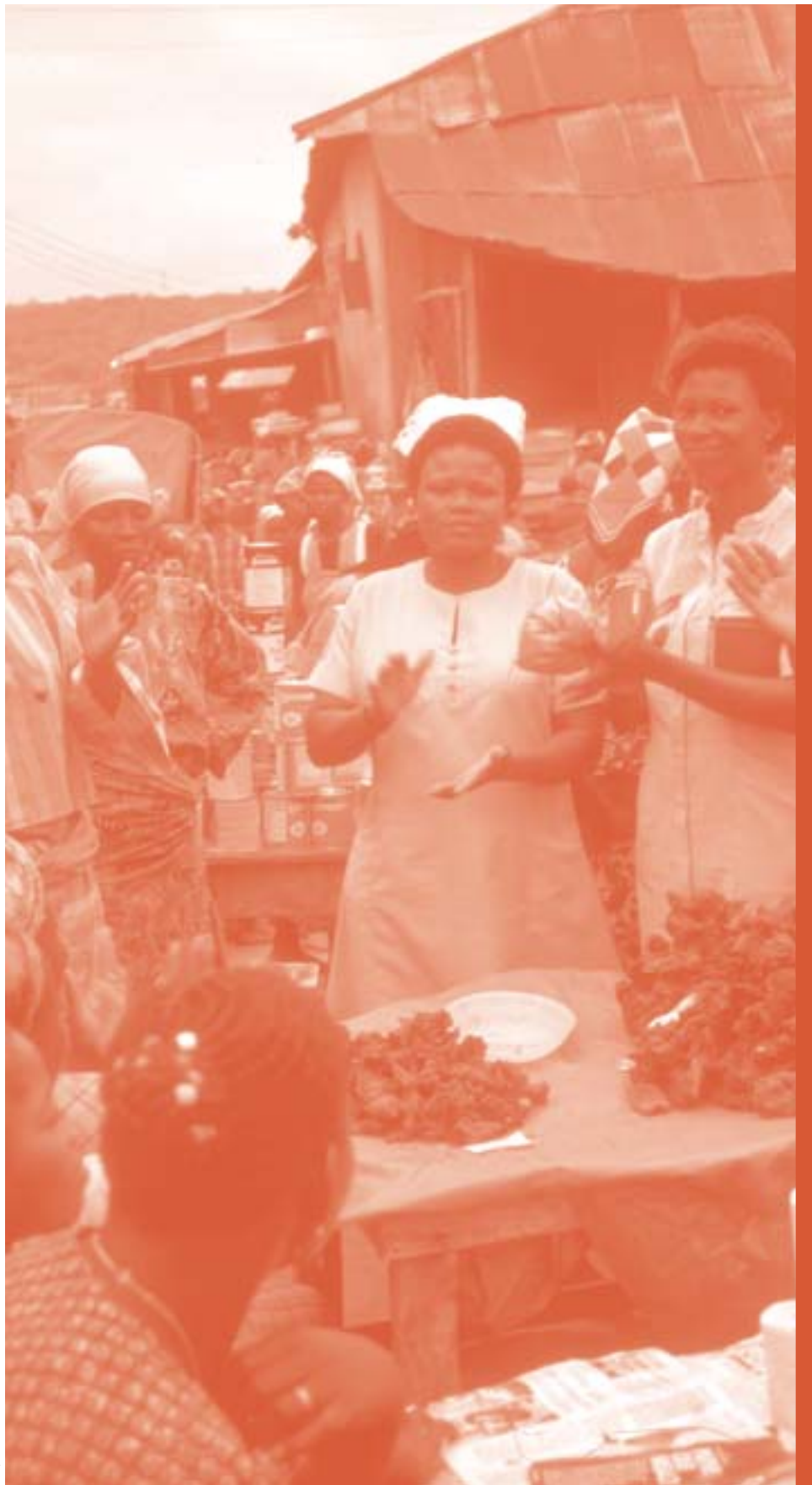
The principal obstacle preventing nurses, midwives, clinical officers and other midlevel providers from helping meet women's needs for safe abortion-related care is that, in many countries, both training and authorization to perform abortions and related procedures are restricted to physicians. Even where policies or regulations do not explicitly include such restrictions, opportunities for non-physician health care providers to learn clinical and other skills needed for abortion care are scarce.

Priority actions for health care policymakers, governments and others committed to reducing maternal deaths and injuries from unsafe abortion and to ensuring that women have access to the full range of reproductive health care that they want, need and deserve include the following:

1. **Commit and plan to increase the number of service delivery sites offering abortion care**, with emphasis on increasing women's access to services at the community or primary-care level. Policymakers need to commit both the human and financial resources necessary to ensure the long-term sustainability of such services.
2. **Authorize all qualified health care personnel**, regardless of their professional titles, to provide appropriate elements of abortion care. In many settings this requires removing existing policy restrictions such as “physician-only” regulations that allow only doctors to perform abortion-related procedures.

3. **Train and support qualified health care personnel** — especially those working at the primary-care level – in uterine evacuation and other essential skills for safe abortion care. Clinical and counseling skills for abortion need to be included in pre-service, on-the-job and refresher training for midlevel providers involved in reproductive health care.
4. **Equip midlevel health care providers and the health facilities where they work** to provide safe abortion care. Policymakers need to increase their commitment to and accountability for high-quality, sustainable services, including by ensuring consistent supportive supervision and the long-term availability of medical instruments, supplies and other materials essential for abortion care.
5. **Compile compelling evidence** on the safety, effectiveness and quality of abortion care provided by midlevel providers, as well as on the impact of making abortion care more accessible to women by training and authorizing these providers. Describing and sharing best practices in abortion care is essential.
6. **Encourage provision of abortion to the full extent permitted by law.** Abortion is legally permitted for some indications in almost all countries. Health-system leaders and others have a duty to educate health care providers, women and communities about the legality and availability of safe abortion care, as part of broader efforts to create an enabling environment for provision of safe abortion.

The international health community and governments worldwide repeatedly have agreed that reducing deaths and injuries from unsafe abortion is a high priority. Though they have made specific commitments toward achieving this objective, progress to date has been wholly inadequate. Significant progress cannot occur until women have much better access to safe abortion care in their communities. Midlevel health care professionals are well-qualified and well-positioned to play a pivotal role in safeguarding women's lives and health by offering this critical component of comprehensive reproductive health care. Policymakers' duty to women worldwide is to take advantage of the valuable opportunity that midlevel providers present.



JHU/CCP

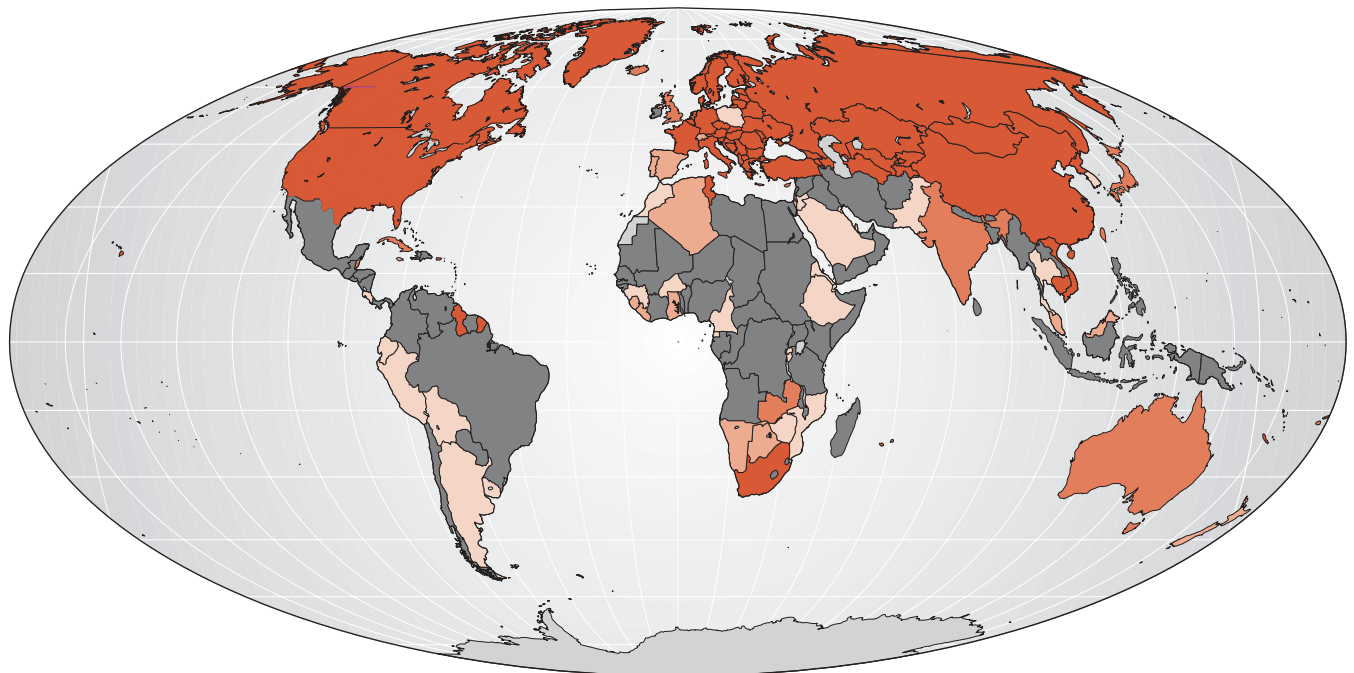
Chapter One: Introduction

In probably every country, nurses, midwives, physician assistants, clinical officers and other midlevel providers deliver the vast majority of health care services. These professionals — whose training, titles and day-to-day duties differ, sometimes dramatically, from country to country — are many people's first, principal and often only points of contact with the formal health care system, especially at the crucial primary-care level.

Already, a wide range of health care practitioners is involved in providing numerous elements of reproductive health care, including pregnancy testing, prenatal care, normal deliveries, and contraceptive counseling and method provision, including inserting intrauterine contraceptive devices (IUDs). In **Kenya**, for example, midwives attend 58 percent of births in urban areas and 29 percent in rural areas; in contrast, physicians attend only 24 percent of urban births and 11 percent of those in rural areas (KDHS, 1998).

One area of reproductive health care from which midlevel providers are usually excluded, however, is abortion care. Abortion is legally permitted for some indications in almost every country, and — legal or not — abortions occur in great numbers worldwide. Researchers estimate that about 22 percent, or 46 million, of the 210 million pregnancies that occur each year end in induced abortion (AGI, 1999); it is estimated that about 20 million of these abortions are performed by unqualified practitioners, in unhygienic conditions, or both (World Health Organization, 1998).

World Abortion Laws



| | |
|---|---|
| Without Restriction - 50 nations, 40.8% of world population | Physical Health - 33 nations, 9.9% of world population |
| Socioeconomic Grounds - 14 nations, 20.7% of world population | Save Life or Prohibited - 74 nations, 26% of world population |
| Mental Health - 20 nations, 2.6% of world population | |

Source: *World Abortion Laws 2000, CRLP 2000*

Making safe abortion accessible to women is a public-health imperative, but one that has been insufficiently achieved. Even for indications that are legal in most countries — such as rape, incest and risk to the woman's life — safe, legal abortion is very difficult for many women to obtain. In addition, as many as 15-20 percent of all clinically recognized pregnancies end in spontaneous abortion, often requiring medical treatment, and especially in countries where induced abortion is legally restricted, complications due to unsafe procedures are a leading cause of deaths of women during their reproductive years. Yet women's access even to treatment for abortion complications is limited, especially in poor countries. Women most affected by lack of access to safe abortion care are those who are most vulnerable to unwanted pregnancy, in particular adolescents and poor women.

International support and commitments

The goal of making safe abortion care accessible to women in their communities is consistent with several international health initiatives, notably Health for All and the Safe Motherhood Initiative.

In 1978, the World Health Organization's International Conference on Primary Health Care in Alma Ata, USSR, recognized the need for all people, as a matter of social justice, to be able to access important preventive, curative and rehabilitative health services — including maternal and child health care and treatment for common diseases and injuries — in their own communities (World Health Organization, 1978). Conferees established a goal of achieving "Health for All" by the year 2000. In 1987, the Safe Motherhood Initiative — a global effort aimed at reducing deaths and illnesses among women and infants, especially in developing countries — was launched in Nairobi, Kenya. Its initial goal was to cut the number of maternal deaths in half by the year 2000 by mobilizing a wide range of partners to improve women's access to essential reproductive health services. By 2000, however, no country had achieved the principal objective. The goal was thus revised; it is now to reduce maternal deaths from 1990 levels by 75 percent by the year 2015.

Several recent United Nations conferences — such as the 1994 International Conference on Population and Development (ICPD) and the 1995 Fourth World Conference on Women — have affirmed that reducing maternal mortality from abortion, including by making safe abortion care locally accessible to women, is an international priority. At ICPD, governments of more than 180 countries agreed that, in circumstances in which abortion is not against the law, such abortion should be safe (United Nations, 1994). The global community has also mandated that "health systems should train and equip health service providers and should take other measures" to ensure that such care is accessible to women (United Nations, 1999).

Consistent with these mandates, the World Health Organization recommends that certain elements of abortion care be available at primary-care facilities. These include recognition of signs and symptoms of abortion and complications; diagnosis of the stages of abortion; and prompt treatment or referral for abortion complications. Where

trained staff and appropriate equipment are available, services should include uterine evacuation with vacuum aspiration for uterine size equivalent to or under 12 weeks of pregnancy. (World Health Organization, 1991, 1995, 2000)

From vision to reality

International commitments to improve women's access to abortion-related care, and guidance in implementing them, contrast starkly with reality in most countries — primarily because of a pervasive lack of political will to tackle the controversial subject of abortion. To reduce the toll of unsafe abortion, governmental and health care leaders need to put women's needs ahead of political constraints.

Making safe abortion-related care available and accessible to women in the communities where they live requires focusing on the skills and competencies needed to give women the full range of reproductive health care that they want and need, rather than on categories of providers. By specifying the clinical and other skills required to offer high-quality abortion care, and by offering training and support for such skills to all qualified providers, health care systems can significantly increase the pool of trained professionals and women's access to needed care. Such an approach recognizes the untapped potential of health care providers other than doctors — a critical need since doctors are in scarce supply globally.

Progressive, realistic health care and political leaders in several countries have already embraced this strategy by authorizing, training and supporting midlevel health care providers to deliver a range of abortion-related services to women. These efforts — several of which are described in detail in this report — have yielded positive results in expanding women's access to needed care close to where they live and in reducing burdens on physicians, referral centers and health care systems. Significant expansion of such efforts is needed, especially in rural areas.

About this report

As previously noted, this report draws on presentations and discussions at the December 2001 "Expanding Access" conference in South Africa, and its structure mirrors that of the conference:

- **Chapter Two** examines how increasing midlevel providers' involvement in abortion-related care can help expand women's access to critical services.
- **Chapter Three** considers this strategy's potential for improving the quality of care, addressing clinical competence and acceptability of services.
- **Chapter Four** looks at policy approaches to overcoming barriers and creating an enabling environment for midlevel providers' involvement in abortion care. It also examines measures required to ensure that abortion-care services delivered by midlevel providers are sustainable over the long term.
- **Chapter Five** focuses on future directions and recommendations for research, policy, training and service delivery.

Preventing deaths and injuries from unsafe abortion requires focusing not on categories of providers but on the skills needed to give women the full range of reproductive health care that they want and need.

Chapter Two: Expanding Access

In most countries there are many more nurses, midwives, physician assistants and other midlevel providers than there are doctors.

Midlevel health care providers, especially those working at the primary health care level, have important roles to play in increasing women's access to reproductive health services, including abortion-related care. Factors contributing to their ability to fulfill these roles include their numbers, their location and the lower cost involved in training them and paying their salaries, relative to physicians. In addition, nurses, midwives, clinical officers and other midlevel health care providers are well-positioned to communicate messages about ways to prevent unintended pregnancy and unsafe abortion and about women's right to safe abortion care.

Availability

Although the specifics vary significantly among and within regions and countries and among specialties, in most countries there are many more nurses, midwives, physician assistants and other midlevel providers than there are doctors. In 1995, for instance, the World Health Organization estimates that there were only about 7 physicians for every 100,000 people in **Zambia**, compared to 113 nurses (World Health Organization, 1998). Their greater numbers are a key rationale for increasing midlevel health care providers' involvement in important areas of health service delivery traditionally reserved for doctors.

In addition, most physicians choose to live in urban centers, whereas the majority of people in many countries live in rural areas. In **Kenya**, for example, 70 percent of doctors live in cities, while 74 percent of the population is rural (Oguttu and Odongo, 2001). This disparity is exacerbated by emigration trends in many poor countries, including the so-called "brain drain," whereby significant numbers of the most educated people, including health workers, choose to leave their native countries for more affluent settings.

The inequitable geographic distribution of physicians, combined with their limited numbers, severely restricts access to many health services which only they are traditionally authorized or trained to perform. It often means that there is no access to these services at all. In the **United States**, for example, 9 out of 10 abortion providers live and practice in metropolitan areas, leaving 86 percent of U.S. counties with no abortion providers (Henshaw, 1998a). The impact of this lack of access is significant, considering that abortion is legal in the United States and that 43 percent of American women will have at least one abortion by age 45 (Henshaw, 1998b). Many women obtain the services they need only at great inconvenience; others never do.

Midlevel health care providers live and work in both urban and rural areas. They may be more likely than physicians to remain at their posts, and in their home communities, for long periods. Moreover, there is — and likely always will be — a nurse, midwife, clinical officer or some other midlevel provider working in most communities.

Affordability

Whether health care services are truly accessible to the people who need them depends not only on their geographic location but also on whether they are affordable. In many countries, including those where provision of induced abortion is legally

restricted, high-quality abortion-related services are accessible to women of means, who have the resources to pay doctors and, when necessary, to travel to urban areas to obtain needed care, but not to poor women. In addition to lacking money, many low-income women cannot spare time away from their household, family or work responsibilities to attend to their own health. Authorizing and training midlevel health care providers to offer safe abortion care addresses such economic inequity by helping make needed services available and affordable at the local level. When health care services are available in women's own communities, they are likely to be both physically and economically more accessible to women.

Furthermore, training and employing midlevel providers may cost health systems less than training and employing physicians, as their professional education typically is of shorter duration and their salaries are lower. In **Mozambique**, for instance, the cost of training doctors is estimated to be at least 10 times that of training medical assistants, maternal and child health nurses and nurse-midwives. This was one reason government officials decided in the early 1980s to create a new category of midlevel providers called *técnicos de cirurgia*, or surgical technicians. More than 85 percent of Mozambique's physicians had left the country during the protracted war that preceded its independence in 1975; consequently, a novel approach to making health care accessible was needed. Surgical technicians were trained to handle all surgical emergencies, including those related to reproductive health, at district hospitals. Notably, a 1995 evaluation of their performance found that uterine curettage accounted for 26 percent of all emergency interventions by the technicians. Several studies have shown that these personnel offer high-quality services at low cost to the health care system. (Limbombo and Ustá, 2001; Pereira et al., 1996; Vaz and Bergstrom, 1992; Vaz et al., 1999)



In Mozambique the cost of training doctors is estimated to be at least 10 times that of training medical assistants, maternal and child health nurses and nurse-midwives.

Case study 1

South Africa: A liberal law is not enough — Strategizing for equitable access

Awareness of the need to address inequities in access to health care was critical in shaping South Africa's 1996 Choice on Termination of Pregnancy (CTOP) Act (see Appendix for full text). Mindful of the disadvantages apartheid had imposed on poor black women, parliamentarians and health policymakers understood that a special effort was required to ensure equitable access for all women to safe, legal abortion. Recognizing the essential role midwives could play in reaching even the poorest women in the most remote areas, they authorized and planned to train midwives to perform vacuum aspiration.

The CTOP act permits abortion on request through 12 weeks of pregnancy, under certain circumstances through 20 weeks, and in very limited circumstances thereafter. It stipulates that registered midwives who have completed prescribed training may perform termination of pregnancy up to 12 weeks of pregnancy. The government's intent is to make manual vacuum aspiration — the recommended technique for early termination of pregnancy and treatment of incomplete abortion — available at every level of the health care system, in the context of comprehensive reproductive health care.

Less than two years after the act went into effect, the government initiated a national Midwifery Abortion Care Training Programme to prepare midwives for their important role in implementing it. The required course consists of 80 hours of theoretical training and 80 hours of supervised clinical training, using a government-approved abortion-care curriculum and manual prepared for this purpose. In addition to clinical skills necessary to provide early abortion and to treat incomplete abortion, the training emphasizes counseling, postabortion contraception, and stabilization and referral of women needing additional care or other reproductive health services. Although training and service delivery have focused on manual vacuum aspiration, midwives are also increasingly becoming involved in administering mifepristone for cervical preparation in induced abortion.

To date, only a small percentage of eligible midwives have undergone training. Nevertheless, a recent evaluation of the program revealed several positive trends as well as important challenges regarding access to safe abortion in South Africa. Records indicate a steady increase in both the number of abortions performed in public-health facilities and in the percentage of abortions performed under 12 weeks of pregnancy, when it is safest for the woman. Presumably midwives are providing services for women who would otherwise go to unqualified providers or carry unwanted pregnancies to term. The evaluation also found that a majority of midwives trained in the national program are providing high-quality abortion services but that supervision and support for these midwives needs to be strengthened. It also underscored that, given the high incidence of HIV infection in South Africa, women seeking termination of pregnancy should consistently receive counseling on effective approaches for preventing HIV and other sexually transmitted infections.

Sources: *Choice on Termination of Pregnancy Act, 1996*
Dickson-Tetteh and Billings, forthcoming
van der Westhuizen, 2001
Varkey, 2000



Case study 2

Kenya: Taking postabortion care to communities

Health care policymakers in Kenya, where unsafe abortion accounts for between 30 and 50 percent of maternal deaths, have seen the benefits of authorizing midwives to deliver postabortion care (PAC) as a key element in national efforts to reduce maternal mortality. What is now a national initiative began in western Kenya in 1996. There, a pilot project with the goal of improving access to high-quality postabortion care through a network of private providers has trained more than 100 midwives, clinical officers and other midlevel providers. To ensure that women know about the availability of services, project staff organized workshops for community health workers and contraceptive distributors, so that these critical personnel would be prepared to provide timely referrals for women requiring care.



Edward Reilly, Lutheran World Relief

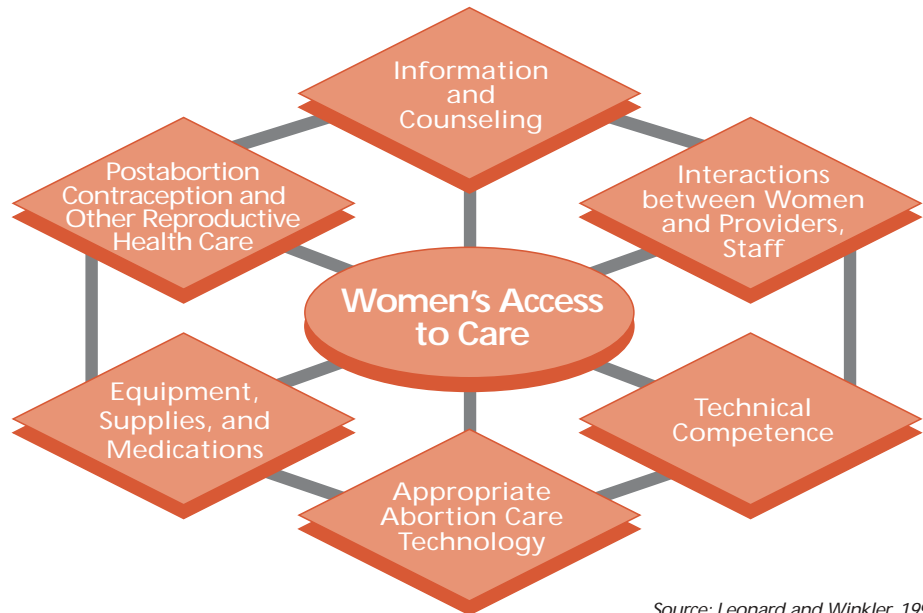
Based largely on this experience, in 1998 the USAID-funded PRIME project began training private midwives in three provinces in postabortion care. Before this training was available, only 2 of 32 facilities staffed by private nurse-midwives in these districts offered manual vacuum aspiration; the other 30 referred patients needing care to district hospitals. Now, PAC services are available at 28 of the 32 facilities. Midwives, after completed training, offer postabortion services as part of a reproductive health care program that includes contraceptive services and information for women about where to go for safe termination of pregnancy in case of an unwanted pregnancy. At least one training site reports a dramatic reduction in hospital admissions for incomplete abortion.

PAC training for midlevel providers in Kenya has expanded to the public sector and is included in the Ministry of Health's reproductive health strategy for 1997-2010. Ministry officials are finalizing a national PAC curriculum and considering including PAC in pre-service training of midlevel providers. In addition, the Nursing Council of Kenya is incorporating postabortion care into its midwifery curriculum.

Source: Oguttu and Odongo, 2001

Chapter Three: Quality of Care

“Quality of care” can be defined in many ways; most definitions refer to and elaborate elements of care that are likely to contribute to positive health outcomes. In reproductive health care, these may include technical and clinical competence; timeliness; affordability; choice of methods; information given to clients; mechanisms to encourage continuity of care; and an appropriate constellation of services (Bruce, 1990; Huezo and Diaz, 1993). The accompanying graphic outlines essential elements of quality that are specific to abortion care (Leonard and Winkler, 1991). This chapter focuses on the roles midlevel providers can play in supporting two key elements of quality of care: clinical competence and acceptability of services to women.



Source: Leonard and Winkler, 1991

Clinical competence

Many midlevel providers have solid reproductive health skills which can readily be expanded to include abortion-related care. For example, many already routinely perform pelvic exams, attend births, insert IUDs and provide follow-up care for IUD insertions. Evidence from countries such as **Malaysia, Sudan, the United Kingdom, the Philippines, Thailand, Iran and Turkey** shows that they do so safely and effectively (Andrews et al., 1999; Aziz and Osman, 1999; Kwa et al., 1987).

Among the clinical competencies required to offer abortion care (see box), the principal skill is uterine evacuation to remove products of conception from the uterus. The preferred method of uterine evacuation is vacuum aspiration, which can be performed using either an electric or a hand-held vacuum source. Vacuum aspiration is proven to be as effective as and significantly safer than sharp curettage (also known as 'dilatation and curettage' or 'D&C') (Baird and Flinn, 2002; Greenslade et al., 1993). Manual vacuum aspiration (MVA), which employs a portable, nonelectric hand-held vacuum aspirator, is particularly appropriate for low-resource and decentralized service delivery settings. The World Health Organization identifies MVA as the method of choice for treatment of incomplete abortion at the primary-care level (World Health Organization, 2000).

Experience from numerous countries shows that with appropriate training and clinical supervision, nurses, midwives and other non-physician health care providers can quickly become proficient in using MVA to treat incomplete abortion and to perform early induced abortion (Billings et al., 1999). Broader documentation of successful delivery of related services by midlevel providers includes the following:

- In **Vermont**, physician assistants — a provider category unique to the United States — have been performing abortions since 1975. A 1981-82 comparative study demonstrated that there were no differences in overall, immediate or delayed complication rates between procedures performed by physicians and physician assistants (Freedman et al., 1986; Kowalczyk, 1993).
- In **South Africa**, 3,927 women received first-trimester abortion in 27 facilities where midwives are actively involved in providing abortion care and treatment for incomplete abortion using both manual and electric vacuum aspiration. In 96 observations of induced abortion clinical practice by midwives, researchers found that midwives provided high-quality comprehensive abortion care (Dickson-Tetteh and Billings, forthcoming).
- Evaluation of the surgical performance of técnicos de cirurgia, or surgical technicians, in **Mozambique** documented successful surgery in 90 percent of 7,080 emergency surgeries undertaken by these providers at rural hospitals. Notably, emergency uterine evacuation accounted for 26 percent of the surgeries, making it the single most common procedure performed. It is also notable that the surgical technicians successfully performed many gynecological procedures that are much more complicated than vacuum aspiration, including caesarean sections and hysterectomies. If not for this novel category of providers, these potentially lifesaving surgeries would not have been available to many of the women served. (Vaz et al., 1999)

Medical abortion may offer even clearer opportunities than surgical abortion for properly trained and supervised midlevel providers, and involving these professionals in delivering it has great potential for increasing women's access to safe abortion (Kruse, 2000). The clinical skills involved in providing pharmacologically induced abortion include physical and psychological evaluation of the woman, pregnancy diagnosis and dating, informing and counseling the woman about her options, administering drugs, monitoring the woman's recovery, counseling her about postabortion contraceptive options, seeing her for follow-up care, and performing surgical evacuation of the uterus in rare cases of method failure. Although in many countries non-physicians are not authorized to prescribe pharmaceutical treatment, administering drugs on a doctor's orders and performing the other steps noted above are all well within most midlevel providers' ability and current practice.

Experience in **Sweden** and some parts of the **United States** supports this observation. In Sweden, for example, physicians' main role in provision of medical abortion is to estimate the duration of pregnancy by ultrasound and to serve as consultants and supervisors; midwives are responsible for counseling women and for administering

Skills and competencies required for abortion care

- *Pre-abortion counseling and physical assessment, including confirming and assessing the duration of pregnancy*
- *Contraceptive counseling and referral*
- *Uterine evacuation, including appropriate infection prevention and pain management*
- *Monitoring and management of abortion-related complications*
- *Recovery and follow-up care*

*Sources: Baird and Flinn, 2002
McInerney et al., 2001*

Many midlevel providers already have solid reproductive health skills which can readily be expanded to include abortion-related care.

mifepristone and misoprostol. Similarly, trained midlevel providers are authorized to give women misoprostol for cervical preparation before first-trimester abortion in **South Africa**.

Training needs

A recent global evaluation of postabortion care specifically recommends training midlevel providers to manage incomplete abortion (Cobb et al., 2001). In addition, expanding women's access to the full range of abortion-related care requires training and equipping midlevel providers in all the skills and competencies noted above. These skills need to be included in pre-service, in-service and on-the-job training for a wide range of health care workers.

In most countries, however, training curricula and education programs for midlevel health care providers — even those directly involved in reproductive health services — do not include these topics. This omission may reflect laws, policies and regulations that specifically designate physicians as the only providers who may perform abortion-related procedures. In other instances, no such explicit restrictions exist, yet clinical, counseling and other skills for abortion care are still neglected in these health care workers' medical education. In these cases, the omission may reflect traditional concepts of physicians' authority, lack of understanding of the impact of unsafe abortion and the social stigma surrounding abortion.

Lack of adequate, ongoing training opportunities undermines service provision even if other important elements, including supportive laws or policies, are in place. In **Cambodia**, for example, since 1997 the law has permitted authorized medical assistants and midwives to perform abortion in government-certified facilities. Partly because abortion skills are not yet included in the midwifery curriculum, however, abortion services are not accessible to the full extent permitted by law.

Examples of successful efforts to train midlevel providers in provision of abortion-related care include the following:

- ◆ In **Peru**, postabortion care with manual vacuum aspiration has been integrated into the undergraduate curricula of 8 of the country's 25 midwifery schools, as a key strategy in making this lifesaving care accessible to women in remote areas. Reported advantages of this pre-service training include improved access for women to postabortion care; improved interpersonal interactions between providers and women; increased acceptance of postabortion contraception; and better use of health-system resources. Women's health advocates are now working to expand incorporation of PAC with MVA into midwifery education and into regulatory oversight of professional midwives, to achieve sustainable improvements in quality of care and access. (Huapaya, 2001)
- ◆ In **Ghana**, a three-year operations research project showed that training midwives in private maternity homes, public health centers and public district hospitals to provide postabortion care enabled them to offer high-quality emergency services in

Case study 3

Vietnam: Improving the quality of care in the private and public sectors

Early abortion has been legal since the 1960s in Vietnam, which has one of the highest abortion rates in the world. An estimated 40-50 percent of all pregnancies are terminated by induced abortion, and the total abortion rate is estimated at 2.5 abortions in a woman's lifetime. Factors contributing to the high number of unwanted pregnancies and induced abortions include a strict population policy, limited choice of and misperceptions about modern contraceptive methods, high failure rates for IUDs due to incorrect usage, and inadequate postabortion counseling.



Pham Hong Long, NCPFP

Abortion services are available at all levels of the public health care system, including at commune health centers. At these facilities early abortion procedures are performed by health-center staff or by a family planning team from the district hospital, which visits every one or two weeks. Midwives and assistant doctors are authorized to perform abortions up to six weeks of pregnancy. Abortions for pregnancies of more than eight weeks' duration are available at public hospitals, where physicians perform them.

In the late 1980s, as part of an effort to curb population growth, the Vietnamese government greatly expanded contraceptive and abortion services, including by authorizing private providers to perform first-trimester abortions. Women who can afford them appreciate private services because they typically offer better pain relief and more privacy, and because waiting times are shorter than at public-health facilities.

Public-health services in Vietnam are well-developed for a low-income country, but several factors still limit women's access to high-quality comprehensive abortion care. In particular, there is a need to increase training opportunities for midwives and assistant doctors in abortion procedures, and to improve pre- and postabortion counseling and surgical abortion protocol. In addition, private-sector abortion services would be strengthened by better monitoring.

In response to this situation, documented in 1999 by the World Health Organization, the Vietnamese Ministry of Health's National Reproductive Health Strategy for 2001-2010 outlines commitments to reducing women's recourse to abortion by 50 percent and to improving the quality of abortion services by having 70 percent of abortion clients informed and counseled on reproductive health and contraception. The strategy also aims to offer postabortion counseling to 60 percent of abortion clients.

To meet these needs, the Ministry of Health is partnering with the two largest obstetrics and gynecology teaching hospitals in Vietnam — the Institute for the Protection of Mothers and Newborns in Hanoi and Tu Du Obstetrics and Gynecology Hospital in Ho Chi Minh City — and Ipas to create a model for implementing a comprehensive approach to high-quality, client-centered abortion care that can be replicated at all levels of the health system. The partnership, supported by the Ford Foundation and the World Health Organization, includes development of standardized national guidelines, protocols and curricula, and establishment of two exemplary, regional abortion training sites. Midwives are receiving formal training in surgical abortion at Tu Du Hospital and in abortion counseling at the Institute for the Protection of Mothers and Newborns.

*Sources: Dang and Khe, 2001
Goodkind, 1994
Vietnam Ministry of Health, 2000
World Health Organization, 1999*

Case study 4 **Cambodia: Urgent need to train midwives in abortion care**

The long and devastating civil war in Cambodia during the 1970s almost totally destroyed the country's health system. Particularly in the past decade, health services have been gradually re-established and important policy developments

have taken place. Cambodia's Safe Motherhood Policy and Strategy document of 1997 and the abortion law enacted the same year represent encouraging strides for women's reproductive health and rights. But poverty, limited public awareness of the abortion law and lack of trained health providers means that Cambodian women's access to safe abortion care is still severely limited.

Contraceptive use is very low in Cambodia, despite high awareness among women and a widespread wish to space or limit births. Between one-quarter and one-half of Cambodian women have had at least one abortion, mostly provided at private clinics.

The abortion law establishes women's right to first-trimester abortion on any grounds, performed by a qualified doctor, medical assistant or midwife at public or private health facilities licensed by the Ministry of Health. Midwives and other medical staff working in gynecological services report that performing abortions, commonly by curettage, is a major part of their work both in private and public facilities. They have no formal training but learn the skills by practicing on-the-job with obstetricians. While guidelines for formal training in safe abortion care have been developed, they have yet to be formally adopted or implemented by the Ministry of Health.

The abortion law offers an important opening to expand access to safe abortion care in Cambodia. The challenges for women's health groups, professional associations and other partners include raising popular awareness of the law and ensuring that the Ministry of Health adopts and implements abortion training guidelines into basic training of medical, nursing and midwifery students, as well as into specialized training for doctors and midlevel providers working in reproductive health care.

Source: Long and Ren, 2001



Population Services International

women's own communities. To promote a team approach and enhance referral and continuity of care, the project trained midwives and physicians together. Its success has since prompted additional training. (Billings et al., 1999a & b)

- ◆ The government of **Bangladesh** has long collaborated with nongovernmental organizations to train female paramedics called "family welfare visitors" to perform menstrual regulation, which it defines as "an interim method for establishing non-pregnancy." As of this writing nearly 7,000 trained paramedics work in government clinics, with many more in private practice.

In addition to training qualified midlevel health care personnel to provide abortion care, it is important to inform all health care workers that unsafe abortion is a serious public-health concern and that, in accordance with local laws, safe abortion is an element of essential reproductive health care. Further, all primary-care providers should be taught to recognize complications of both spontaneous and unsafe abortion — as well as the rare complications of safe, induced abortion — to stabilize women suffering such complications, and to refer women for treatment of abortion complications if they cannot provide needed care. Finally, because of their critical support roles and their positions in communities, it makes sense to prepare all nurses, midwives and other midlevel providers to counsel women about how to avoid unwanted pregnancy and unsafe abortion, how to recognize pregnancy and complications of both pregnancy and abortion, and when and where to seek medical attention for such conditions.

Acceptability

Reproductive health services' acceptability to women is determined by factors such as clients' confidence in the provider's competence, the quality of interpersonal relations, privacy and confidentiality, respect for clients, and the degree to which services meet all of women's needs — medical, emotional, psychological and sociocultural. Although there may be challenges, many midlevel health care providers can develop both the technical and interpersonal skills needed to provide high-quality abortion care.

Attitudinal obstacles

Among the challenges health care program managers seeking to expand midlevel providers' role in abortion care may encounter is resistance from the providers themselves. For instance, midwives may view themselves as instrumental in caring for women during pregnancy but may not consider management of pregnancy outcomes other than childbirth their responsibility.

In addition, health care providers bring personal views and values to their work. Given abortion's controversial nature in many societies, it is not uncommon for these views to include negative thoughts and feelings about abortion and about women who seek abortion. Health care workers may also be reluctant to participate in abortion-related care because they fear disapproval or harassment from their colleagues, families or communities, or even violence from anti-abortion extremists. Such fears are justified in certain settings: In the **United States**, there were 2,100 reported incidents of violence against abortion providers, including 6 murders and 15 attempted murders, between 1977 and 1997.

Health care providers' views and attitudes toward abortion — of which they may not even be fully aware — can interfere with their ability to provide comprehensive, compassionate, high-quality care and can drastically affect services' accessibility. For instance, providers who personally oppose abortion may refuse even to refer women seeking abortion to qualified medical personnel who are willing to deliver needed care. In a recent study, nurses in **South Africa** and **Zambia** were interviewed about their experiences with and perceptions of abortion services. Although elective abortion is legally permitted in both countries, nurses' attitudes toward abortion were either judgmental or conservative. They admitted to being more sympathetic toward women

Sample Objectives from a Values Clarification Training for Health Workers

Health workers were asked to:

- *describe the way society expects boys and girls (and men and women) to behave, and to investigate its influence on unwanted pregnancy and health worker-client interaction;*
- *identify the reasons why women may require abortion services, and based on these reasons, to identify how abortion services need to be delivered to deal with unwanted pregnancy;*
- *examine their perceptions of clients requesting abortion services and colleagues providing abortion services, and how this influences their interaction with clients and colleagues;*
- *discuss their personal rights and their professional responsibilities in delivering abortion services;*
- *investigate factors health workers identify in their work situation that affect their relationship with clients requesting abortion services;*
- *identify steps that can be taken at their own health facilities to improve the quality of abortion services.*

Source: The Women's Health Project, 2001

seeking treatment for spontaneous abortion than toward those who had had induced abortions. The nurses also said they took less interest in the health needs of women who requested abortion. (Ndhlovu, 1999; Solo et al., 1998 and 1999)

In addition, anecdotal reports from numerous countries suggest that health care staff sometimes subject women — especially adolescents — seeking abortion care to punitive treatment. For example, staff may verbally abuse women, make them endure unnecessarily long waits to be treated or withhold pain medication. Women who took part in a community survey on the quality of postabortion care in **Haiti**, reported mistreatment including public scolding and ridicule. The women also said providers commonly did not respect their confidentiality and confirmed that community knowledge of such poor treatment made women more likely to delay seeking treatment for abortion complications. (Israel and Webb, 2001)

To improve and ensure quality of care, health program managers must address attitudinal barriers among health care staff of all categories and model positive behaviors and attitudes. Steps they can take include developing, disseminating and enforcing behavioral standards that specify the need to treat women compassionately, respectfully and nonjudgmentally. It may also be helpful for professional associations or health care institutions to create support groups for personnel involved in abortion care to reduce their isolation and create positive reinforcement for what, because of social factors, can be difficult work.

Education can also help ensure that health care workers' personal interactions with

Case study 5

Sweden: Medical abortion provided by midwives: Increased access and options

According to the Swedish Abortion Act of 1974, a woman is entitled to have a pregnancy terminated on request until the end of 18th week of pregnancy. The law requires that abortions be performed at a public hospital by a qualified medical doctor.

The vast majority (93 percent) of induced abortions are performed during the first trimester. Vacuum aspiration remains the method of choice for early abortions, although since the early 1990s women have also been able to choose medical abortion during the first nine weeks of pregnancy. Gradually, the use of medical abortion has increased; in 2000 it accounted for about 40 percent of early abortions.

For many years, nurse-midwives with special training have been the main providers of contraceptive services with the authority to prescribe oral contraceptives and insert IUDs. Many also serve as educators on sexuality, birth control and abortion in the community, in schools and at youth clinics. Although by law only physicians are entitled to perform abortion, nurse midwives' responsibilities for counseling and care during medical abortions has steadily increased. In settings where they have the authority to administer drugs, some midwives are actually providing medical abortions. Of about 5,000 midwives in maternal health, an estimated 200-300 are currently involved in providing medical abortion and/or postabortion care.

Source: Jonsson, Zätterström and Sundström, 2001

women are positive. Training for health care workers who will participate in abortion care should clarify the legal status of abortion, including reviewing indications for legal abortion, and the public-health impact of unsafe abortion. Focused training can also help staff better understand the factors that lead to unwanted pregnancy and thus become more sensitive to women's personal circumstances. "Values clarification training" with these objectives proved helpful in reducing negative attitudes toward abortion in **South Africa**, where health-system leaders working to implement that country's 1996 Choice on Termination of Pregnancy Act initially encountered attitudinal barriers among midwives and other health care professionals. The training workshops, in which more than 4,000 health care providers have participated, helped staff reflect on their own feelings and thoughts about abortion and encouraged a nonjudgmental approach to service provision, with emphasis on treating women with dignity and respect regardless of the provider's personal views. Subsequent evaluation found that

To improve and ensure quality of care, health program managers must address attitudinal barriers among health care staff of all categories and model positive behaviors and attitudes.

nearly 70 percent of workshop participants felt the sessions helped them clarify their values in such a way as to improve their relations with abortion patients ‘quite a bit’ or ‘a lot.’ (Marais, 1997)

The life-cycle approach to reproductive health care

In recent years, reproductive health professionals have increasingly come to understand the value of a life-cycle approach to providing care. A life-cycle orientation is particularly appropriate for primary-care providers, who may be women’s first or only contact with the health care system for many years. For personnel involved in delivering reproductive health care, this approach implies an obligation to help women obtain the full range of reproductive health services they want and need throughout their lives, including:

- ◆ education about gender equality, sexuality and reproduction for young girls and boys;
- ◆ information, counseling and services on sexuality and contraception for female and male adolescents;
- ◆ contraceptive information and services to help sexually active women and men prevent unwanted pregnancy;
- ◆ assistance resolving unwanted pregnancies, including through pregnancy termination (in accordance with local law);
- ◆ postabortion counseling and services for miscarriage and induced abortion;
- ◆ prenatal care and other services to ensure healthy pregnancies;
- ◆ assistance during childbirth;
- ◆ information, prevention and treatment of sexually transmitted infections;
- ◆ screening for cervical cancer;
- ◆ preparation for and assistance through menopause.

Offering abortion care as one component of comprehensive reproductive health care — rather than as an isolated service — is consistent with and supports a life-cycle approach to care and women’s overall health. It can also have an important impact on destigmatizing abortion.

In **Sweden**, midwives play a primary role in making a wide range of sexual and reproductive health services accessible in public-health facilities, and especially in meeting the special needs of young people. Young people rely heavily on youth clinics staffed by nurses, midwives and doctors for reproductive health services, including contraceptive advice and services and help preventing and treating sexually transmitted infections.

In health care delivery — and perhaps particularly in relation to abortion services — policy and practice are not always synonymous. In some countries with very restrictive abortion laws, such as **Kenya**, some women are able to find high-quality abortion services. Conversely, even the most liberal abortion laws do not guarantee that safe abortion care is broadly available or accessible to women. Such is the case in **India**, for instance, where unsafe, illegal abortion remains a serious health problem despite a liberal law that has been on the books for decades.

It is clear, however, that abortion services are most likely to be accessible and of high quality when they are supported by positive laws, policies and regulations which health care providers consistently interpret in a way that enhances access. Health-system leaders in both the public and private sectors need to pay special attention to providing logistical and other support to ensure the long-term availability and quality of services; to educating health care providers about laws and policies; and to encouraging positive interpretations of such laws and policies. Failure to create and maintain an enabling environment for the provision of high-quality abortion care can lead to fragmented services, inconsistent quality and lack of service sustainability — all of which are detrimental to women's health.

Making Services Sustainable

Ensuring that women have regular, dependable and ongoing access to the full range of reproductive health care services that they want and need requires planning and commitment on the part of health-system managers. Thoughtful attention to elements necessary for service sustainability is especially important for controversial services such as those related to abortion, which may encounter resistance both from within the health system and from the community.

In many settings, midlevel health care providers already face enormous challenges as they strive to meet great demand for services, often with scant resources. Increasing the scope of their practice to include one or more aspects of abortion-related care may require reassigning some of their current tasks to others. In all cases, it requires giving them additional support in the form of training (as previously discussed), supervision and ongoing supply of needed medical instruments, medications and other materials, to ensure that services continue in the long term, despite changes in personnel or resources.

Quality assurance through supervision

Supportive supervision of abortion services entails providing clear, consistent guidance regarding how services should be delivered and monitoring adherence to established standards. This requires creating, disseminating and enforcing norms and standards for abortion care that support provision of services to the full extent allowed by law. Effective norms and standards regarding provision of abortion care spell out the types of services to be offered at each level of the health care system; essential equipment, supplies, medications and facility capabilities; and referral mechanisms.

Chapter Four: Policy Strategies

Abortion services should be performed as close to women's homes as possible, by qualified personnel without regard to their professional titles.

Case study 6

Mozambique: Expanding access when resources are scarce and doctors few

In Mozambique, where the law regulating abortion remains restrictive, multiple factors led to an interesting policy development which has allowed for the provision of safe abortion in select public hospitals. Since implementation of the policy, fewer women present in such settings with serious complications resulting from unsafe abortion.

Mozambique is a poor country with low contraceptive-prevalence rates, high abortion-related mortality and morbidity, and high expenditures to treat women presenting with these complications. To address these conditions, in 1981 the Ministry of Health authorized the provision of safe abortion in the first 12 weeks of pregnancy, originally only at Maputo Central Hospital. After comparative studies showed that the costs of treating women with complications was significantly higher than performing safe abortions, safe abortion services were extended to other major hospitals, down to the provincial level.

Given the scarcity of ob-gyn specialists in Mozambique, postabortion care and abortion services are generally provided by midlevel providers, notably maternal child health (MCH) nurses and assistant medical officers. Both surgical (manual vacuum aspiration) and medical (miso-prostol) methods are used. Frequent in-service training and monitoring are used to improve and maintain the quality of services.

Increasing availability and use of contraception to bring down rates of unwanted pregnancy remains a challenge for Mozambique. In addition, despite the wide availability of abortion services in hospitals, many women still cannot access these services and resort to unsafe abortion. By expanding information on and access to both contraceptive and abortion services, Mozambique might realize significant reductions in complications related to unsafe abortion.

*Sources: Mocumbi, 2001
Libombo and Ustá, 2001*



Along with health system leaders and sometimes parliamentarians, managers have an important role to play in removing unnecessary restrictions on the types of facilities and categories of health care personnel authorized to provide abortion-related services. As a general principle, abortion services should be performed as close to women's homes as possible, by qualified personnel without regard to their professional titles.

Ghana was one of the first countries to incorporate attention to unsafe abortion into Safe Motherhood policies and programs. Ghana's National Reproductive Health Service Policy and Standards, introduced in 1996, emphasizes the need to make postabortion care accessible to women throughout the country, including by authoriz-

ing and training midwives to use manual vacuum aspiration for treatment of incomplete abortion.

Similarly, to improve both the accessibility and the quality of reproductive health services, the Ministry of Health of **Vietnam** has begun to develop national standards and guidelines for service delivery that define what services are to be delivered at each level of the health system, by whom and using what techniques. Proposed specifications for abortion stipulate that trained midwives and assistant doctors may perform vacuum aspiration up to 12 weeks of pregnancy at the central, provincial and district levels, and up to six weeks of pregnancy at the commune level.

Once norms and standards have been developed and disseminated, it is important for managers to establish mechanisms to ensure that they are upheld. Routine, accurate collection and analysis of service statistics are key to maintaining and improving the quality of services and to measuring their impact.

Long-term logistics

Consistent logistical support is indispensable to launching new services and to ensuring long-term service sustainability. It is important to establish clear systems and procedures at the earliest stages of training and service delivery for supply and security of relevant medical instruments (for example, for manual or electric vacuum aspiration), drugs for medical abortion and pain management, and ancillary materials such as gloves, clean water and disinfection agents. If such needs are not addressed systematically, interruptions in supplies can bring service delivery to a halt.

In **Tanzania**, for instance, government health officials discovered that some public hospital staff who had been trained in MVA for postabortion care had reverted to using sharp curettage — a method no longer recommended — because of a shortage of MVA instruments and the lack of a prescribed way to obtain more. In response, the Ministry of Health added MVA instruments to its official procurement list, making it possible for public facilities to have ready access to the instruments through standard distribution channels.

Attention to pre-service and on-the-job training is also critical for service sustainability, as approaches for institutionalizing services and countering natural staff attrition.

Overcoming policy barriers

To enhance women's access to abortion-related services, health-system leaders and program managers need to assess existing laws, policies and regulations. Those that impose unnecessary restrictions on delivery of care can be revised without compromising safety or quality. Examples of policies that may appropriately be revised include:

- ◆ *“physician-only” requirements that prohibit anyone who is not a physician from performing uterine evacuation or other abortion-related procedures.* Such stipulations inappropriately focus on categories of medical personnel rather than on the skills and competencies needed to ensure delivery of high-quality services where they are needed.



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The Ministry of Health of Vietnam has begun to develop national standards and guidelines for service delivery that define what services are to be delivered at each level of the health system.

Case study 7

India: Is there a role for midlevel providers in abortion care?

Since the Medical Termination of Pregnancy Act (MTP) was passed in 1971, first-trimester abortion has been legal in India for a broad range of indications, from risk to the woman's life to contraceptive failure. However, service delivery is drastically impeded by restrictive policies governing where pregnancy termination may be performed, who must approve it and who may perform it (physicians only). Cumbersome licensing and certification procedures for service delivery sites exacerbate women's difficulty obtaining needed care, especially in rural areas where most women live. As a result, unqualified, often unsafe practitioners perform an estimated six times as many abortions as government-approved providers. Clearly, India's relatively liberal law has not translated into access to safe and legal abortion services for the majority of women.

The Indian government and key NGO actors recognize the importance of decentralizing abortion services and have taken steps to address this need. In 2000, the government introduced a national population policy whose objectives include:

- expanding the number of service delivery sites offering abortion;
- improving quality of care;
- adopting simple technologies such as manual vacuum aspiration to support decentralization of services;
- eliminating onerous procedures for registering abortion clinics;
- formulating and disseminating standards for abortion service delivery;
- encouraging the training of midlevel providers.

Priorities under this policy include establishing vacuum aspiration as the standard of care for first-trimester procedures; providing abortion training and certification for general physicians (MBBS doctors) already working in the public health system but not yet involved in abortion care; and streamlining requirements so more physicians will receive training and certification. To date the recommendation to prepare non-physician providers in abortion care has not been made a priority. Given that 75 percent of Indian women live in rural areas and that most MBBS doctors live in urban areas, it remains unclear whether this approach will have a significant impact on making safe abortion accessible to the women who most need it.

*Sources: Government of India, 2000
Government of India, Parivar Seva Sanstha and Ipas, 2000
Registrar General, India, 1992*



Todd Shapera

Case study 8

Zambia: Bridging the policy-service delivery gap

Although Zambia has one of the most liberal abortion laws in sub-Saharan Africa, unsafe abortion remains a major cause of maternal mortality and morbidity. Women's access to safe, legal abortion is constrained by limited public awareness about the legal indications or requirements for obtaining an abortion, as well as by medically unnecessary, bureaucratic restrictions written into the law. For example, abortion may be performed only by a medical doctor at a government hospital, with approval and signatures from three physicians, one of whom must be a specialist in the field related to the stated indication. This requirement results in abortion being available at only one hospital in the entire country.

In addition, many Zambian women — whose access to high-quality contraceptive services is also very limited — do not even know that abortion is legally permitted. As a result, many women resort to self-induced and other unsafe interventions to terminate unwanted pregnancies.

In recent years the Ministry of Health has acknowledged the problem of unsafe abortion and undertaken a number of efforts to increase women's access to treatment for abortion complications, including training doctors, nurses and midwives in postabortion care. The Nurses and Midwives Act of 1997 allows midwives to perform manual vacuum aspiration for treatment of incomplete abortion, in addition to counseling women. In Zambia nurse-midwives' involvement in postabortion care has contributed to more supportive attitudes toward women who request termination of pregnancy. It has also proved to be a bridge to other reproductive health services, such as contraceptive counseling and methods and safe abortion care. For instance, when counseling women with incomplete abortion about how to avoid another unwanted pregnancy, midwives also advise them about their legal rights and where to go for safe, legal abortion.

Other efforts underway to bridge the policy-service delivery gap in Zambia include lobbying by women's health advocates and professional associations for a review of the law governing termination of pregnancy to make services more accessible. Suggested improvements include reducing the number of doctors' signatures required, allowing other health care providers to perform abortion and allowing private hospitals to offer abortion. In addition, training for midwives in vacuum aspiration, postabortion counseling and contraceptive services is being expanded nationally.

Additional attention must also be focused on the reproductive health needs, including abortion care, of Zambia's youth. Finally, more effort is required to inform Zambian women, health care providers and communities of the impact of unsafe abortion, of the legal status of abortion and of the law's potential to reduce maternal mortality.

Sources: Kaseba et al., 1998
Mtonga and Ndhlovu, 2001

- ◆ *unduly complicated licensing and certification requirements that inhibit provision of care at facilities that are staffed by qualified personnel.* In the **United States**, for instance, anti-abortion legislators in several states have succeeded in passing laws imposing onerous and medically unnecessary physical requirements on health care facilities that provide abortion, forcing some abortion providers to abandon their practices.
- ◆ so-called “*conscientious-objection*” clauses that allow health care providers to refuse to perform abortion. Where such provisions exist, it is important for health-system leaders to clarify that they apply to individuals rather than institutions, and that health care

Case study 9 **Bangladesh: Policy response to the reality of unwanted pregnancy and unsafe abortion**

Bangladeshi law permits abortion only to save the life of the pregnant woman. In a unique policy response to high rates of hospitalization and deaths due to complications of unsafe abortion, however, menstrual regulation services have been permitted and widely available through the government's family planning program for nearly 30 years. The Bangladeshi government defines menstrual regulation, or MR, as "an interim method for establishing non-pregnancy" and authorizes trained female paramedics called "family welfare visitors" (FWVs) to perform the procedure up to eight weeks of pregnancy; trained doctors may perform MR up to 10 weeks since the woman's last menstrual period.

Family welfare visitors, who are posted in almost all of Bangladesh's rural health centers, have been instrumental in decentralizing delivery of MR services since 1978, when the government initiated a national training program for them. Currently approximately 7,000 trained paramedics work in government clinics, with many more in private practice.

Studies published in 1980 and 1982 found that, when properly trained, FWVs provided MR services as safely as physicians. Subsequent research has also shown a steady increase in the proportion of MR procedures performed by medical personnel in Bangladesh, indicating women's decreased reliance on unqualified practitioners. With this trend, studies also document a decrease in the incidence of severe infection.

Challenges remain in making safe MR services widely accessible. One of the most significant is women's widespread lack of knowledge about the availability of MR and of the time limit for obtaining it. The most common reason women's requests for MR are rejected is that they report to health centers seeking services when their pregnancies are more than 10 weeks of duration. About one-fifth of maternal mortality in Bangladesh is still attributed to unsafe abortion. Maintaining high quality of services, especially in remote settings, has also proved difficult. For instance, some paramedics reportedly perform MR beyond the period for which they are authorized to do so, which sometimes results in complications requiring hospitalization.

These challenges notwithstanding, Bangladesh's unusual policy approach to the public-health problem of unsafe abortion has significantly increased the proportion of safe procedures. A corresponding decrease in mortality from unsafe abortion — from 5 percent in 1977 to 0.2 percent in 1994 — attests to the potential for progress in addressing women's needs through the provision of MR despite a restrictive law.



JHU/CCP

Sources: Akhter, 1998
Akhter, 2001
Bhatia, 1980
Khan, 1984

facilities have an ethical and, in many cases, legal obligation to provide or refer women for requested care that is permitted by law.

- ◆ *policies that allow health care professionals in training to opt out of learning to provide abortion care.* Such policies contribute to shortages of providers trained to perform life-saving treatment of abortion complications.

Creating an enabling environment

Beyond eliminating existing restrictions and establishing and enforcing supportive policies, there is much that health-system leaders and program managers can do to create an environment that supports provision of abortion care to the broadest extent possible. Necessary steps include nurturing support for expanding midlevel providers' role in abortion and actively countering resistance.

Countering resistance from physicians

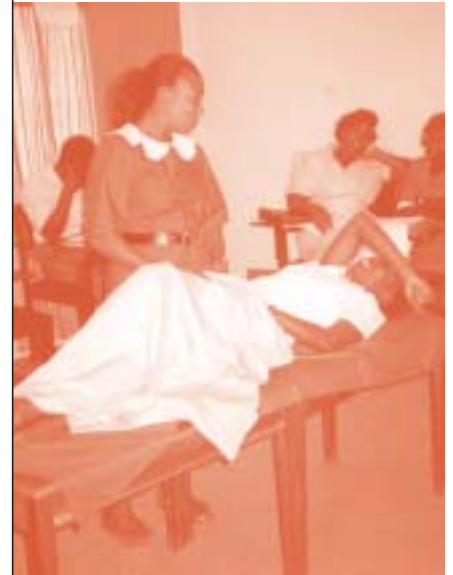
It is not unusual for physicians to resist proposals to delegate to other categories of health care providers authority for procedures traditionally reserved for them. One common objection is concern about midlevel providers' capabilities. Further research to document the safety and effectiveness of abortion services performed by midlevel providers is certainly needed; it should be noted, however, that data that do exist concerning midlevel providers' ability to provide safe, effective abortion-related care are positive.

The potential for loss of earnings may also play a role in physicians' resistance to delegating authority to midlevel providers. This resistance may dissipate once doctors understand that delegating some aspects of service delivery can benefit them, by reducing their workload and giving them more time to attend to other patients.

As previously noted, physicians in **Sweden** initially resisted midwives' involvement in providing medical abortion. Over time, however, many grew to appreciate the benefits they themselves saw from delegating authority. Now, provision of medical abortion in Sweden is truly a team effort involving a range of providers, including midwives, nurses, social workers and doctors. Despite this practical experience, however, some doctors are still reluctant to give up their exclusive, formal right to perform abortion.

In **Ghana**, influential obstetrician-gynecologists' leadership and support for delegating authority to midlevel providers was important in building the political will necessary to launch a program (described previously) to train private midwives in uterine evacuation for postabortion care, as well as in disseminating the results of this successful effort.

The scarcity of trained physicians has already led to delegation of duties in many settings, especially in rural areas. Supporting this de facto transfer of authority with proper training, supervision and logistical support makes sense from a public-health perspective.



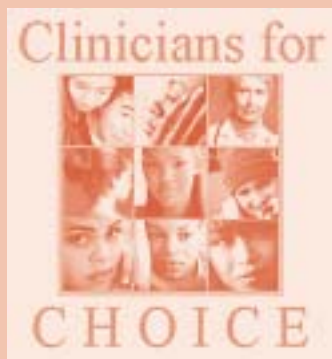
In Ghana, influential obstetrician-gynecologists' leadership and support for delegating authority to midlevel providers was important in building the political will necessary to launch a program to train private midwives in uterine evacuation for postabortion care.

Case study 10

United States: Building professional support

In the United States, which permits abortion on request in the first trimester of pregnancy, restrictive policies are the main impediments preventing nurse practitioners, midwives and physician assistants from providing abortion care. Nationwide, only about 20 midlevel providers currently perform surgical abortion, in only 5 of the country's 50 states (Kruse et al., 2001).

After the U.S. Supreme Court legalized abortion in 1973, most states instituted laws and policies limiting the practice of abortion to licensed physicians. Initially, this was an effort to protect women



from unlicensed, untrained practitioners rather than to limit the role of midlevel providers, which, at that time, was a relatively unknown category of clinicians in the United States. As these newer professions have developed, however, it has become clear that their scopes of practice could safely include both manual vacuum aspiration and medical methods of abortion.

Nonetheless, 44 states still have "physician only" provisions regarding abortion care. The American political climate surrounding abortion is such that efforts to modify the laws and regulations have made little progress.

Advocates for involving midlevel providers in abortion care are making inroads with decisionmakers in professional and health care organizations. A national network of pro-choice midlevel providers, "Clinicians for Choice," has representatives in nearly all 50 states. Work is ongoing to incorporate midlevel providers into abortion care in Planned Parenthood affiliates. The National Abortion Federation has issued a strong statement in favor of including midlevel providers in all aspects of abortion care. In addition, statements of support have come from several very large member associations including the American Public Health Association and the American College of Obstetricians and Gynecologists.

Source: Kruse, Gordon and Tanenhaus, 2001

Advocacy

One reason that health systems have addressed women's needs for abortion care inadequately is that the topic remains stigmatized in many societies. Rightfully positioning abortion as a public-health rather than a moral issue requires neutralizing this taboo. At the local, national and international levels, advocacy is needed to foster understanding of women's need for and right to postabortion and abortion care, as well as to promote expanding midlevel providers' role in abortion care as an essential strategy for increasing women's access to care.

Nongovernmental organizations have successfully advocated for increasing women's access to abortion care in numerous countries. According to an analysis by a **South African** group called The Women's Health Project, the most successful advocacy efforts are built around goals, messages and strategies determined by the specific legal and policy context governing abortion. For example, in countries with liberal laws and policies, appropriate advocacy goals might be to increase women's access to high-quality services, to maintain previously won legislative gains, to build midlevel providers' skills and to increase the health-system capacity. In a restrictive legal environment, appropriate advocacy goals might include increasing public discussion of abortion as a precursor to liberalizing legislation. (Klugman and Budlender, 2001)

International policy support

Growing international support for increasing midlevel providers' role in abortion care is evident in statements and guidance from influential organizations, including medical associations, and coalitions. In 1990, for example, a statement jointly endorsed by the International Confederation of Midwives (ICM), the World Health Organization (WHO) and UNICEF (the United Nations Children's Fund) called for countries to incorporate training in emergency uterine evacuation in midwifery education, in the context of their efforts to promote safe motherhood (ICM/WHO/UNICEF, 1990). In addition, the World Health Organization has recommended that uterine evacuation be available at primary-level health care centers where trained, qualified health care personnel are available, and includes this skill in materials intended for midwives (World Health Organization, 1994, 1995, 2000). Since midlevel providers constitute the principal and often only staff at such facilities, it follows that they need to be trained and equipped to perform this service. Accordingly, midwifery training materials forthcoming from WHO include a module on management of incomplete abortion (World Health Organization, forthcoming).

In 1996, the International Confederation of Midwives approved a resolution affirming that women who have had abortion, whether spontaneous or induced, have the same need for care as women who have given birth. The resolution asserts that "the midwife should ... consider such care to be within her role ... provide any immediate care necessary following abortion [and] appropriately refer for any further treatment that may be required and which is beyond the limits of her practice (International Confederation of Midwives, 1996). This statement was amended at the 2002 ICM Council meeting in Vienna, Austria. Additions include statements affirming that mid-

wives should be taught to care for women postabortion and that midwifery associations should take action to ensure that midwifery training programs include PAC skills.

Materials from the Safe Motherhood Initiative note many health workers' lack of skills needed to save the lives of women who suffer emergency complications related to pregnancy, including complications from abortion. They highlight the need "to train, authorize and equip midwives, nurses and community physicians to provide all feasible obstetric services ... especially emergency intervention" at the community level (Safe Motherhood Initiative, 1998a).

Increasing midlevel providers' involvement in provision of abortion care in order to safeguard women's health and lives requires the participation of stakeholders of all kinds and at all levels, as well as commitment of human and financial resources. Based largely on discussions at the December 2001 "Expanding Access" conference, this chapter suggests specific directions forward for a range of stakeholders in the areas of research, policy, education and training, and service delivery.

Research

Although strong programmatic and anecdotal evidence supports expanding midlevel providers' role in abortion care, systematically collected data are needed to convince local, national and international decisionmakers of the critical importance of this strategy. Several types of studies are required, including health systems operations research and community-based exploratory research. The following broad research recommendations were distilled from the numerous, detailed suggestions generated at the "Expanding Access" conference:

Compile compelling evidence on quality

In some countries women have benefited for decades from midwives, family welfare visitors, medical officers and other midlevel providers delivering abortion services. However, rigorously collected data demonstrating that these personnel can consistently provide high-quality care in remote settings is lacking and would be compelling to decisionmakers. In addition, there is a need for evidence from multiple settings demonstrating that providers with clinical training above a specified minimum level can provide high-quality abortion care.

Show impact

Researchers need to demonstrate the impact of midlevel providers' involvement in abortion services. A key question — and a challenging one to answer convincingly — is: To what extent does positioning midlevel providers of abortion care at decentralized levels increase women's access to essential care? The cost impact of training and equipping midlevel providers to offer abortion care also needs to be well documented.

Describe best practices

Researchers need to document models of best practices of abortion service delivery at decentralized levels for private- and public-sector providers. Operations research can demonstrate the impact of different training and refresher training strategies; values clarification education; active involvement of professional associations; and levels of technological, logistical, supervisory and other support necessary to enable midlevel providers to offer high-quality abortion care at a decentralized level.

Explore women's needs and perspectives

Research models should be developed to investigate women's perspectives of quality of abortion care, examining such questions as their expectations, their relationships to female providers, and how they define respectful treatment and confidentiality. The results can be used in training programs for medical students and basic education for nurses.

Chapter Five: Future Directions



Increasing midlevel providers' involvement in provision of abortion care in order to safeguard women's health and lives requires the participation of stakeholders of all kinds and at all levels.

Explore community needs

To increase their impact, abortion care providers must understand and strive to meet the needs of the communities they serve. Exploratory research to identify community needs in terms of abortion service delivery can be used to inform and improve decentralized abortion service delivery. Such work should include a focus on populations with special or unique needs, notably adolescents. Exploring the needs of this very vulnerable group requires qualitative approaches that are mindful of the taboos around adolescent sexuality in many cultures. Effective programs will incorporate the perspectives of both girls and boys concerning their reproductive health rights and needs.

Policy

Decentralizing care to primary health care facilities and enabling appropriately skilled providers to offer abortion services are key, related strategies for expanding women's access to abortion care. Implementing these strategies requires addressing a range of legal, policy and regulatory barriers worldwide, as well as encouraging their positive interpretation by health administrators, professional bodies such as nursing councils and medical committees, health care providers and others. Suggested policy approaches to increasing service provision by midlevel providers address three areas: providers, institutions and advocacy.

Provider approaches

Ensuring that all qualified health care providers are trained and equipped to contribute as appropriate to increasing women's access to safe abortion care is an essential step. To meet public-health goals, it makes more sense to define health care providers according to competency standards than by professional specialty or title.

Explicitly including postabortion care and induced abortion, for circumstances in which it is legal, in guidelines defining midlevel providers' minimum scope of practice can help increase women's access to needed care, as can eliminating "physician-only" regulations.

Similarly, guidelines for service provision should specify skills required and standards of competency rather than categories of providers, with competencies based on best available evidence of what skills are critical to such service provision. Such evidence should also form the basis of clinical practice guidelines for early abortion care. Development of strong professional connections among different types of providers can help increase understanding of their common purpose to meet women's full reproductive health needs, including abortion.

Institutional approaches

To increase women's access to needed care, governments and health systems need to establish management guidelines that specify required facilities and equipment for provision of high-quality abortion care including referral and supervision protocols. These guidelines should be based on common health care setting scenarios; requirements based on worst-case scenarios — including regulations that permit abortions to be performed only in hospitals — unduly limit service provision.

To support accessible, high-quality abortion care, health system leaders and program managers need to strengthen their commitment to and accountability for supervision, supply, referral and transport systems. Similar attention to additional factors such as affordability, confidentiality and respect for clients will help assure the safety and quality of care. Integrating abortion services with other elements of reproductive health care may be an effective strategy for increasing women's access to care in many settings.

Advocacy and related approaches

Health systems, nongovernmental organizations and others need to be proactive in encouraging provision of abortion services to the full extent allowed by local laws, policies and regulations. This includes analyzing and clarifying existing laws, regulatory standards, and professional guidelines and standards. In restrictive settings there is an urgent need to increase policymakers' and health care providers' knowledge of the circumstances in which abortion is legally permitted, such as for rape and incest. Without such support, practices may evolve and be assumed to have the weight of law, when in fact they do not. It is also essential to educate women about their legal rights to abortion and about where and how they can obtain abortion for legal indications.

Even before training providers and implementing services, professional organizations, accrediting bodies, policymakers and communities can help build support systems for midlevel provision of abortion services. Support activities should include protecting midlevel providers in challenging legal contexts; identifying appropriate and strategic entry points for expanding midlevel providers' roles (for example, by first adding postabortion care to their scope of practice); and educating administrators and policymakers.

Development of an international network of health care professionals dedicated to expanding access to safe abortion care by involving midlevel providers (the nucleus of which was formed at the "Expanding Access" conference) would serve to disseminate information and advance work in the areas of research, policy and advocacy, service delivery, education, and training.

Efforts also need to be directed to identifying the most effective advocacy strategies for influencing professional associations, policymakers, legislators and the public. Promising strategies include bringing policymakers and technical experts together in a participatory process of examining current policies and their impact at national and international meetings. Existing data can also be used to better advantage, including by developing more effective strategies for sharing it with specific audiences.

Education and Training

Commitment to competency-based, evidence-based and values-clarification training at all levels of the health care system is important to support integration of safe abortion care into the health care delivery system and to maximize women's access to needed services. This requires involvement from the health-education system, the health care delivery system, providers in the field and from the broadly defined community.



Health systems, nongovernmental organizations and others need to be proactive in encouraging provision of abortion services to the full extent allowed by local laws, policies and regulations.

Health care training

Information on reproductive health and rights, including content on safe abortion care, should be “normalized” by being integrated into basic education for all health care providers who care for women during their reproductive years. Clinical skills (including counseling) for termination of pregnancy should be integrated into training for midlevel providers who will provide reproductive health care for women through pre-service training, on-the-job training and clinical workshops for those already working in the field, continuing education for those providing abortion and postabortion services.

Health care delivery system

Health care systems should implement and sustain best practices for postabortion care and abortion by:

- creating and disseminating training guidelines;
- training private as well as public providers;
- encouraging international (cross-border) initiatives and learning experiences;
- establishing standards for ongoing supervision and monitoring of training and services;
- ensuring opportunities for continuing education;
- educating providers about all legal issues involved in abortion service delivery;
- training providers to offer evidence-based postabortion and abortion services for all legal indications.

Community level

Mobilizing community support is necessary to create an enabling environment for provision of safe abortion care. Educational efforts needed to build community support include: medically accurate and age-appropriate sexuality education in schools and community groups; sensitivity to cultural and gender perspectives in reproductive health education and training; male involvement and responsibility in reproductive life; and dissemination of information about legal issues related to induced abortion and postabortion care.

Service delivery

There are numerous steps health-system managers can take in the area of service delivery to maximize women’s ability to obtain services they want and need for postabortion care, menstrual regulation and induced abortion. Suggestions for future action in this area can be grouped into the general themes of increasing access and improving quality.

Increasing women’s access

To make safe abortion care as accessible as possible, public- and private-sector health care systems should identify and remove policies and practices that inhibit women’s access to care at service delivery sites that already offer abortion-related services; increase the number of sites offering such care; and strengthen referral systems so that women needing abortion care can readily access services from any point in the health

care system. Making better use of midlevel providers' skills, capabilities and experience is important for each of these strategies. Specific steps required include:

- engaging the informal health care sector in referring women to safe abortion care providers;
- ensuring that every service delivery site offering abortion care has and complies with clinical and management guidelines that include elements necessary for provision of high-quality, affordable services;
- working toward integration of reproductive health care services without compromising immediate access to care;
- establishing networks of providers, including midlevel providers, committed to providing safe abortion care.

Improving quality

From a public-health perspective, abortion-care programs' effectiveness can be enhanced or diminished by the quality of the services provided. Midwives and other midlevel providers can make unique contributions to improving quality of care; they can also create obstacles. To improve existing services and ensure that newly established abortion-care programs will be safe, accessible and acceptable, public- and private-sector health-system managers need to:

- provide information, education and communication to communities about the availability of safe contraceptive, abortion and postabortion services;
- ensure the existence of skilled and competent teams at all service delivery sites;
- create and disseminate clinical guidelines on abortion care, regularly update them, and monitor their use;
- ensure that service delivery sites have adequate supplies, equipment and personnel to sustain services;
- collaborate with community networks to solicit community input on the design, operation and evaluation of services;
- identify, document and share information on best practices relative to quality of abortion care.

Summary of recommendations from “Expanding Access” conference

Research

- Compile compelling evidence on the quality of midlevel service provision
- Document the impact of training and authorizing midlevel providers to offer abortion care
- Describe best practices
- Explore women’s needs and perspectives
- Explore community needs

Policy

■ Provider approaches

- Train and equip all qualified health care providers in abortion care
- Define providers by competencies and skills
- Include abortion care in midlevel providers’ scopes of practice
- Eliminate restrictive “physician-only” regulations

■ Institutional approaches

- Create, disseminate and monitor adherence to supportive service delivery guidelines
- Increase commitment to and accountability for high-quality, sustainable services

■ Advocacy approaches

- Encourage provision of abortion to the full extent permitted by law
- Build support for midlevel provision of abortion services

Education and Training

■ Health care training

- Integrate information on reproductive health and rights into basic health education
- Offer pre-service, on-the-job and refresher training in clinical and counseling skills for abortion for all midlevel providers involved in reproductive health care

■ Health care delivery

- Identify, disseminate and sustain best practices for abortion and postabortion care

■ Community

- Expand medically accurate, age-appropriate sexuality education
- Educate the community about the legal status of abortion and postabortion care

Service Delivery

■ Increasing access

- Identify and remove barriers hindering women’s access to abortion care
- Increase the number of sites offering abortion care
- Strengthen referral systems
- Work toward integration of reproductive health care services
- Establish networks of providers committed to safe abortion care

■ Improving quality

- Create, disseminate and monitor use of clinical guidelines on abortion care
- Ensure adequate supplies, equipment and personnel to sustain abortion services
- Involve communities in the design, operation and evaluation of services

Appendix I: Country reports

The following reports were prepared for the conference “Expanding Access: Advancing the Role of Midlevel Providers in Menstrual Regulation and Elective Abortion Care,” which took place in Pilanesberg National Park, South Africa, 2-6 December 2001. Full text of the reports is available on the conference website, as noted below.

Bangladesh

Akhter, Halida Hanum. 2001. *Expanding access: Midlevel providers in menstrual regulation, Bangladesh experience*. Available at <http://www.ipasihcar.net/expacc/reports/BanglCR.html>

Cambodia

Long, Chhun and Neang Ren. 2001. *Abortion in Cambodia: Country report*. Available at <http://www.ipasihcar.net/expacc/reports/CambCR.html>

Kenya

Oguttu, Monica and Peter Odongo. 2001. *Midlevel providers' role in abortion care: Kenya country report*. Available at <http://www.ipasihcar.net/expacc/reports/KenyaCR.html>

Mozambique

Libombo, Aida and Momade Bay Ustá. 2001. *Mozambique abortion situation: Country report*. Available at <http://www.ipasihcar.net/expacc/reports/MozambCR.html>

South Africa

van der Westhuizen, Christa. 2001. *Midwives' roles in expanding access to and the management of safe abortion care. South Africa country report*. Available at <http://www.ipasihcar.net/expacc/reports/SAfricaCR.html>

Sweden

Jonsson, Ing-Marie, Catharina Zätterström and Kajsa Sundström. 2001. *Midwives' role in management of medical abortion: Swedish country report*. Available at <http://www.ipasihcar.net/expacc/reports/rev1SwCR.html>

United States of America

Kruse, Beth, Rivka Gordon and Jini Tanenhaus. 2001. *The role of midlevel providers in abortion care in the United States*. Available at <http://www.ipasihcar.net/expacc/reports/USreport.html>

Vietnam

Dang Thi Nghia and Nguyen Duy Khe. 2001. *Vietnam abortion situations. Country report*. Available at <http://www.ipasihcar.net/expacc/reports/VietnCR.html>

Zambia

Mtonga, Velepi and Martha Ndhlovu. 2001. *Midwives' role in management of elective abortion and post-abortion care: Zambian country report*. Available at <http://www.ipasihcar.net/expacc/reports/Zambrep.html>

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A conference statement from
Expanding Access: Advancing the Role of Midlevel Providers
in Menstrual Regulation and Elective Abortion Care
2-6 December 2001, Pilanesberg National Park, South Africa



Worldwide, nearly 80,000 women die every year and millions more suffer serious complications and disabilities from unsafe abortion, which is wholly preventable. Even in countries where abortion-related maternal mortality is low, women still often lack access to abortion care and other reproductive health services that they want and need.

Increasing the accessibility of menstrual regulation (MR) and/or safe abortion care is a key strategy in reducing unacceptably high rates of maternal mortality and morbidity, and in ensuring women's ability to exercise their sexual and reproductive rights. Since midlevel health care providers are more numerous and tend to be closer to women than physicians, they have a critical role to play in meeting women's needs for postabortion care, MR and — in circumstances where it is legal — termination of pregnancy.

Experience in Bangladesh, South Africa and several other countries demonstrates that authorizing, training and equipping midlevel providers to deliver MR and/or abortion care can make an important difference in improving women's access to needed services.

Creating an enabling environment to expand and strengthen midlevel providers' scope of practice is especially important in situations where they are the principal or only health care providers in the communities where women live.

As health care providers, researchers, policymakers and representatives of technical agencies, we, the participants in the first-ever international meeting exploring midlevel providers' role in MR and abortion care, strongly believe:

- ◆ that women deserve prompt access to high-quality MR and/or abortion care,
- ◆ that it is essential for health systems to create policy and service-delivery environments that enable MR and/or abortion care to be as accessible as possible to women, and
- ◆ that women's access to such care can be greatly enhanced by better integrating these services into midlevel providers' scope of practice.

All of us who are committed to enhancing women's health and lives have a responsibility to facilitate women's access to the reproductive health care they want and need, including menstrual regulation and abortion care.

Appendix III:
"Expanding Access"
Conference Statement

This conference has strengthened our commitment to fulfill this critical mandate — an effort in which midlevel providers clearly play a key role. As a network of concerned professionals, we call on governments, health policymakers, nongovernmental organizations, international organizations, donors and others to take action in support of advancing the role of midlevel providers in menstrual regulation and safe abortion care.

The 50 conference delegates included teams from 10 countries as well as representatives from the African Midwives Research Network, the International Confederation of Midwives, Partners in Population and Development, the Reproductive Health Alliance and the World Health Organization. Ipas and IHCAR, the coordinating agencies, would like to express appreciation for financial support from the Danish International Development Assistance (Danida), the Norwegian Agency for Development Cooperation (NORAD), the Swedish International Development Cooperation Agency (Sida), the Swedish Ministry for Foreign Affairs and the David and Lucile Packard Foundation. For additional information, contact johnstonh@ipas.org.

International Confederation of Midwives (ICM)

Care of Women Post Abortion

The International Confederation of Midwives believes that a woman who has had an abortion, whether spontaneous or induced, has the same need for care as a woman who has given birth. In keeping with this belief, the midwife should:

- i) consider such care to be within her role
- ii) provide any immediate care necessary following abortion
- iii) appropriately refer for any further treatment that may be required and which is beyond the limits of her practice
- iv) provide education concerning the woman's future health, this education to include family planning
- v) recognize the emotional, psychological and social support which may be needed by the woman and respond appropriately.

Adopted by the International Confederation of Midwives Council, May 1996, Oslo, Norway

Legislation To Govern Midwifery Practice

Statement of belief

The International Confederation of Midwives believes that there should be appropriate legislation relating to the practice of midwives in all countries.

Policy

Legislation which is enacted to govern the practice of midwives should enable midwives to practise freely in any setting: ...

- support the midwife who exercises life saving knowledge and skills in a variety of settings in countries where there is no ready access to medical support;
- support the acquisition of ongoing education;
- require regular renewal of right to practise;
- adopt a 'Definition of the Midwife' appropriate to the country within the legislation;...
- recognise the importance of separate midwifery regulation and legislation which supports and enhances the work of midwives in improving maternal, child and public health; ...
- provide for regular review of the legislation to ensure it remains appropriate and not outdated, as midwifery education and practice and the health services advance;
- encourage the use of peer review and analysis of perinatal, maternal and newborn outcomes in the legislative review process;
- provide for transition education programmes in the adoption of new legislation requiring increased levels of competency of the midwife.

Adopted by the International Confederation of Midwives Council, Manila, May 1999

Appendix IV: Statements by the International Confederation of Midwives (ICM)

Appendix V: The Republic of South Africa's Choice on Termination of Pregnancy Act

REPUBLIC OF SOUTH AFRICA CHOICE ON TERMINATION OF PREGNANCY ACT, 1996. PRESIDENT'S OFFICE

No. 1891. 22 November 1996
NO. 92 OF 1996: CHOICE ON TERMINATION OF PREGNANCY ACT, 1996.

It is hereby notified that the President has assented to the following Act which is hereby published for general information:

ACT

To determine the circumstances in which and conditions under which the pregnancy of a woman may be terminated; and to provide for matters connected therewith.

(Afrikaans text signed by the President.)

(Assented to 12 November 1996.)

PREAMBLE

Recognising the values of human dignity, the achievement of equality, security of the person, non-racialism and non-sexism, and the advancement of human rights and freedoms which underlie a democratic South Africa;

Recognising that the Constitution protects the right of persons to make decisions concerning reproduction and to security in and control over their bodies;

Recognising that both women and men have the right to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and that women have the right of access to appropriate health care services to ensure safe pregnancy and childbirth;

Recognising that the decision to have children is fundamental to women's physical, psychological and social health and that universal access to reproductive health care services includes family planning and contraception, termination of pregnancy, as well as sexuality education and counselling programmes and services;

Recognising that the State has the responsibility to provide reproductive health to all, and also to provide safe conditions under which the right of choice can be exercised without fear or harm;

Believing that termination of pregnancy is not a form of contraception or population control;

This Act therefore repeals the restrictive and inaccessible provisions of the Abortion and Sterilization Act, 1975 (Act No. 2 of 1975), and promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs.

BE IT ENACTED by the Parliament of the Republic of South Africa, as follows:-

Definitions

1. In this Act, unless the context otherwise indicates-

- (i) "Director-General" means the Director-General of Health; (iii)
- (ii) "gestation period" means the period of pregnancy of a woman calculated from the first day of the menstrual period which in relation to the pregnancy is the last; (iv)
- (iii) "incest" means sexual intercourse between two persons who are related to each other in a degree which precludes a lawful marriage between them; (ii)
- (iv) "medical practitioner" means a person registered as such under the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No. 56 of 1974); (v)
- (v) "Minister" means the Minister of Health; (viii)
- (vi) "minor" means any female person under the age of 18 years; (vii)
- (vii) "prescribe" means prescribe by regulation under section 9; (x)

- (viii) "rape" also includes statutory rape as referred to in sections 14 and 15 of the Sexual Offences Act, 1957 (Act No. 23 of 1957); (ix)
- (ix) "registered midwife" means a person registered as such under the Nursing Act, 1978 (Act No. 50 of 1978); (vi)
- (x) "termination of a pregnancy" means the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman; (i)
- (xi) "woman" means any female person of any age. (xi)

Circumstances in which and conditions under which pregnancy may be terminated

2. (1) A pregnancy may be terminated-
 - (a) upon request of a woman during the first 12 weeks of the gestation period of her pregnancy;
 - (b) from the 13th up to and including the 20th week of the gestation period if a medical practitioner, after consultation with the pregnant woman, is of the opinion that-
 - (i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or
 - (ii) there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or
 - (iii) the pregnancy resulted from rape or incest; or
 - (iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman; or
 - (c) after the 20th week of the gestation period if a medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy-
 - (i) would endanger the woman's life;
 - (ii) would result in a severe malformation of the fetus; or
 - (iii) would pose a risk of injury to the fetus.
- (2) The termination of a pregnancy may only be carried out by a medical practitioner, except for a pregnancy referred to in subsection (1) (a), which may also be carried out by a registered midwife who has completed the prescribed training course.

Place where surgical termination of pregnancy may take place

3. (1) The surgical termination of a pregnancy may take place only at a facility designated by the Minister by notice in the Gazette for that purpose under subsection (2).
- (2) The Minister may designate any facility for the purpose contemplated in subsection (1), subject to such conditions and requirements as he or she may consider necessary or expedient for achieving the objects of this Act.
- (3) The Minister may withdraw any designation under this section after giving 14 days' prior notice of such withdrawal in the Gazette.

Counselling

4. The State shall promote the provision of non-mandatory and non-directive counselling, before and after the termination of a pregnancy.

Consent

5. (1) Subject to the provisions of subsections (4) and (5), the termination of a pregnancy may only take place with the informed consent of the pregnant woman.
- (2) Notwithstanding any other law or the common law, but subject to the provisions of subsections (4) and (5), no consent other than that of the pregnant woman shall be required for the termination of a pregnancy.
- (3) In the case of a pregnant minor, a medical practitioner or a registered midwife, as the case may be, shall advise such minor to consult with her parents, guardian, family members or

friends before the pregnancy is terminated: Provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them.

- (4) Subject to the provisions of subsection (5), in the case where a woman is-
- (a) severely mentally disabled to such an extent that she is completely incapable of understanding and appreciating the nature or consequences of a termination of her pregnancy; or
 - (b) in a state of continuous unconsciousness and there is no reasonable prospect that she will regain consciousness in time to request and to consent to the termination of her pregnancy in terms of section 2, her pregnancy may be terminated during the first 12 weeks of the gestation period, or from the 13th up to and including the 20th week of the gestation period on the grounds set out in section 2(1)(b)-
 - (i) upon the request of and with the consent of her natural guardian, spouse or legal guardian, as the case may be; or
 - (ii) if such persons cannot be found, upon the request and with the consent of her curator personae:

Provided that such pregnancy may not be terminated unless two medical practitioners or a medical practitioner and a registered midwife who has completed the prescribed training course consent thereto.

- (5) Where two medical practitioners or a medical practitioner and a registered midwife who has completed the prescribed training course, are of the opinion that-
- (a) during the period up to and including the 20th week of the gestation period of a pregnant woman referred to in subsection (4)(a) or (b)-
 - (i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or
 - (ii) there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or
 - (b) after the 20th week of the gestation period of a pregnant woman referred to in subsection (4)(a) or (b), the continued pregnancy-
 - (i) would endanger the woman's life;
 - (ii) would result in a severe malformation of the fetus; or
 - (iii) would pose a risk of injury to the fetus, they may consent to the termination of the pregnancy of such woman after consulting her natural guardian, spouse, legal guardian or curator personae, as the case may be: Provided that the termination of the pregnancy shall not be denied if the natural guardian, spouse, legal guardian or curator personae, as the case may be, refuses to consent thereto.

Information concerning termination of pregnancy

6. A woman who in terms of section 2(1) requests a termination of pregnancy from a medical practitioner or a registered midwife, as the case may be, shall be informed of her rights under this Act by the person concerned.

Notification and keeping of records

7. (1) Any medical practitioner, or a registered midwife who has completed the prescribed training course, who terminates a pregnancy in terms of section 2(1)(a) or (b), shall record the prescribed information in the prescribed manner and give notice thereof to the person referred to in subsection (2).
- (2) The person in charge of a facility referred to in section 3 or a person designated for such purpose, shall be notified as prescribed of every termination of a pregnancy carried out in that facility.
- (3) The person in charge of a facility referred to in section 3, shall, within one month of the termination of a pregnancy at such facility, collate the prescribed information and forward it by registered post confidentially to the Director-General: Provided that the name and address of a woman who has requested or obtained a termination of pregnancy, shall not be included in the prescribed information.

- (4) The Director-General shall keep record of the prescribed information which he or she receives in terms of subsection (3).
- (5) The identity of a woman who has requested or obtained a termination of pregnancy shall remain confidential at all times unless she herself chooses to disclose that information.

Delegation

- 8. (1) The Minister may, on such conditions as he or she may determine, in writing delegate to the Director-General or any other officer in the service of the State, any power conferred upon the Minister by or under this Act, except the power referred to in section 9.
- (2) The Director-General may, on such conditions as he or she may determine, in writing delegate to an officer in the service of the State, any power conferred upon the Director-General by or under this Act or delegated to him or her under subsection (1).
- (3) The Minister or Director-General shall not be divested of any power delegated by him or her, and may amend or set aside any decision taken by a person in the exercise of any such power delegated to him or her.

Regulations

- 9. The Minister may make regulations relating to any matter which he or she may consider necessary or expedient to prescribe for achieving the objects of this Act.

Offences and penalties

- 10. (1) Any person who-
 - (a) is not a medical practitioner or a registered midwife who has completed the prescribed training course and who performs the termination of a pregnancy referred to in section 2(1)(a);
 - (b) is not a medical practitioner and who performs the termination of a pregnancy referred to in section 2(1)(b) or (c); or
 - (c) prevents the lawful termination of a pregnancy or obstructs access to a facility for the termination of a pregnancy, shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding 10 years.
- (2) Any person who contravenes or fails to comply with any provision of section 7 shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding six months.

Application of Act

- 11. (1) This Act shall apply to the whole of the national territory of the Republic.
- (2) This Act shall repeal-
 - (a) the Act mentioned in columns one and two of the Schedule to the extent set out in the third column of the Schedule; and
 - (b) any law relating to the termination of pregnancy which applied in the territory of any entity which prior to the commencement of the Constitution of the Republic of South Africa, 1993 (Act No. 200 of 1993), possessed legislative authority with regard to the termination of a pregnancy.

Short title and commencement

- 12. This Act shall be called the Choice on Termination of Pregnancy Act, 1996, and shall come into operation on a date fixed by the President by proclamation in the Gazette.

SCHEDULE

| No. and year of law | Short title | Extent of repeal |
|---------------------|--------------------------------------|-------------------------------------|
| Act No.2 of 1975 | Abortion and Sterilization Act, 1975 | In so far as it relates to abortion |

