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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 Pakistan

Unsafe abortion remains a major health concern in South-Central Asia, where the World Health Organization (WHO) estimates that more than 6.8 million unsafe abortions took place in 2008—the highest number of any region in the world (World Health Organization, 2011).[1] 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 that shows abortion can be safely provided by any properly trained health provider, including non-physician 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 midlevel cadres is endorsed by the 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). The WHO defines midlevel providers with regard to abortion care as a range of non-physician clinicians such as midwives, nurse practitioners, clinical officers, physicians assistants, family welfare visitors and others who are trained to provide basic clinical procedures in reproductive health care (WHO 2012).

Millennium Development Goals

In September 2000, the largest gathering of world leaders in history adopted the UN Millennium Declaration, committing their nations to a new global partnership to reduce extreme poverty and setting out a series of time-bound 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. *The assessment results and recommendations presented below focus on Pakistan.*

1 The World Health Organization reports unsafe abortion data by region. South-Central Asian 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 Pakistan Context

Available data suggests that abortion and unwanted pregnancy are prevalent in Pakistan. A study in 2004 by the Population Council revealed high levels of unwanted pregnancy, induced abortion, and postabortion complications in Pakistan, with an estimated 890,000 induced abortions performed annually. The study also revealed that the average Pakistani woman will experience one abortion in her lifetime, and that most women who have induced abortions are aged 30 or older, are nearing the end of childbearing years, and typically have had three or more children (Center for Reproductive Rights, 2004; Z. A. Sathar et al., 2013).

Abortion is legal in Pakistan to save the woman's life or to provide "necessary treatment" but safe abortion services are not easily accessible. Factors such as restrictive local interpretation of the law, high levels of stigma and service cost barriers result in the majority of abortions being clandestinely performed in clinics in urban areas and/or by midwives and traditional birth attendants in rural areas (Z. A. Sathar, et al., 2013). The impact on health facilities is clear; a 2012 study found that 696,000 women were treated for postabortion complications in health facilities throughout Pakistan (267,000 were treated in public facilities). Many women with abortion complications go untreated due in part to the fact that the care provided falls short of desirable standards: staff are not adequately trained, methods used for uterine evacuation are often outdated and unsafe, female staff are in short supply, and appropriate equipment and technologies are lacking (Z. Sathar, et al., 2013). Additionally, 62 percent of the Pakistani population resides in rural areas with poor health-care infrastructure and limited access to preventive and life-saving maternal health services. Clearly, serious complications and morbidity from unsafe abortion have a substantial impact on women's health and on the health-care system.

In an effort to address the growing need for safe abortion services, Pakistan's Ministries of Health and Population Welfare pledged in the Karachi Declaration in 2009 to institutionalize postabortion care in health policies, protocols and standards at the national level as part of the national strategy toward attainment of the Millennium Development Goals. However, when the Ministries of Health and Population Welfare were abolished in 2011, this commitment was decentralized with each province expected to develop its own health policy, which has contributed to delays in the institutionalization of postabortion care at the provincial level (Z. Sathar, et al., 2013).

Given this environment, there is a need to greatly increase the number of competent health providers to further expand women's access to safe abortion care as well as preventive reproductive health services. To this end, the assessment in Pakistan examined the expansion of pre-service training for postabortion care (PAC) and abortion-related care to support the decentralization of services.

Postabortion care (PAC) is an approach for reducing deaths and injuries from incomplete and unsafe abortions and their related complications (Ipas, 2013). Postabortion care is an integral component of comprehensive abortion care and includes five essential elements:

1. Treatment of incomplete and unsafe abortion and complications
2. Counseling to identify and respond to women's emotional and physical health needs
3. Contraceptive and family-planning services to help women prevent future unwanted pregnancies and abortions
4. Reproductive and other health services that are preferably provided on-site or via referrals to other accessible facilities
5. Community and service-provider partnerships to prevent unwanted pregnancies and unsafe abortions, to mobilize resources to ensure timely care for abortion complications, and to make sure health services meet community expectations and needs.

Excerpted from Postabortion Care. Ipas, 2013. http://www.ipas.org/en/What-We-Do/Comprehensive-Abortion-Care/Elements-of-Comprehensive-Abortion-Care/Postabortion-Care.aspx

Cadres of midlevel health-care providers

At the time of the assessment, six cadres of midlevel providers were active in Pakistan, all of which are required to be female: Registered Nurse Midwife (RNM), Lady Health Visitor (LHV), Community Midwife (CMW), Pupil Midwife (PM), Midwife (MW), and Traditional Birth Attendants (TBAs). TBAs, who are trained informally by elders and other providers and are thus outside of the formal pre-service training systems, were not included in this assessment. The chart below provides an overview of each of the remaining five cadres' length of training, number of training institutions, and average number of graduates per year.

Cadre	Length of training	Number of training institutions	Average number of graduates per year
Registered Nurse Midwife (RNM)	4 years (3 years nursing, 1 year midwifery)	128	9,300
Lady Health Visitor (LHV)	2 years (1 year public health, 1 year midwifery)	29	2,100
Community Midwife (CMW)	18 months	95	3,000
Pupil Midwife (PM)	15 months	40	400
Midwife (MW)	12 months	99	2,600
Total		**391**	**17,400**

The Pakistan Nursing Council (PNC) is responsible for approving the curriculum for each of the above cadres and for accrediting academic institutions and licensing providers. The PNC has approved a basic midwifery curriculum that is used by all cadres—with the exception of the Community Midwives (CMWs). This basic curriculum was last revised in 1994 and is loosely based on a prescribed reference text but is not competency-based (again with the exception of the CMWs). The basic curriculum includes some classroom training in family planning and abortion but is out of date and does reflect current standards of practice for management of PAC/abortion-related care or family planning. Additionally, CMWs comprise the only cadre that has its own training manual to ensure systematic implementation of training among midwifery teachers or tutors.

Registered Nurse Midwives: RNMs training is the most extensive, with three years general nursing training and one year specialization in midwifery. RNMs generally work in secondary or tertiary care hospitals and in urban settings. Under the supervision of doctors, they may also work in operating theaters assisting during obstetric or gynecological surgical procedures, labor and delivery, postabortion or postnatal care. This cadre was identified in the assessment as priority for pre-service abortion training due to their high levels of skill and knowledge.

Community Midwives (CMWs): This new cadre was introduced in 2008 and deployed over 1,200 new CMWs between its inaugural year and 2011 (Campbell et al., 2011). As of 2013, CMW is the only cadre with defined competencies set in accordance with the International Confederation of Midwives (ICM) standards, although efforts are underway to make revisions and develop competencies for other cadres (International Confederation of Midwives, 2010)[1]. CMWs are also the only cadre that has a specific training manual for trainers' and tutors' reference. They receive theoretical and practical training, with 25 percent of their time

1 For details see ICM's Essential competencies for basic midwifery practice: www.internationalmidwives.org/assets/uploads/documents/CoreDocuments/ICM%20Essential%20Competencies%20for%20Basic%20Midwifery%20Practice%202010,%20revised%202013.pdf

dedicated to theoretical training and the remaining 75 percent of their training spent in supervised and hands-on practical training in both the community and institutions.

Lady Health Visitors: LHVs are based in primary care facilities in community settings. They provide antenatal, natal and postnatal care and family planning counseling, services including intrauterine contraceptive devices (IUCDs), and also do community outreach and home-based services. LHVs undergo one year of training in public health and community medicine and an additional year in midwifery training. Clinical training includes home-based care, and students are required to pass licensing examinations prior to certification. The level of supervision is dependent on the setting in which they work, but they often work independently with little oversight. The curriculum used for LHVs is the same as for the other cadres, and the assessment revealed that pre-service training was similarly lacking in demonstration of core competencies in abortion or family planning.

Midwives and Pupil Midwives: MWs and PMs work in primary or secondary care facilities under the supervision of a doctor. Training in family planning methods is primarily limited to classroom training, and although trainees rotate through clinical facilities, they are often restricted to observational learning. Hands-on skill development is minimal, and generally there are no formal systems for internships or for supervision of clinical training. Training in postabortion care is not included. Midwives were often recruited from the base of traditional birth attendants already working in communities. These cadres are being phased out and supplanted with the new cadre of Community Midwife; therefore, they were not recommended for pre-service training.

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.*

Recommendations

Three cadres were identified as high priority for expanding the health system's capacity to best meet the national demand for postabortion care and provide life-saving services that can help Pakistan in attaining national goals for improving women's health and reducing maternal mortality (see box titled "Millennium Development Goals" for more details). These cadres are: **Registered Nurse Midwives, Lady Health Visitors** and **Community Midwives.**

Registered Nurse Midwives have the highest level of professional training among these cadres and are recommended for training in both medical and aspiration abortion methods. Community Midwives are a cadre of growing importance (they will eventually supplant the pupil midwives and midwives groups), LHVs are key providers of basic reproductive care, and both cadres would be effective providers of medical methods.

There were commonalities identified across the three cadres regarding gaps in curricula and other educational needs. These needs were consistent also with the findings of external evaluations of the community midwives program conducted in 2010 (Shah et al., 2010; Technical Resource Facility, 2010; Wajid et al., 2010). Both the current assessment and the evaluations identified the need to strengthen faculty/tutor teaching capacity (knowledge, skills and teaching tools), to refine curricula and teaching materials, to improve hands-on clinical practice and to improve supervision and monitoring of trainees. A key concern was the need to ensure that curricula across all cadres are consistent, competency-based and evidence-based, reflecting current scientific knowledge and global standards of practice.

Priority Recommendations

1. **Revise/update curricula for priority cadres (RNM, CMW and LHV).**
    - The Midwives Association of Pakistan, the Pakistan Nursing Council and key academic institutions should collaborate to ensure that curricular materials conform with international standards and guidelines, ensuring that PAC/abortion-related care is included as an essential competency, in accordance with International Confederation of Midwives recommendations (International Confederation of Midwives, 2010).
2. **Build institutional capacity for pre-service education for the priority cadres.**
    - Improve faculty/tutors' teaching capacity to deliver training in PAC/abortion-related care in their educational institutions (via training manuals and a teachers training system that includes adult learning techniques and clinical skills-building for teachers).
    - Translate manuals and reference materials into Urdu.
    - Strengthen and equip training schools and sites, including provision of skill labs and models.
3. **Strengthen health system capacity to support provision of PAC/abortion-related care by midlevel practitioners.**
    - Develop and implement clinical protocols, supervision and follow-up systems, including verification logs for core competencies.
    - Strengthen clinical practice through improved workplace environment, caseload, continuous supplies and coordination between school and clinical faculty.
    - Ensure that adequate supplies and medications are available and accessible to all three priority cadres at clinical training sites to enable both training and full service provision.
4. **Create an enabling policy environment at the provincial level for increasing midlevel providers' role in prevention and management of unsafe abortion.**
    - Adapt WHO standards and guidelines to Pakistan's local needs to create simple and safe standards of care that can be implemented by trained providers (both midlevel and physicians). Ensure that midlevel providers are authorized to administer misoprostol and medical abortion and that these medications, manual vacuum aspirators (MVAs) and family-planning commodities are available in provincial essential drug and equipment lists.

- Advocate for midlevel provision of PAC/abortion-related care in light of government commitments to the various United Nations conventions, protocols, and conference documents (such as the Karachi Declaration) and inform health sector and professionals about the current parameters for provision of abortion care under existing legal frameworks (to save a woman's life or to provide "necessary treatment").

Conclusion

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

Acknowledgments

Ipas would like to thank the David and Lucile Packard Foundation for the support that enabled us to conduct this assessment.

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EPBPAK-E13