A report on the Expanding the Provider Base Workshop

Ipas
Health. Access. Rights.

Bangkok, Thailand
January 19-21, 2013

Produced in the United States of America

Ipas is a nonprofit organization that works around the world to increase women's ability to exercise their sexual and reproductive rights, especially the right to safe abortion. We seek to eliminate unsafe abortion and the resulting deaths and injuries and to expand women's access to comprehensive abortion care, including contraception and related reproductive health information and care. We strive to foster a legal, policy and social environment supportive of women's rights to make their own sexual and reproductive health decisions freely and safely.

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Acknowledgements

This report is dedicated to the many health-care providers who support women in accessing safe abortion and postabortion care.

We gratefully acknowledge the members of the workshop planning committee for their hard work in developing the workshop program. We appreciate the engagement and commitment of all the workshop participants, and look forward to celebrating their ongoing success in expanding the provider base in their countries. We also thank Kara Davies for writing, Margie Snider for editing, and Jamie McLendon for designing this report.

Ipas Special Projects Unit and Ipas Asia Regional Support Team – workshop sponsors

Table of Contents

Introduction

On January 19, 2013, 38 delegates representing nine countries[1] in Africa, Asia and North America came together for the Expanding the Provider Base (EPB) Workshop hosted by Ipas. The three-day workshop facilitated the sharing of resources and strategies across regions related to expanding the role of non-physician providers in abortion-related care, with a focus on task-sharing in comprehensive abortion care (CAC) and postabortion care (PAC).

The EPB Workshop was a synergy meeting designed to bring Ipas staff and key partners together to share experiences and strategies and increase capacity on essential abortion-related care topics. The workshop recognized and contributed to the global movement to expand the provider base in order to make abortion-related care more accessible in underserved areas and especially to reach poor and marginalized women.

While recognizing that each country has unique challenges and opportunities, the workshop had five specific objectives:

- Understand best practices and lessons learned from existing evidence and from other countries
- Explain the policy support, opportunities and limitations for expanding cadres of CAC/PAC providers
- Analyze how different cadres of providers can better meet women's needs
- Identify and utilize key tools and resources for country specific planning
- Plan for context-appropriate next steps

The EPB Workshop addressed these objectives with a robust agenda that reviewed the current evidence and climate for expanding cadres of CAC/PAC providers internationally. A key point was to think together about how the roles and skillsets of a variety of health workers, including some not currently engaged in abortion-related care, could reasonably expand and thus improve women's access to reproductive health care. During the workshop, the participants discussed a range of cadres—including, but not limited to, midwives, nurse practitioners, clinical officers, physician assistants, family welfare visitors, and community health workers—who can be trained in components of safe abortion or postabortion care.

Workshop discussions and exercises explored key issues surrounding advancing health worker roles, including health system capacity, overcoming political opposition and the debate over how much supervision midlevel providers require when involved in abortion-related care. Focusing on both obstacles and opportunities to expanding the provider base, participants strategized on how to best use existing evidence to address barriers in an effective and meaningful way. The workshop concluded with country teams designing their own context-appropriate next steps.

1 Invited partners and Ipas staff included delegations from Bangladesh, Ethiopia, India, Nepal, Nigeria, Pakistan, Sierra Leone, and Zambia, as well as Ipas's global and U.S. staff.

This report provides a discussion of three key outcomes from the workshop:

- Identifying the need for and evidence behind expanding cadres of CAC/PAC providers;
- Cross-country learning and hearing from midlevel providers; and
- Country strategizing and planning with partners on expanding the provider base.

Identifying the need for and evidence behind expanding cadres of CAC/PAC providers

A woman's ability to access safe and comprehensive reproductive services is critical to her overall well-being. But millions of women around the world face barriers to access or no access at all to safe abortion services. Even in countries where abortion is legal, the cost, transportation challenges, distance to the nearest clinic, lack of trained providers, stigma surrounding abortion and sexuality, and restrictive policies all influence when and how women can exercise their right to an abortion (Ipas, 2013).

One of the most prominent barriers to abortion access is the global health worker shortage. According to a 2006 report by the World Health Organization (WHO), 57 countries[2] face a chronic human resource deficit in the health sector; 36 of those countries are in Africa and six are in Southeast Asia (World Health Organization, 2006). The burden of this shortage is felt directly by women seeking PAC/CAC services. Lack of properly trained service providers, particularly in rural areas, contributes to an estimated 22 million unsafe abortions being performed worldwide each year, resulting in the deaths of an estimated 47,000 women and disabilities for an additional 5 million women (Åhman & Shah, 2011).

One promising strategy for addressing health workforce insufficiencies and improving access to essential health services is task-sharing, a team-based approach in which a more rational division of labor is developed among health workers. Task-sharing is "medical care provided to a patient by a set group (team) of different health professionals with different roles that maximize the skills and abilities of each team member… Team-based care is designed to enable different health professionals to achieve their full potential and improve quality, reduce costs, and increase access to health services." (Olson, 2012)

A similar concept is task-shifting. According to the World Health Organization, task-shifting occurs when "specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of available resources for health" (World Health Organization, 2008). Task-shifting frees up advanced providers to carry out more complex care and may involve the delegation of specific task/s or the substitution of one type of health care worker for another (Dawson, Buchan, Duffield, Homer, & Wijewardena, 2013).

2 All countries represented at the EPB Workshop are considered by the WHO to have a critical health worker shortage, which means they have fewer than the recommended 23 health workers per 10,000 people.

In the context of the EPB Workshop the term "midlevel provider" refers to a range of non-physician clinicians, including, but not limited to midwives, nurse practitioners, clinical officers, physician assistants, family welfare visitors, and community health workers who can be trained to provide components of safe abortion care.

The terms are often used interchangeably and both strategies are important for expanding the provider base for abortion and postabortion care. For the purpose of the workshop we emphasized task-sharing, looking at provider teams both within and across facilities, as it is a less physician-centric model and it is a model inclusive of training, certification and support (Olson, 2012). While task-sharing is a relatively new term, the concept behind it is not new at all. Family planning programs have been sharing various tasks between doctors and nurses, and between nurses and community health workers, for years (Janowitz, Stanback, & Boyer, 2012). The evidence base in favor of moving abortion care to non-specialists and midlevel providers is well established. Over the past decade, the WHO has released several formal statements in support of both the task-sharing/shifting models and the provision of PAC/ abortion care by midlevel providers. In 2012, the WHO reinforced its position saying, "Abortion care can be safely provided by any properly trained health-care provider, including midlevel providers" (World Health Organization, 2012, p.65).

Guidance with respect to midlevel providers and abortion, including PAC, also has been available for years. While the focus traditionally has been on midwives (and related cadres), the EPB Workshop sought to bring into consideration a variety of other providers who could share the work even further. From birth attendants to health assistants to community health extension workers, many countries have the ability to provide safe abortion care through a range of cadres. In the context of the EPB Workshop the term "midlevel provider" (hereinafter MLP) refers to a range of non-physician clinicians, including, but not limited to midwives, nurse practitioners, clinical officers, physician assistants, family welfare visitors, and community health workers who can be trained to provide components of safe abortion care.

Day one of the EPB Workshop provided a thorough review of evidence on the subject. Sessions were conducted on clinical and health-systems capacity evidence, evidence for task-sharing, and policy evidence. Workshop participants were generally in agreement with the validity of the evidence presented and the desire to implement task-sharing in their respective settings. Group discussions revealed an eagerness to learn how to integrate MLPs in abortion-related care. In particular, countries where MLPs are not currently authorized to provide services were able to hear from countries that have had success in this area. Similarities across regions and countries were also noted. One participant remarked, "All countries in attendance have a human resource gap—there is no other way [to reach women] except through task-sharing."

Yet, just as there is a wealth of evidence supporting expanding the provider base in PAC/ CAC, there are also numerous challenges to implementing such an expansion. After a thorough evaluation of existing evidence and discussions on task-sharing, time was devoted

to recognizing and examining barriers to expanding the provider base. Samples of barriers identified by participants in their countries were financial concerns, worries about the "misuse and abuse" of technology by MLPs and preserving quality of care, and the lack of training and post-training supervision available to MLPs. Many of these barriers stem from fundamental gaps in the capacity of public health systems in the areas of monitoring and supervision.

Through sessions that explored both evidence for and attitudes against expanding the provider base, workshop participants were able to see how the opportunities and evidence outweighed the barriers (Figure 1). For example, the common argument that the use of MLPs with shorter training and lower qualifications will inevitably lead to lower quality of care than higher level health-care providers, can be refuted with evidence. In fact, with sufficient training and support, MLPs can improve access to and coverage of health services at levels of quality comparable to (or in some cases higher than) physicians (Brown et al., 2011). Regarding abortion care specifically, a systematic review concluded that MLPs can be trained to provide first-trimester surgical (using vacuum aspiration) and medical (mifepristone and misoprostol) termination of pregnancy services as safely and effectively as physicians (Renner, Brahmi, & Kapp, 2013).

Perhaps more importantly, workshop participants explored how to access and integrate existing clinical and policy evidence into their country-level decisionmaking for clients/patients. Specifically, country working groups were tasked with identifying barriers relevant to their setting, the underlying beliefs/causes driving those barriers, and possible solutions.

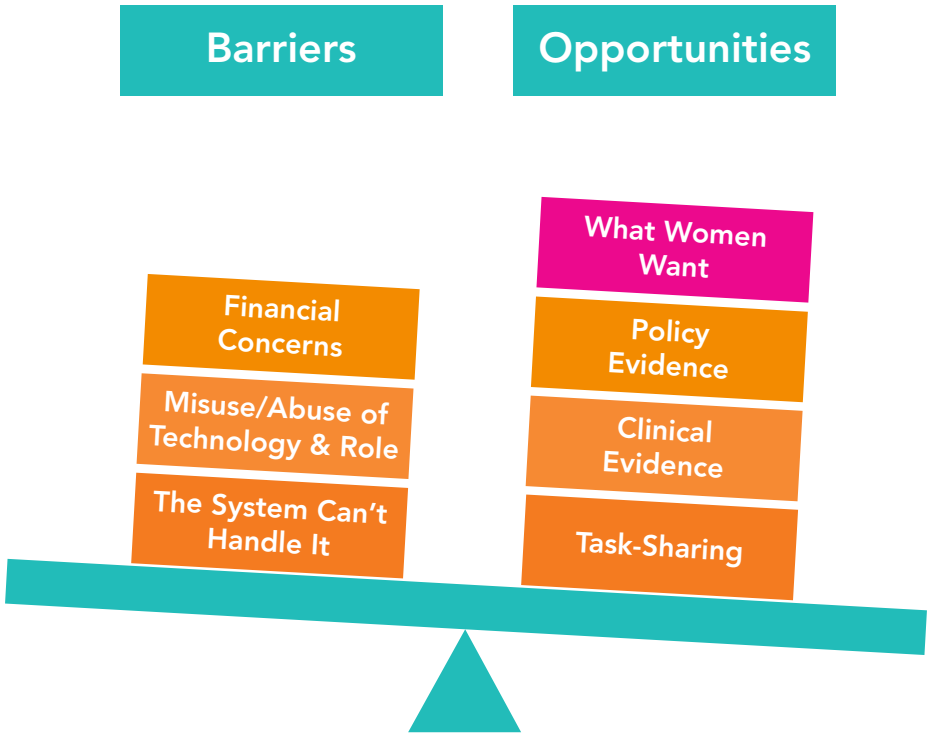

Figure 1. Barriers and opportunities to expanding the provider base

Cross-country learning and hearing from midlevel providers

The EPB Workshop participants came with a wealth of experience and varying backgrounds: MLPs, leaders of nursing and medical associations, physicians, program managers, and ministry and other government officials. This diverse mix of attendees provided the unique opportunity to learn across regions, countries and cadres. With this in mind, the EPB Workshop dedicated a significant amount of time, both through formal sessions and break-out sessions, for participants to share with and learn from one another.

Day two of the workshop opened with hearing directly from providers. The panel, made up entirely of non-physician providers, included a senior staff nurse from Bangladesh, an auxiliary nurse midwife from Nepal and a nurse midwife from Nigeria, and focused on these providers' roles and experiences in providing safe abortion and CAC to women. Formatted as a talk show, the session allowed for open dialogue in which panelists shared their specific scope of work, challenges they've faced as MLPs, and their thoughts on how to best address expanding the provider base in their particular settings. One-third of participants identified hearing from midlevel providers as the most helpful aspect of the workshop.

"I know my patients are happy with my services, they tell me. Women's satisfaction is also evident in our increasing caseload."

— Senior staff nurse, Bangladesh

"The people trust me because I live in the community that I serve."

— Auxiliary nurse midwife, Nepal

"Observation and hands-on training are key. This will build nurses' confidence to 'take the reins.'"

— Nurse midwife, Nigeria

"Sharing Tools and Resources for Expanding the Provider Base" was another workshop session that provided ample cross-country learning. Country participants were asked in advance to bring examples of tools and resources they use in their country settings, and Ipas's head office staff brought core Ipas print and online materials. During the session a variety of stations were set up around the conference room to display the tools and resources. Small groups of participants then rotated around the room to hear an overview of the various tools and resources and how they can be applied specifically to expanding the provider base. Participants were encouraged to ask questions, share their experiences with similar or different tools, and explore how the tools could be adapted for use in their country setting.

This interactive session included a variety of resource stations and poster presentations including:

- Job aids
- Policy aids (including sample codes of ethics, standards and guidelines, and guideline language from notable organizations and governments)
- Safe abortion care (SAC) indicators and the use of monitoring data for program review and advocacy
- Model curricula to build provider competencies
- Community awareness/education tools (including youth toolkits, IEC/BCC materials and PE curriculums)
- Providers as Advocates for Safe Abortion Care Training Manual

Participants circulated among stations to hear an overview of tools and resources and discuss how each can be applied towards expanding the provider base.

Country strategizing and planning with partners

Building on country sharing, the EPB Workshop also gave participants an opportunity to together identify priorities and strategies for expanding women's access to safe abortion care at the country level. Through a variety of sessions, country teams were able to synthesize information and plan context-appropriate next steps for expanding the provider base in their communities (see Figure 2).

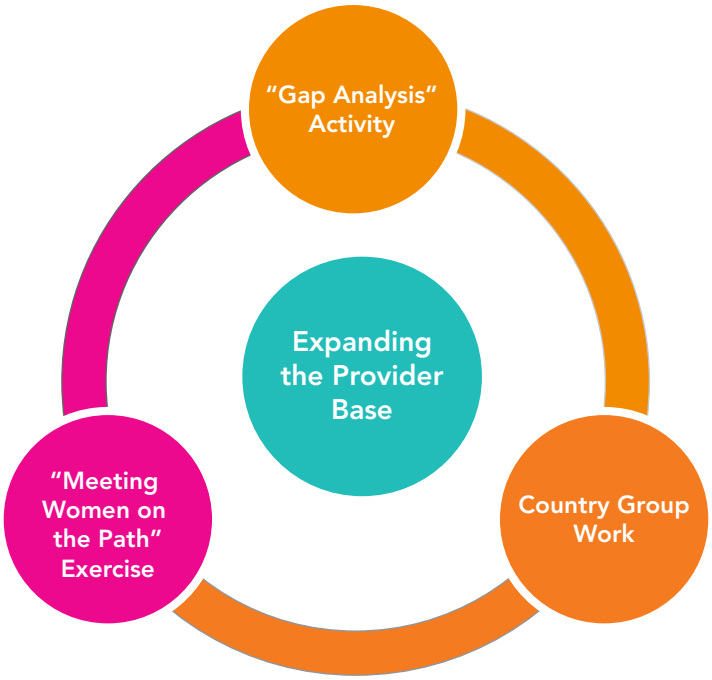

Figure 2. Interrelated sessions to expanding the provider base

Meeting Women on the Path

A plethora of variables, many previously identified and discussed in this report, contribute to unsafe abortion rates. Two highlighted by the Guttmacher Institute are lack of access to contraceptives and lack of access to safe services (Guttmacher Institute, Spring 2011). Rural women in particular are forced to rely on unsafe methods of abortion and illegal providers due to lack of access. The interactive session, "Meeting Women on the Path," highlighted the plight of many women seeking abortion services. During this session, country groups were tasked with describing and drawing a typical woman from the community they serve – they assigned her a name, age, marital status and income level. Participants then charted the woman's journey to end a pregnancy.

This exercise called attention to the wide variety of factors that impact a woman's decision to access unsafe abortion services— including, but not limited to, stigma, financial cost, lack of knowledge about safe services and distance from nearest health center.

Participants identified obstacles women face when trying to access safe abortion care and opportunities to reduce those obstacles

Once country groups had detailed their woman's "path" and obstacles, participants reconvened as a group for a comprehensive discussion about their findings. Key questions and objectives of the discussion are detailed in the chart below.

Discussion Questions	Discussion Objectives
How many stops did the woman make along the way? Note average stops among the groups.	Identify the obstacles women face and opportunities to reduce those obstacles
What makes these stops more difficult along the way? Note role of non-functional health institutions, distance/transportation, unsafe services, lack of information, stigma, money, age, etc.	Consider opportunities to reach women at different points in the health system and the community as a way to increase access to abortion/post-abortion care
Role of costs: the more places the woman goes the more costs she incurs. Cost is a significant barrier to service and an implication of the services.	Analyze how different cadres of providers can better meet women's needs, including earlier intervention, along the path to abortion services

What participants illustrated has been borne out in studies: Women often make multiple attempts to end a pregnancy, incurring more cost and spending more time along the way. The women in the examples created by country groups had an average of three to four stops on their journeys before being able to access abortion services – and many of the stops had unsafe practices or provided incorrect information. *Exploring the Pathways of Unsafe Abortion,* a study conducted in Madhya Pradesh, India, similarly found that out of 381 women identified as PAC cases, more than 90 percent sought care from a sub-optimal provider (most frequently a chemist/medical shop on their first visit) and 41 percent visited a variety of providers unsuccessfully (includes qualified and illegal providers). The study also found the delay in service directly led to an average cost increase of $16 USD (up to $21 USD for women who make three or more visits to other providers); average time delay to reach a hospital for PAC was 16 days (Banerjee & Andersen, 2012).

Had well-trained and motivated MLPs been available in these women's communities, lives, money and time could have been saved. Rural areas and small communities would greatly benefit from moving beyond the traditional definition and role of who and what an MLP is. In order to effectively reach women, the full spectrum of health workers must be appropriately utilized and trained to promote safe options and postabortion complication management.

"Gap Analysis" Activity

According to the WHO, the availability of facilities and trained providers within reach of the entire population is essential to ensuring safe abortion services. Furthermore, the WHO asserts, "Regulation of providers and facilities should be based on evidence of best practices and be aimed at ensuring safety, good quality and accessibility of services" (World Health Organization, 2012). In 2012, the WHO released its recommendations for optimizing health worker roles for maternal and newborn health (see interactive chart online at http://optimizemnh.org/index.php). Adapting the WHO model and informed by the 2012 WHO Safe Abortion Guidance, Ipas created a similar chart displaying proposed abortion care interventions by cadre and facility level (see Annex 1). The adapted chart was used by country groups to discover how their country's current policies and practices for midlevel and community providers align with WHO recommendations – allowing them to evaluate gaps in services and identify key opportunities to expand the provider base in their particular setting.

Ghana group members recognized they could work towards expanding the scope of community health extension workers to include provision of family planning methods and misoprostol in PAC/CAC. Similarly, India group members agreed to increase efforts in advancing approval for nurse midwives to provide misoprostol for incomplete abortions. Pakistan and Ethiopia both picked up on the opportunity to work with professional bodies to develop joint position statements and technical and procedural guidelines, respectively, for advancing safe abortion care services in their countries. Regardless of their individual environments, each country was able to gain insight on gaps in their provider base and approaches to filling them.

Country Group Work: Turning Opportunity into Action

Based on their findings in the gap analysis exercise, country groups were tasked with generating a comprehensive list of opportunities for change in their setting, as well as articulating the impact these changes would bring. Groups then prioritized their opportunities. The "Opportunities Worksheet" can be found in Annex 2.

Building on the previous exercises, country groups transferred their top two opportunities to an "Action Worksheet" (see Annex 3). The worksheet required in-depth thought on how to best bring the opportunity into action. Participants were asked to detail existing barriers, action steps and resources needed in a variety of thematic areas. Their completed action worksheet was designed to map strategies for expanding the provider base in their setting, including detailed steps that could be worked into existing country plans. In order to make sure plans were as realistic and refined as possible, country groups were paired to share their action plans, exchange feedback and troubleshoot barriers to success. An example action plan is detailed on the following page.

Expanding the Provider Base Workshop: India Action Worksheet

Opportunity	Expand the scope of nurses/midwives to include provision of misoprostol for incomplete abortion		
Desired Result	Women will receive medical care for incomplete abortion at the first level of contact		
	Change Needed	**Action Steps: Who? When?**	**Resources Needed (people, orgs, tools, etc.)**
Research, M&E: data needed/ being gathered?	None needed - use global evidence to support the change in service provision.	Conduct a small survey of nurses/midwives and ANMs to get their input on what information, support, and resources they would need to be comfortable treating incomplete abortion with misoprostol.	Financial resources and personnel time to design and pilot survey.
Clinical Practice Issues or Problems: Does this cadre have the clinical skills? If no, what is needed? Other clinical practice issues or questions?	None needed - use global evidence to support the change in service provision.		
Service Delivery:	Once the provision has been approved, ensure sustainable supply of misoprostol.	To be determined along side policy action steps. Work with Ipas HQ sustainable supply team to design best approach.	Personnel time to engage with drug manufacturers and approval bodies, financial resources for the purchasing and secure transport of reproductive health medicines.
Training: curriculum, training approaches, etc.	Incorporate the drug regimen for MPAC into the existing in-service and pre-service training for nurses, ANMs and AYUSH (preferably packaged along with contraception or SBAs or other).	Indian Nursing Council (with support from Ipas) will work to incorporate this information into the in-service training for nurses, midwives, and ANMs. Next, Indian Nursing Council (with support from Ipas) will work to incorporate MPAC hands-on practice into the pre-service training for nurses, midwives, and ANMs. Work with AYUSH councils to incorporate information and hands-on practice for MPAC in their in-service and pre-service curriculum/training.	Personnel time to support the process of updating service provision guidelines and curriculums.
Policy:	Continue advocacy efforts for nurse and AYUSH cadres to provide all CAC services. Need approval of misoprostol for incomplete abortion by the drug controller in India. Operational guidelines for use of misoprostol for incomplete abortion by the Ministry of Health and Family Welfare AND that it can be used by nurses, ANMs, and AYUSH.	Identify a drug company to initiate the approval process with support from FOGSI. Partner with them to apply to drug controller to approve this use of misoprostol. After approval, advocate with officials in the central Ministry of Health and Family Welfare to issue the operational guidelines for official approval for use AND that it can be used by nurses, ANMs and AYUSH.	Ipas representative to engage with FOGSI and drug company contacts, evidence by WHO and other professional bodies.

The Way Forward

The Expanding the Provider Base Workshop concluded with an enthusiastic discussion of next steps. Ipas representatives in each country group pledged to integrate their EPB action worksheets into their programmatic plans. The workshop's planning team committed to partnering with country teams to achieve their goals, providing logistical support, supporting documents and tools, and to continue to provide opportunities for cross-country learning. Inspired by the workshop, each participant also shared closing commitments for how they will individually contribute to expanding the provider base in their countries. These commitments included statements such as these:

"Ensure meeting with Health Professionals Council will be held to review policies to include midlevel providers."

"Take a lead role to integrate MA into SBA training and pre-service nurses training."

"Tell my colleagues that the MLPs are the key person in the community and we need to change their skill level and practice to save the lives of mothers and to advocate to the authorities to incorporate safe abortion course in pre-service training."

"Help women who have unwanted pregnancies by pushing for a comprehensive system of services."

"Speak with confidence in requesting for community health extension workers and curriculum to incorporate miso and FP."

"Bring task shifting and task sharing back to my colleagues."

The EPB workshop equipped participants with tools, strategies and energy to promote the provision of CAC and PAC services by a broader range of health workers. As progress continues, we will continue to document processes and results and share lessons across settings to maximize task shifting and task sharing opportunities. It is clear that expanding the provider base for safe abortion and postabortion care is feasible and will make a meaningful difference to women.

Workshop presentations and resources are available on request

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Annex 1

Evidence Base for Abortion Care by Cadre and Facilty Level

Green = assumed that this cadre can effectively and safely deliver this intervention
Orange = potentially appropriate cadre; limited evidence available
Red = assumed that this cadre should not deliver this intervention
Black = not applicable

	LHWs/TBAs	Auxiliary Nurses	Nurses	Midwives	Associate Clinicians / Advanced level associate clinicians	Non-Specialist Doctors	Informal Drug Sellers	Pharmacists
Community Level								
public health education/information on reproductive health, including contraception and abortion								
community-based distribution of appropriate methods of contraception								
all health-care workers trained to provide information on, and referral to, pregnancy-detection and safe, legal abortion services								
all health-care workers trained to recognize abortion complications and promptly refer women for treatment								
transportation to services for management of complications of abortion								
all health-care workers (and other key community professionals such as police or teachers) trained to recognize signs of rape and to provide referral to health-care or other social services								
Primary-care facility level								
all elements of care mentioned for the community level								
all health-care workers providing reproductive health services trained to provide counselling on contraception, unintended pregnancy and abortion								
a broad range of contraceptive methods, including IUDs, implants, and injectables	condoms / OCPs / Injectables						condoms / OCPs /injectables	condoms / OCPs / Injectables

Adapted from Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting (WHO, 2012) and Safe Abortion: technical and policy guidance for health systems, 2nd ed. (WHO, 2012).

Evidence Base for Abortion Care by Cadre and Facilty Level

Green = assumed that this cadre can effectively and safely deliver this intervention
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Black = not applicable

	LHWs/TBAs	Auxiliary Nurses	Nurses	Midwives	Associate Clinicians / Advanced level associate clinicians	Non-Specialist Doctors	Informal Drug Sellers	Pharmacists
vacuum aspiration (manual or electric) for first trimester pregnancies								
medical methods of abortion for pregnancies of gestational age up to 9 weeks								
medical methods of abortion for pregnancies up to 12 weeks if the woman can stay in the facility until the abortion is complete								
clinical stabilization, provision of antibiotics, and uterine evacuation for women with complications of abortion								
vacuum aspiration or treatment with misoprostol for incomplete abortion								
prompt referral for women needing services for abortion or for management of abortion complications that cannot be provided on-site								
Referral hospitals								
all elements of abortion care mentioned for the primary-care level								
provision of sterilization in addition to other contraceptive methods								
abortion services for all circumstances and stages of pregnancy, as permitted by law		As appropriate for woman's condition -- consider additional roles/supportive tasks as part of care team as complexity increases						
management of all abortion complications								
information and outreach programmes covering the full catchment area								
training of all relevant cadres of health-care professionals in abortion provision								

Adapted from Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting (WHO, 2012) and Safe Abortion: technical and policy guidance for health systems, 2nd ed. (WHO, 2012).

Annex 2

Opportunities Worksheet

Opportunity for Change	Impact of Change	Rank (to be completed after all opportunities are fleshed out)

Annex 3
Expanding the Provider Base Workshop

Opportunity				
Desired Result				
	Existing Barriers	Change Needed	Action Steps: Who? When?	Resources Needed (people, orgs, tools, etc.)
Research, M&E: data needed/ being gathered?				
Clinical Practice Issues or Problems: Does this cadre have the clinical skills? If no, what is needed? Other clinical practice issues or questions?				
Service Delivery:				
Training: curriculum, training approaches, etc.				
Community:				
Policy:				

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