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Expanding the Provider Base for Abortion-Related Care:

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

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 Nepal, Bangladesh, India and Pakistan to determine the specific needs and gaps in the pre-service education systems for mid-level providers (MLPs) 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 assessment results and recommendations presented here are focused on Nepal.*

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 Nepal Context

Since 2002, abortion has been legally permitted in Nepal during the first 12 weeks of pregnancy for any indication, with the request of the woman; up to 18 weeks in cases of rape or incest; and at any time during pregnancy (with approval from a medical practitioner) if the mental/physical health or life of the pregnant woman is at risk or if the fetus is deformed and incompatible with life (Samandari et al., 2012). Prior to the 2002 law, Nepal had some of the most restrictive abortion laws in the world and one of the highest maternal mortality rates in Asia; more than half of all gynecological and obstetric hospital visits were due to abortion-related complications (PATH, 2013).

Since the ban was overturned, abortion-related complications have been on the decline. A maternal mortality and morbidity study carried out in eight districts under Nepal's Ministry of Health and Population found that abortion-related complications fell from 54 percent to 28 percent at relevant facilities between 1998 and 2009 (Suvedi et al., 2009). Yet, an estimated 165,000 abortions, both safe and unsafe, take place annually in Nepal and abortion is still the third-highest direct cause of maternal death in the country (CREHPA, 2011). And although the percentage of abortion-related complications is significantly lower, the percentage contribution of abortion (induced and spontaneous) to hospital deaths was found to be higher (14 percent, up from 10 percent in 1998). This suggests that while fewer abortion complications are presenting at facilities, they are more serious and/or their management levels need to be improved (Suvedi et al., 2009).

Both treatment of unsafe abortion and elective abortion are provided by trained allopathic physicians, staff nurses and Auxiliary Nurse Midwives (ANMs). Additionally, all personnel trained in Skilled Birth Attendance (SBA)[2], which includes abortion care, are permitted to provide medical abortion (MA) and staff nurses with training in postabortion care (PAC)/manual vacuum aspiration (MVA) are permitted to provide MVA for postabortion care. Homoeopaths and Ayurveds are active physicians cadres in Nepal but are not allowed to provide any abortion services under current regulations (Population Council, 2011). As of December 2011, Nepal had rapidly scaled up its safe abortion services model by training 881 physicians and 371 staff nurses in comprehensive abortion care; 255 ANMs in medical abortion provision; registering 532 facilities for provision of abortion care, with at least one trained provider and facility in all 75 districts, resulting in 497,804 women served (Samandari et al., 2012). (It should be noted also that subsequent to this pre-service assessment, a national-level task force formed in Nepal to review curricula for gaps in content related to comprehensive abortion care. Revisions to address those gaps are in process.)

> *"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)."*
>
> —World Health Organization, 2012

2 Health workers trained in skilled birth attendance (SBA) have received standard training in a set of core midwifery skills as defined by international standards, and have a minimum of 18 months of training in midwifery skills. Medical officers, staff nurses and ANMs working at primary health care centres and health posts are prioritized for SBA training in recognition of their role as frontline health service providers (Minca, 2011)

Cadres of midlevel health-care providers

The cadres of MLPs included in the Nepal assessment were: **B.Sc Nurses, Proficiency Certificate Level nurses (PCLs), and Auxiliary Nurse Midwives (ANMs).** These three cadres were selected due to their level of training and their essential roles in provision of reproductive health care. Female Community Health Volunteers (FCHVs) were also considered but were not included because they receive basic training in the National Health Training Centres (NTHCs) rather than in academic institutions. Due to the key role they play in the health system, however, they did emerge as a priority cadre for capacity-building through their government-sponsored training programs[3].

Cadre	Length of training	Number of training institutions[4]	Average number of graduates per year[5]
B.Sc Nurses	4 years	39	NA[6]
PCLs	3 years	84	3,160
ANMs	2 years (+5 months on-the-job training)	50	1,732
Total		173	4,892

General Bachelor in Nursing (B.Sc Nurses): Nurses in this cadre have general nursing skills and a higher level of training than other nurse cadres. After graduation, they often go on to work in district or tertiary care hospitals, or become teachers or managers in different health or academic institutions. Their curriculum includes basic maternal and reproductive health care, including theoretical classes covering safe abortion services and family planning (FP) methods, but FP is minimal and abortion is not included in clinical practice. As with other nursing students, they are not allowed to practice any clinical procedures until they graduate and complete additional in-service training on abortion conducted by the government-sponsored National Health Training Centres (NHTCs).

Proficiency Certificate-level Nursing (PCL): The PCL nursing educational programme is affiliated with different universities and the Council for Technical Education and Vocational Training (CTEVT) to produce the basic level of nursing profession called "staff nurse." The curriculum has incorporated core competencies in Skilled Birth Attendance (SBA) since 2006. After the completion of their training, PCLs work at the tertiary level, district level hospitals and primary health care centres. Their curriculum is authored by the CVEVT and the Nepal Nursing Council. Their curriculum includes all the reproductive health components, including theoretical content on abortion as per the NHTC curriculum, but historically their training has not included abortion care. Their training does cover SBA, however, the assessment revealed that they do not get proper guidance and coaching in clinical settings as part of their practicum. Additionally, they do not develop competency in skills related to long-acting contraceptives or to aspiration abortion with MVA.

Auxiliary Nurse Midwife (ANM): ANMs in Nepal play an essential role in primary care and are closely connected to the communities in which they work. Education for this cadre includes primary health care and midwifery education for 18 months, followed by an additional five months of on-the-job training (OJT) in hospitals and/or birth centres. Their curriculum includes theory on reproductive health topics, including

3 FCHVs are community volunteers who provide basic health information to their respective community members, especially women, and may also provide screening and referrals.

4 Numbers of training institutions are approximate, as they were inconsistent across sources.

5 Average numbers of graduates are approximate.

6 Data was unavailable for the number of B.Sc. Nurses graduating annually from all training institutions

abortion, but it does not reference the national abortion program guidance (NHTC training package on SBA and safe abortion). Furthermore, clinical competency is a critical issue due to inadequate supervision and coaching for pre-service trainees to acquire clinical practice in FP methods and abortion care. Their education falls under the authority of the Council for Technical Education and Vocational Training (CTEVT), a body of the Ministry of Education. Some ANMs receive in-service training in MVA as a part of emergency obstetric care (SBA training) after which they are eligible to attend medical abortion in-service training. (Note: more than 300 ANMs have received in-service training through the NTHC with support from Ipas Nepal, but training has not been extended to pre-service educational institutions).

A final note regarding priority cadres: as previously mentioned, Female Community Health Volunteers are a vital part of the informal health care system. Numbering more than 48,000, the FCHVs are an important cadre that provides preventive care in Nepal's remote communities. They receive two days of training in the legal status of abortion, early pregnancy detection through urine pregnancy tests, and referral. As of 2013, there is a study in process to evaluate their ability to assess gestational age and provide medical treatment of incomplete abortion that could have implications for their roles in education, screening and referrals.

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

All three professional nursing cadres evaluated were found to have similar gaps in their pre-service preparation. These include:

- Theoretical content and clinical skills for both comprehensive abortion care (CAC) and FP are not consistently or adequately covered in curricula, coursework and clinical practice during pre-service training.
- Pre-service training institutions lack adequate skills laboratories for FP and CAC skills practice.
- National guidelines, manuals and logbooks are needed in pre-service training courses (through integration of NHTC training into pre-service to develop competency among graduates).

- Government procedural guidelines do not support adequate skills development in the pre-service period.
- Nursing faculty lack the knowledge or expertise to deliver the course content and supervise students.
- Linkages are needed between pre-service training institutions and supervisors in clinical teaching facilities—including a need for supervision at the community level for nurses and extending support to FCHVs.

The first-level priority cadres identified in the assessment were due to their central role in provision of reproductive health services and the characteristics of their training. B.Sc Nurses were designated as a second tier of priority, primarily due to their extensive involvement in multiple health programme priorities in Nepal. Additionally, although the training for FCHVs is not directly affiliated with academic institutions and is less formal, this cadre was identified as an important resource in the provision of medical abortion and, pending results of a forthcoming feasibility study, should be considered for further training and service interventions.

Priority recommendations

1. **Build pre-service training capacity for delivery of competency-based training in comprehensive abortion care and contraceptive methods (especially long-term methods, such as IUDs and implants).**
    - Revise pre-service training curricula for all cadres to be competency-based and comprehensive, in accordance with WHO recommendations.
    - Strengthen faculty/instructors' knowledge and capacity to deliver competency-based training. (Provide training, practical teaching modules and other teaching aids and on-going support for training instructors, clinical preceptors and students.)
    - Increase faculty members' and clinical preceptors' capacity to provide supportive supervision and monitoring.
    - Strengthen clinical training in selected hospitals/clinics in collaboration with the government, non-government and private service sites to enhance the development of students' clinical skills.
2. **Develop physical infrastructure and secure resources and equipment to support pre-service training in schools and clinical training sites.**
    - Update skill laboratories of the nursing campuses and ANM schools with necessary equipment for simulation learning (such as pelvic models, supplies, FP commodities).
    - Ensure that teaching tools and other materials that facilitate learning (e.g., journals, manuals, handbooks and easy-to-use teaching aids) are easily accessible.
3. **Coordinate efforts between nursing schools and clinical training sites to promote policies and procedures and training materials that promote competency-based training of midlevel providers so that they can provide CAC and FP services consistent with WHO guidelines.**
    - A joint collaboration with a regulatory body (Nepal Nursing Council) and the Nepal government should be undertaken to develop accreditation guidelines, procedural orders and provision of accreditation and endorsement of curricula. (Note: A multi-sectoral taskforce has already formed to this end).
    - The pre-service training curriculum of all midlevel cadres should be carefully reviewed and updated to promote competency-based training and to facilitate their independent practice post-graduation. Curriculum reviews should seek to emphasize skills development and the duration of training should ensure that it is adequate for producing skilled graduates.

- Update policies, regulations and procedures that impede the training process and/or independent provision of services by midlevel providers. (Regulations and procedures should permit hands-on skills practice by students during the pre-service period, and current barriers to clinical skills practice in the pre-service phase should be removed.)

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 reproductive health, including comprehensive abortion care, should be a standard component of initial pre-service education for midlevel health care practitioners in Nepal. Training these cadres to provide this life-saving care can contribute to protecting women's health and attaining national goals of reducing maternal deaths.

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