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Expanding the Provider Base for Abortion Care:

Findings and Recommendations from an Assessment of Pre-Service Training Needs and Opportunities in Bangladesh

Unsafe abortion remains a major health concern in South-Central Asia (World Health Organization, 2011).[1] The World Health Organization (WHO) estimates that more than 6.8 million unsafe abortions took place in 2008—the highest of any region in the world (World Health Organization, 2011). Maternal deaths resulting from unsafe abortion are also high in the region, with 14,000 estimated in 2008, representing 30 percent of maternal deaths from unsafe abortion worldwide (World Health Organization, 2011). While supportive laws, policies and improved services enable some women to access care, safe abortion services remain unattainable for many. Limited awareness, lack of access to services among rural populations, costs, cultural issues and a shortage of trained physicians all contribute to unsafe abortion rates in the region (Singh et al., 2009).

Expanding the provider base to broaden the number and types of providers authorized and able to offer safe abortion care is a proven strategy in the global research which shows that abortion can be safely provided by any properly trained health provider, including cadres such as midwives, nurse practitioners, clinical officers, physician assistants, family welfare visitors and others who are trained to conduct basic clinical procedures related to reproductive health (Warriner et al., 2006; Warriner et al., 2011). The provision of abortion-related care by these cadres is endorsed by WHO and other global health experts who recognize that the availability of trained providers within reach of the entire population is an essential component of any strategy to reduce unnecessary maternal deaths (Campbell et al., 2011; World Health Organization, 2012).

Millennium Development Goals

In September 2000, world leaders adopted the UN Millennium Declaration, committing their nations to a new global partnership to reduce extreme poverty and setting a series of targets, with a deadline of 2015, that have become known as the Millennium Development Goals (MDGs) (UN Millennium Project, 2006).

The MDGs are time-bound and quantified targets for addressing extreme poverty in its many dimensions—income poverty, hunger, disease, lack of adequate shelter and exclusion—while promoting gender equality, education and environmental sustainability. They are also basic human rights—the rights of each person on the planet to health, education, shelter and security.

Millennium Development Goal 5: Improve maternal health by 2015

The related target and indicators for measurement are as follows:
Target 5 A: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

- Indicator 5.1 Maternal mortality ratio
- Indicator 5.2 Proportion of births attended by skilled health personnel
- Indicator 5.3 Contraceptive prevalence rate
- Indicator 5.4 Adolescent birth rate
- Indicator 5.5 Antenatal care coverage
- Indicator 5.6 Unmet need for family planning

Excerpted from: What they are. UN Millennium Project, 2006.
http://www.unmillenniumproject.org/goals/

In 2012, Ipas undertook an assessment in Bangladesh, India, Nepal and Pakistan to determine the specific needs and gaps in the pre-service education systems for midlevel providers (MLP) and to identify opportunities, strategies and recommendations for creating more equitable access to safe abortion care. Sources for the pre-service assessment include curricular review; government documents; key informant interviews; reports; assessments of provider performance and training; and site observation visits.

The following assessment results and recommendations focus on Bangladesh.

1 The World Health Organization reports unsafe abortion data by region. South-Central Asia countries grouped according to the United Nations Population Division include: Afghanistan, Bangladesh, Bhutan, India, Iran, Kazakhstan, Kyrgyzstan, Maldives, Nepal, Pakistan, Sri Lanka, Tajikistan, Turkmenistan, and Uzbekistan.

The Bangladesh Context

Under the Penal Code of 1860, induced abortion in Bangladesh is permitted only to save the life of the woman (Hossain et al., 2012). Despite its restrictive abortion policy, Bangladesh's policy on menstrual regulation (MR),[2] which does not fall under the Penal Code, has been part of the national family planning program since 1979 as an interim method for establishing "nonpregnancy after a missed period" (Government of the People's Republic of Bangladesh, 1979). Government regulations specify that MR can be performed up to eight weeks after the last menstrual period by a Family Welfare Visitor (FWV) or by a trained paramedic, such as Sub-Assistant Community Medical Officers (SACMOs) and Medical Assistants; and up to ten weeks by a trained allopathic physician (Hossain, et al., 2012; Population Council, 2011). Provision of MR has spread nationally, with services available throughout the country and at most levels of the health system, and has proved to be an important contributor to women's reproductive health and to dramatic reductions in maternal mortality (Global Health Workforce Alliance, 2013a; Hossain, et al., 2012). Postabortion care (PAC) to treat complications of unsafe or incomplete abortion is primarily performed by trained allopathic physicians, with the exception of Ipas intervention sites where PAC provision has been expanded to include midlevel providers with specialized training.

Even with MR services widely available in Bangladesh and recent efforts to improve PAC, unsafe abortion persists. According to a 2012 Guttmacher report, an estimated 572,000 unsafe abortion procedures performed in 2010 led to complications, and about 231,000 women received PAC at a health facility for treatment of complications. Furthermore, an estimated 341,000 women experienced complications from unsafe abortion but did not receive care (Hossain, et al., 2012) due to factors such as: a shortage of trained health workers, basic supplies and equipment; informational barriers regarding the legal parameters for provision of MR and abortion; and economic and cultural barriers (Hossain, et al., 2012; Singh et al., 1997).

Bangladesh has made significant progress toward attainment of MDG 5. Maternal mortality has dropped 40 percent and gains have been made in building human resource capacity in the health sector (Bangladesh Planning Commission, 2013; (World Health Organization, 2010). However, there is a severe shortage of health workers and many reproductive health services still are unavailable or inaccessible, especially to rural women(Global Health Workforce Alliance, 2013b). Expanding the base of qualified providers offering comprehensive MR, family planning (FP) and PAC could further contribute to attainment of MDG 5.[3]

> *"Abortion care can be safely provided by any properly trained health-care provider, including midlevel (i.e. non-physician) providers… (e.g., midwives, nurse practitioners, clinical officers, family welfare visitors, and others)."*
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> —World Health Organization, 2012

2 MR refers to uterine evacuation using vacuum aspiration or medications to bring on menstruation and is not defined as a method of pregnancy termination.

3 Since this assessment was conducted, important strides have been made by the national health system, with the inclusion of nurses in MR and PAC in-service training and the endorsement of MR with medication (MRM). These changes have the potential to improve quality and broaden access to safe MR and PAC services as well.

Cadres of midlevel health-care providers

There are seven cadres of midlevel health care workers currently providing reproductive health services in Bangladesh. Of these, five receive pre-service training of at least 18 months or more: B.Sc Nurses, Sub-assistant Community Medical Officers (SACMOs), Nurse-midwives, and Family Welfare Visitors (FWVs). Registered Midwives, a new cadre of midlevel providers in Bangladesh which began training in 2013, were also included in this assessment. These five cadres were selected on the basis of their level of training and potential capacity to provide services and because of their eligibility to perform both MR and PAC under existing government policy.

Cadre	Length of training	Number of training institutions	Average number of graduates per year
B.Sc Nurses	4 years (+ 6 month internship)	19 (7 public, 12 private)	700
Medical Assistant / Sub-Assistant Community Medical Officer (SACMO)	3 years (+ 1 year internship)	96	1,100
Nurse-midwives	3 years	82	1,600
Registered Midwives	3 years	20[4]	TBD
Family Welfare Visitors (FWV)	18 months[5]	12	860
Total		**297**	**4,260**

B.Sc Nurses: This cadre provides general nursing care as well as MCH services. Pre-service training covers obstetric and reproductive health (RH) care, including pelvic exams; care during pregnancy, birth and post-partum; and contraception. Training also includes limited training in MR. As of 2012, the Directorate of Nursing Services (DNS) and Ipas Bangladesh received MOH&FW approval to initiate an integrated nurse training program for MR, PAC and FP services.[6] This cadre will also be involved in infection prevention services and counseling and is assigned to the primary level with inpatient service. The Bangladesh Nursing Council oversees their curriculum content and registration.

Medical Assistants/ Sub-Assistant Community Medical Officers (SACMOs): This cadre provides Primary Health Care in primary and secondary facilities, with an emphasis on basic services, prevention and treatment of infectious disease, and some MCH and FP services. They also provide first aid, prescribe medicines and perform some health service management at primary and secondary levels. During pre-service training, this cadre does not learn MR; however, they are allowed to practice MR/PAC independently after receiving on-the-job or in-service training. The State Medical Faculty determines the curriculum in collaboration with the Center for Medical Education for the training of Medical Assistants and the Bangladesh Medical and Dental Council provides registration.

Nurse-midwives: Nurse-midwives provide basic maternal and newborn care in secondary and tertiary level hospitals (including specialty, district-level hospitals and Upazila Health Complexes). Their required competencies include: providing ante-natal, natal and post-natal care in normal pregnancy; recognizing

4 This is an estimated number of pre-service programs planning to offer professional training for Registered Midwives.

5 Some FWVs receive additional 6 months of midwifery training.

6 Only nurses who have received training (with Ipas technical assistance) are permitted to provide these services.

abnormal pregnancies and referring to obstetricians or other medical doctors, when necessary. Their training involves basic information in neonatal care, MR, family planning (oral pills, Depo-Provera, IUD), sexual and reproductive health and general nursing but not skill development in these areas. The Bangladesh Nursing Council (BNC) regulates the development of the curriculum and provides registration.

Registered Midwives: Training for this new cadre began in 2013 and is expected to be launched in 20 training institutions, with approximately 525 students in the inaugural class. Initial review of the curriculum revealed that it is comprehensive and competency-based in accordance with international guidance. In addition to the range of topics listed above for Nurse-midwives, both abortion and MR are covered. (It remains to be locally determined whether postabortion care is included under the topic of removal of retained products of conception.) This new cadre of professional midwives is under the purview of the Bangladesh Nursing Council and is being developed with assistance from UNFPA, WHO and the International Confederation of Midwives (ICM).

Family Welfare Visitors (FWVs): FWVs provide FP and maternal-child health services at the grassroots community level, in primary and some secondary facilities (Union Health and Family Welfare Centers, satellite clinics, in Upazila facilities and some district hospitals). This cadre is also the most common provider of MR since the 1980s. Training of this cadre was discontinued in 1995 and only recently has been revived. The FWVs receive training on anatomy and physiology (especially female), labor and delivery, ante-natal, neo-natal and post-natal care, child health and FP (including short-acting FP methods, IUD, implants). Pre-service training also includes MR and PAC, but coverage is minimal and theoretical only. The Bangladesh Nursing Council is the certifying body for FWVs.

Pre-Service Training Methods: To contextualize the assessment findings, it is useful to clarify some terms and review the range of pre-service learning activities described in this document. Below are the various modes of pre-service education used for knowledge acquisition and skills development.

- **Theoretical or didactic training.** Health-care knowledge and skills can be acquired through manuals, textbooks and other resource materials, and through verbal transmission vis-à-vis classroom lectures, seminars, and workshops. This method may also utilize visual and audio-visual aids through various technology platforms.
- **Simulated practice or skills labs.** This method of instruction serves as an extension of the clinical experience where students gain competency in designated skills, and may include observing a procedure in a clinical setting or the use of teaching aids, interactive models, and simulators to practice procedures.
- **Hands-on clinical training or practicum.** Students rotate through specific clinics and learn through supervised practice, usually working with a preceptor in an internship setting. Sometimes students are not allowed to engage in practical training until they complete all the requirements for their degree, graduate, and/or become certified. In other settings, the practical training internship is a basic component required for graduation or certification. Some settings offer or require post-basic training to acquire specific job-related skills.

Note: Once a provider begins employment, additional training is referred to as *in-service training.*

Priority needs identified

Pre-service training programs (both didactic and practical) in MR and PAC for all cadres, with the exception of Registered Midwives, were found to have similar weaknesses: minimal coverage of topics related to RH, FP, MR and PAC. Only the FWVs and Registered Midwives' curricula specifically included MR. (Note: Recent efforts to address the gaps in provider training have resulted in the development of a newly approved

government training manual for in-service training, but pre-service training materials have yet to be modified).

Teaching institutions were found to be lacking in trained faculty who could offer the course content and teaching tools to aid them in the delivery of theoretical content. Additionally, during the pre-service phase there are few opportunities for hands-on clinical training, and clinical exposure generally is limited to observation, as schools also lack pelvic models in skills labs for simulated practice. Furthermore, there is a lack of coordination between pre-service institutions and clinical internship sites and, generally, supervisors/preceptors are not held accountable for ensuring that trainees develop the necessary skills during their clinical internships. Most clinical training in family planning, MR and PAC occurs at the in-service or facility level and any updates in provider knowledge/skills generally happen in in-service training under the relevant directorate of services. Key informants reported that pre-service institutions and leaders in professional associations and councils were often excluded from technical updates and training, thereby weakening their technical leadership capacities.

Priority recommendations

The assessment revealed clear gaps in current pre-service curricula, guidelines and training. Recommendations included incorporation of MR and PAC into pre-service training for the following priority cadres: **B.Sc Nurses, Nurse-midwives, and FWVs,** in addition to **Registered Midwives,** whose curriculum already includes MR and PAC. SACMOs were seen as lower priority due to their more general primary care role and lesser relevance in women's reproductive health care. The following recommendations could ensure that sustainable mechanisms are in place that would enable midlevel providers to further contribute to improvements to maternal health goals:

1. **Develop pre-service curricular materials and build human resource capacity**
    - Update curricula and ensure that both didactic and practical content in FP, MR and PAC are delivered in pre-service training for all recommended cadres.
    - Develop a base of qualified instructors with theoretical and practical knowledge about safe abortion, MR and PAC.
    - Create sample course materials and tools that will facilitate incorporation of abortion-related topics and skills into coursework (teaching aids, manuals, model presentations, checklists for skills labs, etc.).
2. **Improve practical training on FP, MR and PAC**
    - Improve links between pre-service and practical training (clinical rotations with preceptors) with clearly defined roles/job descriptions, competency requirements, verification systems and preceptor/supervisor responsibilities.
    - Ensure that pre-service skills labs and practicum training sites are well equipped with supplies, models and commodities for practical training.
3. **Update written guidelines and policies for midlevel providers' roles in FP, MR and PAC**
    - Work with relevant regulatory, academic and health service officials in the Directorate General for Health Services (DGHS), Directorate of Nursing Services (DNS) and Directorate General of Family Planning (DGFP) to share results of the assessment and coordinate plans for expanding midlevel providers' scope of work to include these neglected areas.
    - Build policy support for pre-service inclusion, with special attention to promoting midlevel provision of MR (currently nurses cannot prescribe medications).

- Update job descriptions so that these cadres can perform MR, PAC and FP and prescribe medications in accordance with global technical guidance.

Conclusion

The recommendations in this assessment are consistent with findings and evidence-based guidance from global health expert organizations and reinforce the need to ensure that MR/PAC should be a standard component of initial pre-service education for midlevel health care practitioners in Bangladesh. Training these cadres to provide this life-saving care can contribute to protecting women's health and attaining national goals of reducing maternal deaths and improving maternal health.

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