



A coordinated approach to policy change and programmatic integration of safe uterine evacuation and postabortion care services in Punjab province, Pakistan

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Acronyms

AusAID – Australian Agency for International Development
BHU – Basic Health Unit
CMW – community midwife
D&C – dilation and curettage
DFID- - Department for International Development
DGHS – Director General of Health Services
DHIS – District Health Information System
DOH – Department of Health
EPHS – Essential Package of Health Services
IEC – Information Education and Communication
IUD – intrauterine device
LHV – lady health visitor
LHW – lady health worker
MAP - Midwifery Association of Pakistan
MISP - Minimum Initial Service Package
MLP – midlevel provider
MNCH – Maternal Newborn Child Health
MVA – manual vacuum aspiration
OB-GYN – Obstetrics and Gynecology
PAC – postabortion care
PNC – Pakistan Nursing Council
PPH – postpartum hemorrhage
PRHTAC - Punjab Reproductive Health Technology Assessment Committee
PSPU - Policy and Strategic Planning Unit
RHC - Rural Health Center
RMNCH- Reproductive, maternal, newborn and child health
SOGP – Society of Obstetricians and Gynecologists of Pakistan
SRHTAC – Sindh Reproductive Health Technology Assessment Committee
TBA – traditional birth attendant
TORs – terms of reference
TRF – Technical Resource Facility
UE – uterine evacuation
UN – United Nations
UNFPA – United Nations Population Fund
UNICEF – United Nations Children’s Fund
USAID – United States Agency for International Development
WCG - WomanCare Global
WHO – World Health Organization

INTRODUCTION

In Pakistan, abortion is legal “to save the life of the woman or to provide necessary treatment.” Given the narrow legal grounds for abortion, the lack of clarity in interpreting the law by both women and health-care providers, and other barriers to accessing abortion care, women with unintended pregnancies often are forced to resort to clandestine abortion providers.¹ According to a nationwide study by the Population Council, in 2012, there were approximately nine million pregnancies in Pakistan, of which 4.2 million were unintended. Of these, almost 2.2 million (54 percent) were terminated by induced abortion, which represented a rise in abortion rates from 27 per 1,000 women (15-49 year aged) in 2002 to 50 in 2012. Nearly 80 percent of these induced abortions are estimated to be at the hands of unskilled and untrained providers.²

The resulting morbidity and mortality associated with unsafe abortion places a burden not only on women themselves, but also on their families, communities and the country’s health system. According to the 2006-2007 Pakistan Demographic and Health Survey, the country’s maternal mortality ratio was 276 per 100,000 live births, and 6 percent of maternal deaths resulted from complications of abortion.¹ This may be an underestimate, as the sub-regional average is 13 percent.³

The Population Council study also showed that almost 32 percent (700,000) of the 2.2 million induced abortions resulted in medical treatment for complications at health-care facilities, mostly due to clandestine procedures performed by traditional birth attendants (TBAs) or untrained midlevel providers (MLPs) such as lady health visitors (LHVs), nurses and midwives.² Of these, 267,000 were treated in public facilities, while the remaining accessed services in the private sector. Yet, many women with abortion complications go untreated due, in part, to the quality of health care, which often falls short of preferred standards; staff are not adequately trained, methods used for uterine evacuation (UE) are often outdated and unsafe, female staff are in short supply and appropriate equipment and technologies are lacking. 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.⁴ Clearly, serious complications and morbidity from unsafe abortion have a substantial impact on women’s health and on the health-care system.

According to the World Health Organization’s *Safe Abortion: Technical and Policy Guidance for Health Systems* (2012), postabortion services can be safely provided by any properly trained health-care provider, including MLPs. National evidence underscores a need for policy changes which include incorporating WHO-recommended methods of UE such as misoprostol and manual vacuum aspiration (MVA) in the list and package of essential health services, authorization of MLPs to use these safe postabortion care technologies (misoprostol and MVA), and a formal integration of abortion into MLP curricula and trainings.

This brief describes the advocacy efforts, led by Ipas Pakistan and local partners, to integrate WHO-approved approaches (UE methods and training of additional cadres of providers) into the health-care system. In particular, it details the work done to establish the Punjab Reproductive Health Technology Assessment Committee (PRHTAC)—a provincial body formed to review existing evidence on UE technologies, address concerns about stigma, examine a legal basis for clinical expansion to MLPs, consider the financial implications of new technologies, and, ultimately, to make recommendations/changes for the adoption of misoprostol and MVA into the local health-care system.

ADVOCACY MEETING ON ABORTION POLICY IN PAKISTAN

In 2011, the 18th constitutional amendment led to the devolution of the Pakistan Ministry of Health, giving authority for policy formation to the provincial governments, rather than the national government.⁵ In this context, Ipas Pakistan hosted a policy advocacy meeting with policymakers and key stakeholders in Punjab, the most populace province in Pakistan, on 20th July 2012 to share an overview of the current status of morbidity and mortality related to unsafe abortions and to introduce Ipas and its global model for the prevention and management of unsafe abortion using WHO-endorsed technologies for safe UE. Ipas also shared the global and regional evidence on the use and efficacy of MVA and misoprostol for UE, especially their comparative advantages over the dilation and curettage (D&C) method.^a

The meeting participants were concerned about the high rate of abortion-related morbidity and mortality, but felt restricted by the prevailing stigma around abortion in Pakistan. They were also concerned about the misuse of misoprostol, especially by TBAs and untrained MLPs. However, considering the evidence on morbidity and mortality due to complications of unsafe abortion, there was a consensus in the meeting for efforts to introduce and train providers on the use of the technologies recommended by WHO.

The meeting was concluded with the remarks from the head of the Punjab Policy Unit, “The available evidence is quite convincing and there is need to make an assessment about feasibility of inclusion of these technologies into the health system and trainings bearing in mind that it will have resistance from different corners and also have cost implications, but it is important that we at least decide now about the next steps to integrate MVA and misoprostol into the health system so it should be institutionalized and sustainable.”

ENGAGING THE PUNJAB REPRODUCTIVE HEALTH TECHNOLOGY ASSESSMENT COMMITTEE (PRHTAC)

Based on the conclusions of the policy advocacy meeting and upon Ipas Pakistan’s recommendation, a committee consisting of representatives from the key stakeholder groups was formed to assess the feasibility of this new initiative and make recommendations to the Provincial government. WHO and Ipas led development of the terms of reference (TORs) of the committee, which were later reviewed and approved by the Department of Health (DoH) Punjab (Appendix I).

Due largely to Ipas’s focused lobbying and follow-up efforts, on 1st January 2013, the DoH Punjab formally established PRHTAC to guide it (the DoH) when assessing and adopting new or emerging reproductive health (RH) technologies into the provincial public health-care system. PRHTAC includes representatives from the DoH Punjab’s Policy and Strategic Planning Unit, Maternal Newborn and Child Health (MNCH) program, National Program for Family Planning and Primary Health Care, and the Planning and Development Department. PRHTAC also includes UN agencies (WHO, UNFPA, UNICEF), donors (USAID), the Technical Resource Facility (funded by DFID and AusAID), the Institute of Public Health, and the Punjab Health Care Commission, which is a regulatory agency. The Director General of Health Services (DGHS) chairs the committee. Ipas Pakistan provides technical assistance and the WHO Punjab office provides coordination and administrative support.

^a These recommendations are in line with WHO recommendations in revised policy and technical guidance issued in 2012

PRHTAC’s initial mandate was to support and guide the DoH Punjab in a local assessment on the feasibility of introducing new PAC technologies. Appendix 1 details the roles and functions of PRHTAC specifically as it relates to their work on management of UE services, which spans technical, logistic and policy considerations. In addition to this, PRHTAC also periodically reviews and assesses reproductive health technology relying on scientific or evidence-based information about safety, efficacy and cost-effectiveness to inform decisions and improve the quality of reproductive health services in Punjab based on local needs.

REVIEWING THE ADVANTAGES OF UE TECHNOLOGIES

One of Ipas’s initial tasks was to present the latest clinical evidence to PRHTAC on the use of MVA and misoprostol for UE and PAC management and other OB-GYN indications. The review emphasized both methods as complementary WHO-endorsed technologies for replacing outdated methods such as D&C for uterine evacuation due to their comparative advantages and lower associated risks.

Ipas emphasized three important comparative advantages of misoprostol relative to other UE methods: 1) lower cost for UE and PAC services, as it does not require the immediate availability of sterilized equipment or operation theatres; 2) viability of the drug without refrigeration, which allows its use in settings without electricity; and 3) greater availability and accessibility of misoprostol for UE as well as the training that health staff receive on the medication likely benefit women at the time of childbirth since misoprostol is also used for the treatment and prevention of postpartum hemorrhage (PPH). The benefits highlighted were specifically relevant to the Punjab context, as it would allow for the extension of first-line PAC services beyond urban areas and hospitals to settings where physicians and surgical services are not available, especially in primary health-care settings. Presenters made sure to include that misoprostol has been in the WHO Model List of Essential Medicines for treatment of incomplete abortion and miscarriage since 2009 and in the WHO’s list of Priority Life-Saving Medicines for Women and Children for the same indications since 2012.

Next, Ipas presenters reviewed the evidence for MVA technologies as a safe and effective technology for treatment of incomplete abortion up to 12 weeks from the last menstrual period, first-trimester abortion (menstrual regulation or therapeutic abortion) and endometrial biopsy.

USING DATA TO INFORM POLICY AND PROGRAMMATIC CHANGE

Ipas Pakistan shared data from several national studies on unsafe abortion and postabortion care with PRHTAC. Since modern contraceptive use is low (26 percent) and there is high unmet need for family planning (20 percent), the rate of unintended pregnancy is high and the majority (54 percent) result in induced abortions.

ADDRESSING STIGMA on MISOPROTOL USE

Though misoprostol is registered in Pakistan for prevention and management of PPH, due to prevailing stigma around abortion there are no standards and guidelines or training on misoprostol for UE and PAC. “Abortion is a very sensitive and stigmatized issue, we cannot discuss this openly with providers. Therefore, currently, there are no formal trainings in the system for misoprostol use in PAC, and its use other than PPH rests at the individual service provider’s discretion” a senior government official shared in one of the initial PRHTAC meetings.

Ipas noted that current use for PPH opens the door for expanded policy support for safe UE and PAC. Advocacy to expand guidelines to include UE could also address barriers such as myths and perceptions, improper clinical information, poor training and denial of care due to stigma or lack of policy guidance.

Partners at UNICEF shared that to avoid stigma and denial of care, stakeholders must engage and sensitize service providers and immediately initiate trainings on correct misoprostol dosage.

Ipas shared several key pieces of data to inform and galvanize stakeholders to action, including:

- Almost 32 percent (700,000) of the 2.2 million induced abortions resulted in medical treatment for complications at health-care facilities
- Complications stem mostly from clandestine procedures being performed by TBAs or untrained MLPs
- D&C is still the most common method of uterine evacuation (63 percent) used by any type of provider for PAC in Punjab, and misoprostol is used in less than one-third of cases (23 percent)

A situation analysis of unsafe abortion and its complications in Pakistan conducted by the Society of Obstetricians and Gynecologists of Pakistan (SoGP) in 2008 was also presented. This situation analysis compiled case studies by SoGP members about women coming to public sector hospitals for postabortion care following unsuccessful and often unsafe attempts to terminate pregnancies elsewhere. According to the report, the primary reasons for seeking to terminate pregnancies include family building preferences (67 percent), problems with contraception (12 percent), and socioeconomic concerns (12 percent). Thirty-eight percent of women went to MLPs, 37 percent to TBAs, and only 15 percent accessed doctors when seeking to terminate a pregnancy. D&C (48 percent) and foreign body insertions (45 percent), including laminaria and intrauterine device (IUD), were among the most common methods used by providers. These methods and approaches to inducing abortion resulted in complications which included sepsis (35 percent), visceral injuries including uterine perforation (19 percent), hemorrhage (11 percent), and systemic failure (21 percent).

In addition to an effective presentation of the evidence base, several other opportunities were taken to sensitize and motivate policymakers to include misoprostol and MVA technologies into the essential medicine and equipment lists and trainings:

1. The sharing of regional and local evidence from the 2012 national abortion study and parallel advocacy efforts were timed to coincide with the Punjab government's provincial health sector strategy development process, which provided a window of opportunity to bring this serious public health issue into policy-level discussions.
2. Several PRHTAC members, on invitation of Ipas, participated in a WHO regional dissemination meeting in Nepal in 2012 and learned about the experiences of other countries in the region and success stories for addressing access-related issues. This facilitated dissemination of the WHO revised policy and technical guidance and advocacy for aligning local policies with WHO recommendations.
3. Providers were given the opportunity to share their on-the-ground experiences with existing safe abortion and postabortion services, as well as the challenges and issues they face in offering quality services. These issues highlighted the lack of clear policy on PAC technologies and trainings.
4. Throughout the entire endeavor, focused lobbying with a strategic mix of stakeholders and policy makers in PRHTAC helped advance the cause.

Based on the shared evidence, the committee was persuaded to include misoprostol and MVA in the Essential Drug and Equipment Lists for Safe Uterine Evacuation. These additions will prepare the provincial health system for sustained supply of commodities at the service delivery level. The committee also agreed to the development and implementation of Provincial Standards and Guidelines for Safe Uterine Evacuation per WHO's revised guidance, which will help in setting, implementing and monitoring quality standards and protocols for service provision at the facility and community level. Lastly, the committee agreed to the initiation of clinical skills training for the existing service providers on the use of misoprostol and MVA, which will provide an opportunity to demonstrate quality of care and satisfactory results before possible countrywide scale-up of said technologies.

ADVOCACY FOR EXPANDING THE ROLE OF MIDDLELEVEL PROVIDERS

Ipas's recent assessment^b highlighted the existing global and regional evidence for the expanded role of MLPs in safe postabortion care in many developing countries, including Cambodia, Ethiopia, Nepal, Ghana, South Africa and Vietnam. The evidence showed that uterine evacuation care improves as MLPs are allowed to provide services, but there is a need to improve the skills of midlevel providers through competency-based trainings prior to service provision. The assessment highlighted that LHVs and midwives are the potential cadres to provide PAC services in Pakistan. Some participants shared their concerns regarding misuse of misoprostol by MLPs. In response, Ipas advised that misoprostol misuse can be prevented with training on indications and dosage, regular technical support and on-site follow-up with service providers. Development and implementation of Service Delivery Standards and Guidelines for safe UE and PAC would also improve quality of care. PRHTAC members stressed that in order to engage MLPs in the provision of safe UE services, the training environment should be improved and the provider follow-up system should be strengthened to provide ongoing support to trained providers. To address these concerns, PRHTAC recommended utilizing the district level quality assurance committee under the MNCH program to supervise and support newly trained midlevel providers at service delivery outlets.

There was discussion regarding feasibility and the level of trainings needed, especially to provide MVA, which requires clinical skills and competency. Ipas Pakistan shared global (Ipas and WHO) recommendations on training MLPs in MVA technology. However, based on the existing quality of pre-service trainings for MLP cadres in Pakistan (which includes LHVs, nurse-midwives, and community midwives), where there is only a didactic introduction to UE with D&C and no related clinical skills development, it was determined that these providers lack the minimum clinical proficiency required to switch to performing MVA over other methods. Ipas Pakistan is therefore already actively engaged with the Pakistan Nursing Council to integrate safe PAC skills into the LHV pre-service curriculum and training, albeit with a focus on misoprostol for PAC and only a basic orientation on MVA. The latter is considered an advanced clinical skill for qualified in-service LHVs.

A few members expressed concerns about focusing only on in-service MVA training for LHVs, and suggested that the Committee should consider recommending inclusion of MVA in the LHV pre-service training, irrespective of placement at basic health units (BHUs), rural health centers (RHCs) or above. They argued that LHVs are qualified service providers working in rural health facilities and directly in communities, therefore they must be trained in MVA.

^b Expanding the Provider Base for Abortion Care: An Assessment of Pre-service Training Needs and Opportunities in Four Countries 2012

People also suggested including misoprostol and MVA in the Minimum Service Delivery Standards, which would help to comply with the requirements of the Punjab Health Care Commission, which is involved in regulating and accrediting public and private sector health facilities.

Despite evidence supporting the provision of PAC services by all MLPs if properly trained, representatives from the Pakistan Nursing Council expressed concerns that, due to the ambiguity of the current policy language, MLPs could face legal prosecution. To address this, they recommended that the provincial government authorize all MLPs to provide safe postabortion care services. PRHTAC members agreed that the ambiguity of the policy was a challenge and recommended the following steps to improve the environment for midlevel PAC service provision:

- The policy should clearly define the competencies required for MLPs and the steps required to attain these competencies. Authorization to provide services should be linked with attainment of the defined competencies.
- The health department should extend technical support to the judiciary in the lower courts to help them understand the policy so that they will be better able to address UE service-related complaints against health-care providers, including MLPs. Legal officers are available to help the judge during legal proceedings, but there is a need for a technical person from the health department to be available to the legal officer to provide the state point of view and assist in the court.
- There is also a need for advocacy with the police department, lawyers and the judiciary to avoid the criminalization and prosecution of UE service providers.

Throughout the PRHTAC meetings, important advocates for current technologies voiced their support for adoption of the WHO-approved standards in Pakistan:

“Misoprostol is used for incomplete abortion, missed abortion, PAC, it should be available at RHC and BHU level as it does not need any refrigeration. MVA is WHO-recommended technology for safe uterine evacuation irrespective of the legal status of abortions. We should put aside the excuses that MVA is related to abortion; we need to consider that it saves lives.” (Additional Director General Health, Punjab)

“There is sufficient national evidence to support training and expanding the role of midlevel providers as more than 54 percent poor women from urban and 32 percent from rural areas accessed midlevel providers (LHVs/midwives/nurses) and 30 percent poor women from urban and 42 percent from rural areas went to traditional birth attendants for abortion related care. If providers are not authorized, then services are usually declined by providers at the facility level and the woman gets mal-handled by an untrained person and end up with complications. There should be clear policy that MLPs are authorized to which extent of service provision and then they should be held accountable and at the same time need to have an umbrella for protection.” (Midwifery Association of Pakistan)

PILOT PROJECT FOR MA and MVA TRAINING

The committee decided that before misoprostol and MVA were formally integrated into the curricula and trainings for MLPs, a pilot project focused on developing the training tools and protocols for integration of PAC into standard LHV training and post-training service provision should be developed and implemented in Chakwal district under direct supervision of Pakistan Nursing Council (PNC). Through a consultative process involving SoGP, Midwifery Association of Pakistan (MAP) and other stakeholders, and based on the Ipas training materials, PNC adapted a trainers' guide and reference manual for MLPs, and the training initiative was launched in Chakwal between September and October 2013. Twelve tutors from the district headquarter hospital and midwifery and nursing training schools were trained as trainers in misoprostol and MVA. These trainers, in turn, trained 48 additional midwifery students and in-service MLPs in UE and PAC and are continuing pre-service trainings in the midwifery and LHV schools to date.

EXPERIENCES FROM THE FIELD

- A midlevel tutor expressed that results of the misoprostol training would enable her to better reach underserved and marginalized women.
- A midlevel trainee shared that her classmates and she are very happy with the misoprostol training. They now know the correct dosage, indications and contraindications of the drug and would be able to use it confidently and safely with their clients.
- The MNCH coordinator of Chakwal said that mothers are dying due to complications associated with unsafe abortions and suggested that as community midwives are playing an important role in skilled birth attendance to the rural communities, they should also be included in the misoprostol trainings.

At completion, results of the pilot project were evaluated and shared with PRHTAC and other stakeholders in December 2013. A few trainees and providers also presented their experience to PRHTAC. Additional information can be found in the case study report developed for this pilot project, "Evaluation of Misoprostol for Postabortion Care (PAC) Lady Health Visitors' Tutor Training of Trainers". Key findings were that participants (92 percent) knew the correct regimen for incomplete abortion, mostly (83-100 percent) knew about the potential side effects of misoprostol, and a significant number (33-83 percent) could identify different contraindications of using misoprostol. Overall, the project was successful in integration of misoprostol for PAC into the midlevels' curriculum and trainings, and institutional and midlevel tutors and trainees' capacity development.⁶

PRHTAC was in full support of training MLPs in provision of misoprostol for PAC, but additional discussion was undertaken in regard to MLP provision of MVA services. The WHO recommends that MVA replace D&C, a recommendation that is supported by sufficient and convincing evidence from global, regional and local levels. The committee felt that local evidence suggests many midlevel providers are already performing D&C for uterine evacuation. As a result, the consensus was that MVA is safer for uterine evacuation as compared to D&C, and should be included in MLP training and in the Essential Package of Health Services (EPHS) up to the BHU level. However, the committee recommended a gradual approach. In the first stage, MVA should be included in the procurement plan for RHCs and the 30 percent of BHUs in the province that have been upgraded for 24/7 basic emergency obstetrics and newborn care services. Obstetricians at the district level should conduct training for MLPs and provide follow-up clinical monitoring for MVA. Providers should also ensure that the family planning counseling and services are adequately provided to clients as part of a comprehensive package of care.⁷

FINANCIAL CONSIDERATIONS FOR UE TECHNOLOGY SUPPLY

Several queries regarding MVA availability, cost and usage were raised during the PRHTAC meetings. As noted above, MVA technology is a safe and cost-effective alternative to surgical curettage, and is favorable given the environmental limitations in Pakistan. The Ipas MVA Plus kit (one aspirator + 8 cannulae) and other products are distributed nationally by WomanCare Global (WCG) through commercial distribution channels. There are currently two distributors of Ipas MVA products in Pakistan, each covering distinct geographic zones, and bulk purchase pricing is offered. UNFPA was also recognized as a major source of support to Ministries of Health globally in procuring MVA kits, as the organization has distributed MVA kits to providers in Pakistan through the Minimum Initial Service Package (MISP) serving communities affected by the 2010 floods.

Participants suggested that the Punjab Department of Health look into the available resources, if it decided to include MVA in the EPHS. They also recommended that high-quality and competency-based MVA trainings should be conducted to avoid reversion to the old technology.

MAJOR ACHIEVEMENTS OF PRHTAC MEETINGS

In a series of meetings between February 2013 and November 2014, PRHTAC considered and approved several key steps that will help expand the quality and availability of safe UE and postabortion care for women in Pakistan. Table 2 below lists the decisions and actions in the areas of policy/advocacy, standards/guidelines and training/curricula. Although not presented in strict chronological order, this list describes the major achievements and outcomes of the PRHTAC meetings.

Table 2: KEY DECISIONS/ACTIONS STEMMING FROM PRHTAC MEETINGS	
Policy/Advocacy	<ul style="list-style-type: none">• Misoprostol and MVA technologies for safe UE were included in the Essential Drug and Equipment Lists; misoprostol for expanded indications and MVA to replace outdated and obsolete D&C technology in all public health facilities (18 Feb 2013).• Both misoprostol and MVA were included in the EPHS; misoprostol up to the community midwife level and MVA up to the BHU level, gradually replacing D&C with proper clinical trainings (23 Dec 2013).• All midlevel provider cadres working at facility and community level were authorized to use MVA for safe UE and PAC subject to receiving proper clinical training in MVA (23 Dec 2013).• Department of Health agreed to develop legal framework for defining expanded role of MLPs in reproductive health service delivery, including safe UE and PAC, through technical support of technical resource facility (TRF)^c and Ipas Pakistan (30 August 2013).
Standards/Guidelines	<ul style="list-style-type: none">• Service Delivery Standards and Guidelines for Safe Uterine Evacuation and Postabortion Care (developed through technical support of Ipas in accordance with WHO's revised

^c TRF is a DFID and AusAID funded organization which provides TA to the government on MNCH.

technical and policy guidance 2012) were endorsed for dissemination and implementation in Punjab (24 Nov 2014).

- The Standards and Guidelines were formally approved and disseminated by the Department of Health Punjab (April 2015).

Training/Curricula

- On recommendation of PRHTAC, PNC approved and included misoprostol for postabortion care into the midwifery pre- and in-service curricula and trainings (24 July 2013).
- PNC developed and approved the training material, “Misoprostol for Incomplete Abortion,” through the technical support of Ipas and launched a pilot project for the training of midwifery tutors and midwives in Chakwal through collaboration with DoH Punjab and Ipas Pakistan (20 Sep 2013).
- Through Ipas’s support, MNCH program Punjab trained 53 midwifery tutors from across Punjab province and trainings are being trickled down to 4,500 community midwives (April-May 2014).
- UNFPA included misoprostol and MVA trainings of 300 woman medical officers and Lady Health Visitors at RHCs and 24/7 BHUs in four districts of Punjab (Mianwali, Bhakkar, Hafizabad and Bahawalnagar) under RMNCH Trust fund (May 2015)

Procurement of Misoprostol and MVA

- On recommendation of PRHTAC, Chakwal district allocated a budget and procured 50,000 misoprostol and 300 MVA kits through the district funds (October 2013).
- The Punjab MNCH program procured 250,000 misoprostol and 5,000 MVA kits for the community midwives and health facilities in Punjab (June 2014).

In addition to the key agreed-upon committee action steps, key informant interviews with several PRHTAC members were conducted to document the progress of PRHTAC’s achievements, limitations and future steps. Findings from these interviews can be summarized in the following key areas:

- **Role of PRHTAC in Affecting Policy Change in Punjab:** All PRHTAC members felt it played a very important role in bringing a policy change with respect to management of safe UE and PAC in Punjab. Participants shared that *“Inclusion of misoprostol and MVA in essential package of health services (EPHS) was made possible due to strong advocacy done by PRHTAC”* (Additional Director (Technical) Policy and Strategic Planning Unit Punjab); *“Its role in reshaping and redefining the health policy on PAC was instrumental.”* (Senior OB-GYN consultant and Provincial representative of National Committee for Maternal and Neonatal Health Punjab); and *“It demonstrated a unique precedence of MNCH policy change through an effective and evidence-based policy advocacy”* (WHO representative Punjab).

- **Primary Strengths of PRHTAC Forum:** Members felt that PRHTAC strengths included: 1) providing a multidisciplinary forum where members could share valuable experiences and discuss different aspects of reproductive health with a special focus on PAC; 2) holding regular quarterly meetings since its establishment; and 3) mobilizing support for the capacity building of midwifery tutors on use of misoprostol for management of PPH and PAC.
- **Major Achievements of PRHTAC:** According to members, PRHTAC has: 1) emerged as an effective forum for debate and dialogue for reproductive health; 2) contributed to sensitization of all relevant stakeholders regarding management of PAC, PPH, and issues of adolescent reproductive health; 3) successfully advocated for inclusion of misoprostol and MVA in EPHS, and in the CMW midwifery kit; 4) mobilized support from partners for training of the CMW tutors and health-care providers on management of PPH and PAC through use of misoprostol.
- **PRHTAC's Role in the Future:** Members suggested that the Policy and Strategic Planning Unit or the MNCH Program act as the PRHTAC secretariat to provide support for quarterly meetings and dissemination of minutes. In addition to advocacy on reproductive health, PAC, and inclusion of misoprostol and MVA in EPHS, PRHTAC should work with the government and stakeholders to strategize the scale-up of PAC technology trainings in Punjab and coordinate the training plan and trainings of health-care providers on use of misoprostol and MVA. Members also suggested that PRHTAC be the central platform to formalize guidelines and best practices in all areas of OB-GYN practices.
- **Steps Required to Strengthen PRHTAC's Future Role:** PRHTAC members were asked to identify integral steps for the strengthening of the PRHTAC forum. Their responses included:
 - Promotion of government ownership by establishing PRHTAC secretariat at MNCH/PSPU
 - Inclusion of representatives from SoGP, private sector and nongovernmental organizations in the PRHTAC meetings.
 - Inclusion of the Population Welfare Department in the forum.
 - Working with the education and social development sectors regarding reproductive health.
 - Annual distribution of the PRHTAC newsletter.
 - Inclusion of PAC training in the undergraduate training of doctors and also in nursing curriculum.
 - Strengthen coordination and linkages between all stakeholders, including private sector and nongovernmental organizations.

THE WAY FORWARD

The PRHTAC meetings have resulted in a series of actionable outcomes that are to be rolled out in support of scaling up use of modern UE and PAC technologies across Punjab province by June 2016:

- Dissemination of Essential Package for Health Services along with the Essential Drug and Equipment Lists to all stakeholders including district health managers for implementation and follow up.

- Translation of the misoprostol manual into Urdu (local language) for use with community midwives and trickle-down trainings to 4,500 community midwives in Punjab.
- Dissemination and development of an action plan for implementation of service delivery standards and guidelines in Punjab.
- Costing and inclusion of misoprostol and MVA in procurement plans for RHCs and BHUs.
- Preparing and implementing training plans for capacity building of MLPs in misoprostol and MVA.
- Health systems follow-up and monitoring of PAC and family planning services.
- Inclusion of performance indicators for assessment of the progress on quality of PAC and family planning services and reflection of PAC performance indicators in the revised, integrated planning commission document (PC-1) of the healthcare system.
- Ensuring that PAC data collection and reporting is incorporated into the District Health Information system (DHIS), which already includes data on other maternal, neonatal and child health indicators.
- Launch of a pilot project for development and dissemination of IEC material on PAC and family planning through community based LHWs in one district of Punjab.^d

As of April 2015, the following actions have been completed:

- Essential Package for Health Services along with the Essential Drug and Equipment Lists was disseminated to all stakeholders through a notification issued by the Secretary of Health Punjab.
- Misoprostol has been included into the safe delivery kit of the community midwives in Punjab.
- Training material, “Misoprostol for Treatment of Incomplete Abortion,” has been translated into Urdu and trickle-down trainings of community midwives are in progress through the MNCH program Punjab.
- IEC materials for safe postabortion care have been developed. Printing is in progress and materials will be disseminated through DoH Punjab to all health facilities.
- A plan for formal dissemination of the Standards and Guidelines for Safe UE and PAC has been developed and includes dissemination through Pakistan Alliance for Postabortion Care (PAPAC) and other forums.
- PRHTAC is working with National Council of Homeopathy for inclusion of MVA into the curriculum and trainings of homeopath physicians.
- PRHTAC is working for integration of PAC data into the existing DHIS in Punjab, which would help to collect and utilize information for decisions and addressing women’s needs in rural and underserved areas of Punjab.
- The Sindh Department of Health has agreed to replicate the PRHTAC model and has formed a consultative group which is currently working with other stakeholders to develop TORs for the Sindh Reproductive Health Technical Assessment Committee (SRHTAC).

^d A Lady Health Worker (LHW) is a community-based worker who provides counseling and family planning services and primary health care services including preventive care and treatment of minor ailments to her catchment population. A Lady Health Visitor (LHV) is a skilled birth attendant trained in midwifery and public health, and provides MNCH services to the communities both at facility and community level.

CONCLUSION

PRHTAC has emerged as a government-led consultative strategic forum which meets on a quarterly basis and tracks progress on the issues brought into the agenda by different stakeholders working on reproductive health and postabortion care.

PRHTAC has effectively utilized the evidence base to guide the government of Punjab to include safe PAC technologies in the health-care system and expand the provider base by authorizing midlevel providers in the provision of safe PAC services. It has successfully mobilized the provincial and district governments to allocate resources for the procurement of misoprostol and MVA through government funds. PRHTAC has provided standards and guidelines which will help standardize and strengthen the quality of service delivery.

PRHTAC was successful as a result of several strategic actions by Ipas and partners, including:

- Holding a policy advocacy meeting with key policymakers and stakeholders in Punjab to support creation of PRHTAC.
- Providing local stakeholders and policymakers with relevant local and global data such as the impact of unmet family planning needs and unsafe abortion on women in Pakistan; information on WHO guidelines around UE and PAC; very specific information on MVA and MA and their comparative advantages; and local data from Punjab providers on the severity of unsafe abortion and need for training.
- Providing examples of other countries where MLPs provide PAC services and discussing opportunities for training in the local context.
- Highlighting the fact that MLPs are already performing PAC through D&C, which has much higher rates of complications. This moved the discussion away from whether MLPs should provide services, to how MLPs provide services and whether or not they use the best technologies.
- Conducting a pilot project that provided current local information about MLP PAC provision.
- Addressing the financial costs of UE technology supply in terms of both financial cost of services and technologies and health-care costs from high morbidity and mortality of women.

In conclusion, PRHTAC has established a precedent for the other four provinces of Pakistan by presenting and demonstrating a model with an evidence base and effective advocacy for policy change towards an enabling environment, and addresses women's access and needs for safe UE and PAC services—especially rural and marginalized women—through expanding the provider base and choices.

Appendix I: Punjab Reproductive Health Technology Assessment Committee (PRHTAC)
Terms of Reference

TO BE SUBSTITUTED BEARING THE SAME No. & DATE

NO. 01-12 /PA/DGHS
DIRECTORATE GENERAL HEALTH SERVICES
PUNJAB LAHORE
Dated Lahore the 01-01 2013

ORDER

Reference decision taken in the meeting held on 20th July, 2012 on Health System Integration of WHO-Endorsed Technology for Management of Miscarriage and Associated OBGYN Indications, Punjab Reproductive Health Technology Assessment Committee comprising of the following is hereby notified. Terms of Reference of the Committee are attached.

- | | | |
|------|--|------------------|
| 1. | Director General Health Services Punjab. | Chairman |
| 2. ✓ | WHO Operations Officer Punjab. | Secretary |
| 3. | Dean, Institute of Public Health | |
| 4. | Director Health Services (P&D) | |
| 5. | Programme Director, PHSRP | |
| 6. | Representative from Punjab Health Care Commission | |
| 7. | Provincial Coordinator MNCH Programme, Punjab | |
| 8. | Provincial Coordinator LHW Programme | |
| 9. | Provincial Coordinator, UNFPA, Punjab | |
| 10. | MNCH Officer, UNICEF, Punjab | |
| 11. | Technical Advisor, Ipas Pakistan | |
| 12. | Provincial Head, Technical Resource Facility Punjab. | |


DIRECTOR GENERAL HEALTH SERVICES
PUNJAB

NO. 13-14 /PA

Copy forwarded for information and necessary action to:

1. Secretary to Government of the Punjab, Health Department, Lahore.
2. Special Secretary Health, Government of the Punjab
3. Chief Executive Officer, Punjab Health Care Commission, 73-B, Nisar Colony, Lahore.
4. Officers concerned.


DIRECTOR GENERAL HEALTH SERVICES
PUNJAB

Punjab Reproductive Health Technology Assessment Committee (PRHTAC)

Terms of Reference

Purpose:

The mandate of the PRHTAC is to support and guide the Department of Health-Punjab in the local assessment and adoption of new and emerging technologies, in the public health-care system in the province. The Committee will provide a vehicle for review and monitoring of new technologies and make recommendations to the Department of Health on their identification, prioritization, introduction and evaluation. The Committee will periodically review and assess reproductive health technology relying on scientific or evidence-based information about safety, efficacy and cost-effectiveness to inform decisions and improve the quality of RH services in Punjab based on local needs.

Membership:

The PRHTAC will be notified by the Department of Health Punjab (DoH) and will be chaired by Director-General Health (DG). Committee members will be selected on the basis of representing particular sectors of the provincial health system that are deemed essential to planning and resourcing health technology in Punjab, along with individuals with a particular clinical expertise or interest in reproductive health technology. Members are expected to collaborate and cooperate to provide a range of advice and decisions to the DG and DoH regarding reproductive health technology. Members must recuse themselves if a material conflict of interest exists related to a matter before the PRHTAC.

Role and Function:

RH Component under Consideration: Management of Uterine Evacuation

The PRHTAC will –

1. Review the revised WHO technical and policy guidance for health systems (2012) on uterine evacuation, for adaptation in Punjab.
2. Review available global, regional and national evidence for the use of manual vacuum aspiration (MVA) technology and misoprostol for the management of uterine evacuation.
3. Issue recommendations for the establishment of sub-committees to assist it to effectively undertake its role, such as for review and adaptation of Provincial Standards and Guidelines on uterine evacuation.
4. Issue recommendations to the DoH for inclusion of MVA and misoprostol in the provincial essential equipment and drug lists of Punjab, as per the WHO Model Lists.
5. Make recommendations for managing logistics and supply of appropriate reproductive health technologies for uterine evacuation in the province.
6. Ensure appropriately credentialed and trained staff is in place to assist with new technology introduction for safe uterine evacuation methods.
7. Co-opt members from other thematic areas for addressing Reproductive Health Technology Assessment and incorporation as when needed.

Quorum:

The quorum of PRHTAC members will be half of all members plus one. If a quorum is not met, at the Chair's discretion, the continuation of the meeting will be confirmed. If the meeting proceeds, all decisions will be preliminary. Decisions will then proceed to a consensus out-of-session or at the following meeting. A PRHTAC decision, either in or out-of-session, requires a majority vote in favor of the resolution. Members may abstain from voting. In the event of a tied vote, the Chair has the casting vote.

Meeting Schedule:

The PRHTAC will meet up to four times per year. Sub-committee and working groups may meet more frequently. Business may be conducted out-of-session, via email or teleconference, with face-to-face meetings held, as required.

Technical Assistance and Support:

Technical assistance and administrative support for Committee meetings, preparation and any follow-up will be provided by the WHO-Punjab office, in collaboration with Ipas Pakistan.

Proposed Committee Members

1. Director General Health Services Punjab. Chairman
2. WHO Operations Officer Punjab. Secretary
3. Dean, Institute of Public Health
4. Director Health Services (P&D)
5. Program Director Provincial Health Sector Reform Punjab
6. Representative from Punjab Health Care Commission
7. Provincial Coordinator, MNCH Programme, Punjab
8. Provincial Coordinator LHW Programme Punjab
9. Provincial Coordinator, UNFPA, Punjab
10. MNCH officer, UNICEF, Punjab
11. Technical Advisor, Ipas Pakistan
12. Provincial Head, Technical Resource Facility Punjab

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¹ National Institute of Population Studies (NIPS) [Pakistan] and ICF International. (2013). *Pakistan Demographic and Health Survey 2012-13*. Islamabad, Pakistan, and Calverton, Maryland, USA: NIPS and ICF International.

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⁴ National Institute of Population Studies. NIPS. *Population Growth and its Implications*. Islamabad. 2005

⁵ Amendment XVIII (the Eighteenth Amendment) of the Constitution of Pakistan April 2010

⁶ Ipas Pakistan, Pakistan Nursing Council, World Health Organization. (2014). *Evaluation of misoprostol for postabortion care (PAC) Lady Health Visitors' tutor training of trainers*. Karachi, Pakistan: Ipas Pakistan.

⁷ *Ibid*

