Advancing abortion care workforce policy

Transcript of discussion

Doctors are not the only health professionals who can provide first-trimester abortions. Non-surgical medical abortion administered by non-physician providers such as auxiliary nurse midwives is now considered a safe procedure.

Research and practice suggests this task shifting in the provision of safe abortion using medical methods can reduce prevalence of unsafe abortion by making comprehensive abortion care more accessible, especially in settings with few doctors and limited health resources. Similarly community-based workers can help ensure that women know about appropriate and timely care.

Finally, it is widely acknowledged that un-derreporting and misclassification of physician-provided abortion makes it difficult to measure rates of induced abortion.

Drawing on your research or experiences, what barriers are there to operationalising task shifting in different settings?

Are community-based health workers able – or willing – to help women access appropriate and timely care in all settings?

How does the legal context (the law and its interpretation and implementation) influence how safe delivery of medical abortion by non-physicians is?

What are the advantages of the widespread informal use of misoprostol accessed from non-physicians who are not recommended providers and what are the adverse effects of that?

How might task-shifting influence the measurement of induced abortion? And does it matter?

(77 comments)

Ernestina Coast
Our work in Zambia – where abortion is legally available under a wide range of circumstances, and available through many government and some private/franchised/NGO clinics – shows that substantial proportions of women seek "unsafe" self-administered medical abortion, for a wide range of reasons (no knowledge of safe services / assumption of lower costs / privacy, etc.). Simultaneously, interviews with midwives involved in providing legal abortion services has highlighted the stigma they experience in providing these services – including from their peers. This highlights two issues for abortion workforce policy. Firstly, the need to de-stigmatise this service provision for providers. Secondly, the shortage of service providers, especially outside of urban centres.

Sarah Jane Holcombe
Has anyone heard of any formal research investigating whether stigma plays out differently when a health professional provides medication abortion care versus aspiration abortion care? In Ethiopia, our assumption has been that since midwives are almost exclusively providing medication abortion care, that this may reduce the stigma that they feel/that is generated.

Emily Freeman
I haven't! Would be interested to read some though. Anyone?

Participant 1
We have found in our research in Cape Town South Africa that there is a distinctive difference for many health care providers, who are legally allowed to provide first trimester abortions, both MVA and medical abortion including nurses feel quite differently about the two methods. With medical abortion one is somewhat removed from the process and not actively involved whereas with a surgical procedure there is far more direct involvement. This is even more enhanced with Second trimester abortions in our research providers exhibited an emotional and qualitative shift in their approach to second trimester abortions as distinct from first trimester abortions associated with advanced gestational age, and related to their physical proximity to the client and contact with the products of conception.

Heini Vaisanen
Thanks, that sounds interesting. Is there a link to the study, or a reference you could provide?

Salma Ahmed
Our work in India – where task-shifting is difficult, because it needs funding, appropriate training for non-physician providers, especially in remote rural areas. In addition, auxiliary medical facilities in remote rural areas is difficult to establish. Community-based health workers are often helpful, especially in places with few doctors. However, their visibility is often very low due to social stigma and women's low levels of empowerment in regard to their health care. Even though their high levels of acceptance at the community, community-based health workers are often fail to deliver timely care due to insufficient infrastructural facilities, for example, lack of ambulance during critical moments. In general, there is a social stigma associated with induced abortion. As a result, in many cases, induced abortion has been misreported as spontaneous abortion.

Ernestina Coast
Salma, do you have any links to your work in India that you could share with participants? You mention that community-based health workers are "helpful" – in what respects? Referring women to registered abortion providers? Counselling women about their options?

Salma Ahmed
Thanks Ernestina for your reply. I do not have any complete draft to share with participants. In general, rural health workers provide information related to family planning, refer women to local clinics and hospitals where abortion facilities are available.

Participant 2
Ernestina, I completely agree with your comment around de-stigmatizing service provision. We recently did some interviews with post-abortion care service providers in Kenya. Several

of them highlighted stigma as one of the challenges to providing post-abortion care. We are still analyzing the data but will be happy to share any reports once they are available.

Ernestina Coast
Thanks – always good to hear about pending research – please do share any links you might have to projects or presentations or papers on your work on this subject. Did your interviewees suggest ways in which the stigma associated with providing PAC might be reduced? Given the legal status of abortion in Kenya, was your research able to interview clandestine abortion providers?

Participant 2
Our interviewees were post-abortion care providers (we had to be careful about focusing on post-abortion care provision because of the legal issues surrounding provision of abortion). I haven't had a chance to look closely at all the transcripts; but some of the suggestions were around community sensitization especially around post-abortion care and what it means because some of them felt that the community and other even providers stigmatize those who provide post-abortion care and assume that these providers offer abortion services

Emily Freeman
Your interviews sound really interesting. Were your participants providing abortion despite feeling stigmatised? We are just beginning an exploratory study looking at the reasons for and practices of conscientious objection to providing abortion care by health professionals in Zambia.

Our previous research with women and girls accessing our study hospital for care following an unsafe abortion care had first sought care at a public health facility. However they had been told by healthcare professionals that abortion was never legal or available. While registered medical practitioners have a right to refrain from performing abortions in certain (limited) circumstances, the right to conscientious objection does not extend to health practitioners who are not licenced to carry out abortions (e.g. midwives) or allow practitioners to obstruct a woman from seeking an abortion elsewhere (e.g. by giving misinformation). But, as far as Zambia is concerned, little is known about how practitioners carry out their refusals in practice, how they perceive their refusal to sit between their moral beliefs verses their role as professionals, or how refusals impact patients. Most evidence, as in our previous work in urban Zambia, relies on the reports of women who have requested services and been refused.

Would be really interested to know how your participants dealt with the stigma. Did they continue to provide services? Did they discuss colleagues who didn't?

Participant 5
HI Emily. I guess that I am of two minds about research like this on conscientious objection. I have seen conscientious objection clauses and the entire debate used for great evil in South Africa, where what was supposed to be a human rights debate became a service provision debate that limited further TOP availability and justified providers' unethical behaviors. I am now cautious about this type of work and would be interested to hear others' thoughts about how we keep the policy recommendations that will ultimately come out of your work from being another barrier to women's safe care?

Heini Vaisanen
Interesting point. I would like to hear what others think about this too. My research is mainly in Finland, where conscientious objection is not currently allowed, but the parliament will have to reconsider due to a citizens' initiative asking to allow it. At the moment, the debate is heated in between practitioners' and women's rights. I am concerned that allowing conscientious objection would lead to more difficult access to termination especially in rural areas where there are fewer doctors available and among poorer women who cannot afford private health care. However, in order to convince those who are not sure what to think of this, I think we need to know more about both: how it would affect access and what the practitioners think.

Emily Freeman
This is a really important point, and one we are grappling with. On one hand, we don't want to ignore this issue, because providers' misinterpretation of conscientious objection (such as not just refusing to perform abortions but telling women who enquire that they are breaking the law in doing so) is certainly responsible for some women seeking unsafe abortion, but as you say, on the other, drawing attention to it might strengthen resolve to limit service provision. My gut feeling is that researchers have to engage with and listen to conscientious objectors if we are going to be able to contribute to formulating messages that can 'speak' to them in order to respond to problems of interpretation and the limitations of conscientious objection.

Do you have any lessons for this kind of research from South Africa in order to minimise unintended consequences? Has anyone else got any thoughts about this?

Participant 2
Emily, we focused on post-abortion care because of the sensitivities around abortion service provision. And, yes, the providers did mention that they themselves face stigma as post-abortion care providers and in some instances some providers will object to providing care. Just to borrow a quote from one of the providers in an FGD "…there is also a problem with us, health workers in the facilities. You may find that some health workers have tagged other health workers with names, not really with names but ideally it is that; this is the one who does that, you see. If a patient comes, you will be called. Someone has been trained yes, but he or she feels that if she or he goes to do that, it is…I don't know if it is a criminal or it is like…unChristian"

Emily Freeman
Thanks – even more keen to read your work when it is available now after that enticing snippet! I think the idea of providers essentially becoming COs not necessarily because of their own beliefs, but because of fear of being stigmatised is a really interesting insight and I wonder how represented it is in the discourse around COs. Has anyone written or read much on this? From initial conversations with providers in Zambia, I sensed there was a general perception of COs as the 'villains' and not much recognition of the personal social risks some providers and would-be providers perceive.

Amy Levi
Good morning from the US! The issue of conscientious objection is very prevalent here among nurses and midwives; I am eager to pursue the relationship of stigma to this in the nursing and midwifery workforce here. Have any of you used any instruments for measuring

stigma specific to nurses and/or midwives? I would appreciate direction to them if they have been published.

We try very hard not to refer to providers other than physicians as "task-shifting" because we are trying to build a more diverse interprofessional approach to all kinds of care delivery. What ideas do you all have for refocusing the concept of task shifting to the development of an interprofessional workforce?

Ernestina Coast
Amy, there was a special edition of Women and Health in 2014 on Abortion Stigma. This article might be of use? http://www.tandfonline.com/doi/abs/10.1080/03630242.2014.919981

Amy Levi
This is perfect! I don't know how I missed it! Thanks so much, Ernestina —

Sarah Jane Holcombe
In that very issue of Women and Health, Lisa Martin and colleagues have developed a stigma scale for current abortion care service providers in the US. I believe that she has also done some work in Ghana, and is currently involved in East Africa.

Here is also a helpful review article by Wendy Chavkin et al. on conscientious objection/refusal to provide sexual and reproductive health services including abortion and contraception:
http://www.pfizerpro.com.co/sites/g/files/g10013506/f/publicaciones/2013_123,-Supplement-3_0_Conscientious-objection-and-refusal-to-provide-reproductive-healthcare-A-White-Paper-examining-prevalence.pdf

Ernestina Coast
Amy, the point you make about the use of language e.g.: "Task shifting" is an important one. First, the language itself "task shifting" – which has become very mainstream in its uncritical use. Second, because I suspect it is used (if not formalised) without attention being paid to the investments in health systems that are needed more generally – rather than "simply" expecting people with low(er) pay and poor(er) working conditions to provide additional services without adequate investment and support. This becomes particularly moot given the stigma associated with providing abortion services, including PAC.

Sarah Jane Holcombe
Hi. I can share the survey we used with the Ethiopian Midwives Association with its membership in 2013. It is an adaptation of the work of Tam Fetters and colleagues at Ipas, and also includes some measures more specific to medical professionals, some related to stigma around provision of abortion care services and reactions of colleagues.

https://drive.google.com/folderview?id=0B5TAP8fdifZHfmhfUDY3a2dVd2VwOC1wOFBxMnVxS1ZnTElSV1lJdlZoZ0pTYkxGRTkyY2c&usp=sharing

Participant 6
It's very interesting, to read some comments from other countries, about this topic, by here in Zambia it's a heated issue, even though the law is there almost all the people they don't know about.

Sarah Jane Holcombe
I'd love to hear your thoughts on the role in Zambia of organized religion and of individual religious beliefs in perpetuating stigma, and of any creative approaches to countering this type of stigma. Thank you!

Participant 6
Here in Zambia first of all our constitution says Zambia is a Christian nation, with this article, all religious groups see abortion as sin. And anyone who has been known to have done abortion, will be a condemned person , the stigma here is very very high when it comes to abortion, we have 72 tribes and these tribes sees abortion as evil, but if our government can put more effect in sensitising to it people about what unsafe abortion has done and also educated our traditional leader on is issue, am sure people will stop the stigma, at first I was also very against about this issue but after doing my own research we cannot continue hiding in the name of Christian nation and our traditional when sisters out there are having unsafe abortion.

From the few youths that I have talked to about this topic all of them have welcomed the move they are saying it will stop stigma because no one will know if I have aborted or not.

Dorothy Shaw
I have advocated at WHO and elsewhere – somewhat successfully – to use the term task-sharing either as well as or instead of task-shifting to avoid undesirable fallout from physicians who may see shifting of one of their skills as problematic. Also I wonder about the potential for [additional] stigma if abortion is shifted to non-physicians vs shared. The evidence is clear that mid-level providers can provide these services safely and midwives passed a resolution at their Congress in 2010 [? this one or one before] to include abortion as one of the services they would include globally in their skill set.

Ernestina Coast
Dorothy, I think your hunch about the potential for additional stigma is probably correct. In the hierarchies of medical professionals, I suspect it's probably relatively "easier" for a more senior physician to deal with stigma (eg: from his/her peers) than it is for eg: a midwife. We have interviewed midwives involved in abortion care in Zambia about this, and they were clear that they frequently experience stigma from their peers (eg: being called baby killers). This isn't an argument against task sharing/interprofessional workforce, but to highlight that it's not "simply" who does which task, but also how equipped they are to deliver it. Part of which is rooted in medical hierarchies.

Martha Silva
Ernestina, this was also the case in New Zealand, where midwives were more likely to be perceived and perceive themselves as "life givers". Midwives had a tougher time justifying why abortion should be part of their work compared to doctors. I'm not sure whether "seniority" had anything to do with it, but rather "you study midwifery to deliver babies".

Emily Freeman
This is really interesting Martha. We have identified similar narratives among midwives in Zambia. Have you (or anyone) written about this? Or are you doing work on this topic now?

Martha Silva
I have a manuscript almost ready to submit. Will share as soon as I can!

Sarah Jane Holcombe
Other commenters are pointing to the definition of the profession's mission as a potential leverage point for increasing medical professionals' willingness to provide abortion care services. My colleagues and I have found this to be true in Ethiopia. Research we have done on midwives in Ethiopia suggests that how the overarching mission of the profession is defined, as well as what the overarching legal context for abortion is, is associated with willingness to provide abortion care services. The government has dramatically expanded the midwifery profession in Ethiopia over the past 5+ years, and has made a special effort to inculcate a mission of maternal mortality prevention amongst the profession and individual midwives. Our interviews with midwives revealed an almost self-definitional commitment to saving women's lives — including from unsafe abortion. Midwives were able to very pragmatically acknowledge what would happen if they did not provide abortion care services (unsafe abortions by untrained people).

[Holcombe, Sarah Jane, Aster Berhe, and Amsale Cherie. 2015. "Personal Beliefs and Professional Responsibilities: Ethiopian Midwives' Attitudes Toward Abortion Care Service Provision After Legal Reform." *Studies in Family Planning* 46 (1): 73–95.]

Amy Levi
Thank you for posting this! Although the links to google weren't working for me, I am able to access this journal. I look forward to reading this!

Heini Vaisanen
Many thanks for sharing this and bringing this angle to the discussion. I believe the article will be an interesting read to many of us.

Sarah Jane Holcombe
I've pasted a link to this article and to the survey instrument (which is based on an instrument developed by Tam Fetters and colleagues from Ipas, and was fielded in Zambia and Cambodia).
https://drive.google.com/folderview?id=0B5TAP8fdifZHfmhfUDY3a2dVd2VwOC1wOFBxMnVxS1ZnTElSV1lJdlZoZ0pTYkxGRTkyY2c&usp=sharing

Amy Levi
Martha, without doing similar research here in the US, I would imagine much of the response of midwives may be similar. One of the things we are finding, however, is that younger midwives who identify themselves as feminists are eager to embrace abortion provision as part of their skill set. Although we cannot point to huge numbers of unsafe abortions occurring, we are certainly struggling with decreased access as a result of legislation that negatively impacts both providers and women seeking care.

Amy Levi
Thank you for emphasizing task-sharing rather than task-shifting! As both a nurse and midwife, I also have concerns about the use of "mid-level professional". Graduate nurses and midwives may have very different levels of education than, say, a clinical officer. But they all get lumped together if they are referred to as mid-levels, and not by their specific title. Will

the mid-level label ever go away? I think some of the hierarchical issues might be diminished if we focused more on the interprofessional team, and what each can uniquely contribute. "You may say that I'm a dreamer, but I'm not the only one…"(John Lennon)

Dorothy Shaw
Thank you Amy and point well taken about the lumping of too many into "mid-level provider". I agree that it is unhelpful. In my own hospital here in Vancouver, we are very focused on what each member can bring to the team – not that culture change is easy, but progress is happening.

I know that Mozambique has/had an active program training midwives to do MVA.
Also, the midwives who brought about the resolution at ICM that midwives should include abortion services in their skill set came from midwives in low resource settings where unsafe abortion and maternal mortality was something they saw often. In a number of high resource settings [e.g. Scandinavia] midwives have a broader scope of practice and I have not heard that they have faced the issue of stigma, but then Sweden has had midwives longer than most places!

Ernestina Coast
In a similar vein, professional organisations can play important roles in influencing law/policy/service/culture change (in either direction). In Zambia, for example, there is an active debate within the ObGyn community about current legal provision of abortion. In Ethiopia, ESOG actively supported reform of national law on abortion. See a recent paper presented by Sarah Jane Holcombe (http://paa2015.princeton.edu/abstracts/150265)

Heini Vaisanen
Interestingly some midwives in Finland have used the "we are supposed to deliver babies/ help bring life into this world, not conduct abortions" argument in a recent debate around conscientious objection.

Ferdousi Begum
Definitely, task sharing is a preferred term.
Regarding nurses providing MR service: they accepted it well.
CO is a problem in some cases, but VT is often done.

Diana Taylor
On nomenclature and abortion workforce capacity building.
I agree with use of the term "task sharing" over task shifting and am glad to hear you have had success within some sections of the WHO to move away from rhetorical imposition of outdated, hierarchical terms. Although, we would all agree that the common goal is to expand the healthcare provider base for safe abortion services, there seems to be an unfortunate movement toward anachronistic rhetoric and politics rather than evidence-based nomenclature (e.g., task shifting vs. team-based care; mid-level providers vs. using definitions from the Global Workforce Alliance).

See a brief commentary in Contraception (Vol 91, 2015, 264–265) on this issue of appropriate nomenclature and the unintended consequences for practice and research. Here are few relevant excerpts:

In reviewing both the World Health Organization (WHO) and Global Health Workforce Alliance (GHWA) websites, there is a lack of consensus about creating new health workforce categories. It appears that one sector of the GHWA and WHO (represented by maternal-child and reproductive health groups) have developed two reports on midlevel providers (2010) and midlevel health workers (2013); these reports were published in spite of major opposition from the members of the GHWA Forum. Most made the case that the focus should be on country-level workforce assessment/planning rather than rhetorical imposition of an outdated, hierarchical term with the recommendation that standard of care and competencies guide the nomenclature and policy debate on health workforce changes. Notably, a 2013 Strategic Plan for Advancing the Health Workforce Agenda within Universal Health Coverage, Strategy 2013-2016 (also by the Global Health Workforce Alliance) does not refer to midlevel providers/workers; rather they recommend focusing on patient needs and care (not merely tasks) from a team-approach. In addition, the Lancet Commission report, Health Professionals for a New Century: Transforming education to strengthen health systems in an interdependent world (2010) criticizes the use of the midlevel term and reinforces the importance of optimizing the deployment of existing health professionals and front line health workers before creating new titles.

Furthermore, the politicization of health care workforce issues also affects our ability to conduct good research. An investigator assumes that if a report has the imprimatur of the WHO or the Global Health Workforce Alliance, that it can be relied upon as peer-reviewed evidence. Clearly, there is evidence that using an imprecise categorical term such as midlevel provider, or even the term health professional, is contrary to internal and external validity criteria necessary for program evaluation purposes or systematic reviews. Rather the unit of analysis is the standard of care not the clinician or health care worker/provider; followed by the specification of competencies (knowledge/attitudes/skills) and education/training standards necessary for achieving the standard of care.

References:

(1) Mid-level health workers in the delivery of essential health services: a global systematic review and country experiences.
http://www.who.int/workforcealliance/knowledge/resources/mlp2013/en/

(2) Global Health Workforce Alliance (2013). Health Workforce Agenda within Universal Health Coverage, Strategy 2013-2016,
http://www.who.int/workforcealliance/knowledge/resources/ghwastrat20132016/en/

(3) Lancet Commission on Health Professionals for a New Century
http://www.healthprofessionals21.org/ and WHO Educational Guidelines for scaling up health professional education and global health care workforce (2013)
http://www.healthprofessionals21.org/index.php/resources/publications/368-new-who-guidelines-on-scaling-up-health-professional-education

Ferdousi Begum
Definitely, task sharing is a preferred term.

Diana Taylor
Hello from USA (San Francisco, CA)…commenting on expanding the study of stigma to include abortion providers along with individual women choosing abortion. A non-profit, also located in San Francisco area, the Sea Change Program is committed to reducing abortion stigma globally using a network called INROADS (the International Network for the

Reduction of Abortion Discrimination and Stigma). Inroads is a global network to advance research and successful interventions around abortion stigma. Read more about their work at http://www.seachangeprogram.org.

The Sea Change model has relevance for the evaluation of abortion workforce capacity building as well as evaluation of stigma reducing interventions. For example, the work with organizations to understand the whole stigma system, conceptualize and measure stigma at various levels, share existing and promising practices for culture change, design strategic and measurable pathways for change, and support communication between change makers. identify, implement, and evaluate culture change and stigma reduction interventions.

Ernestina Coast
Here's a link to inroads http://www.endabortionstigma.com/en.aspx which has some really useful toolkits and examples – and underscores that stigma operate at multiple levels and affects different actors simultaneously (providers and women). If others have examples/resources to share, from around the world, post them in reply

Demeke Desta
Drawing on your research or experiences, what barriers are there to operationalising task shifting in different settings?

The major barriers for task shifting/provision of abortion by midlevel providers include Administrative barriers that restrict the provision of abortion service by highly qualified professionals such as Gynecologists and authorizing abortion care service only at secondary or tertiary health facility levels

Are community-based health workers able – or willing – to help women access appropriate and timely care in all settings?

Yes community based health workers can provide the service safely and effectively, if provided with the necessary training and support they are willing and able to provide abortion care service at community level. They are also very critical to identify, treat or refer cases with complications of abortion and educate the community on how to prevent unwanted pregnancy and how and where to get abortion care service in case unwanted pregnancy happens, signs and symptoms of complications of abortion.

WHO in collaboration with Ipas and MSI conducted validation study in Ethiopia and found that health extension workers, if trained properly, provided with the appropriate job aids and support can safely determine gestational age and provide medical abortion service like other medical professionals

How does the legal context (the law and its interpretation and implementation) influence how safe delivery of medical abortion by non-physicians is?

In most cases the law only specifies under which circumstance abortion should be provided or criminalized. Instead the technical and procedural guide line which is the interpretation of the law that specifies in which hierarchy of the health care service or by which cadre of health professionals the service is provided. This SPGL, in most cases, purposely puts barriers to women to get abortion care service by limiting the provider to highly qualified

professionals, facilities as secondary or tertiary levels, or setting condition on how service eligibility is decided such as need to get the signature of three doctors….. The presence of such battle necks makes abortion care extremely inaccessible to women despite the presence of abortion law that permits abortion care service

What are the advantages of the widespread informal use of misoprostol accessed from non-physicians who are not recommended providers and what are the adverse effects of that?

The advantage is very clear; with adequate information on how to use it and signs and symptoms of complications and what to in such circumstances provided to these non - physician providers, it will help women have more access to abortion care service through providers very close to them. If these providers are informed with the above information, I don't see and adverse event. Actually if these information are included in the package, women themselves even can properly manage themselves using the misoprostol or the combined regimen too.

How might task-shifting influence the measurement of induced abortion? And does it matter?

If these lower health cadre are provided with the skill on how to document and report abortion care services, there will be no fear on the measurement of abortion care service. Moreover the most important thing is to save women's lives, measurement shouldn't be our priority. After all the incidence of unsafe abortion and its complication is much more hidden and unreported

Sarah Jane Holcombe
In support of these comments, there is an interesting 2011 pilot study done in Tigray Region of Ethiopia where community-based health extension workers provided medication abortion care and referred complicated cases to health centers or hospitals. There is certainly room to explore more community-based approaches to providing medication abortion care that will enable rural women to obtain services.
http://bixby.berkeley.edu/wp-content/uploads/2015/03/TRHB_VSI_Bixby-Ethiopia-CAC-Pilot-Final-Report-2011-05F.pdf
http://bixby.berkeley.edu/wp-content/uploads/2015/03/VSI-Ethiopia-CAC-Brief-2011-04-28F.pdf

Ethiopia has done a pioneering job of broadening the range of health professionals authorized to provide abortion care services. The 2006 Technical Guidance on abortion from Ethiopia's Ministry of Health provides helpful description of the roles and responsibilities of health professionals at various levels of the health system with respect to provision of abortion. They authorize health officers, midwives, clinical nurses, public health nurses, laboratory technicians at health services to provide medication and aspiration abortion, and also to train community level workers in provision of abortion services. These Ministry of Health guidelines further liberalized access to abortion care services in Ethiopia.
http://phe-ethiopia.org/resadmin/uploads/attachment-161-safe_abortion_guideline_English_printed_version.pdf

Ferdousi Begum
Bangladesh is an example of successful task shifting. Paramedics are providing MR(Menstrual regulation) services at the most peripheral level health facilities since

seventies ; and recently the nurses/ nurse midwives are also allowed to provide this service including contraceptives.

Emily Freeman
Thanks for the link to this paper on 'improving manual vacuum aspiration service delivery, introducing misoprostol for cases of incomplete abortion, and strengthening post-abortion contraception in Bangladesh' Ferdousi.
http://www.sciencedirect.com/science/article/pii/S0020729214001544

Diana Taylor
Focus on competencies and standards of care vs. non-evidence based nomenclature

To summarize global workforce recommendations related to building health workforce generally and abortion care provision within the context of sexual and reproductive healthcare specifically:

1) Identify overlapping roles of existing health professionals and other health care workers; scopes of practice should be specific to burden of disease (e.g., unsafe abortion) and structure of the health care system; assess patient care needs and competencies needed to meet those needs; identify standards of care, scopes of practice, educational requirements, regulatory issues, adequate/sustainable remuneration; transition to practice support, career path and continuous education; as well as health systems requirements.

2) Alternative recommendations re: provider nomenclature beyond midlevel provider/task shifting terms:
–WHO Sexual & Reproductive Health Competencies 2011: Attitudes, tasks, knowledge and skills that health personnel in primary health care may need to protect, promote and provide SRH in the community
WHO SRH Competencies Supplement, intercountry survey to identify SRH provision in primary health care and which health care workers are providing 7 technical areas of SRH services (who, setting, degree of SRH integration into PHC): antenatal, childbirth, newborn, family planning/infertility, abortion, STI/RTI, violence/cancer screening, sexual health promotion/education. Summary of services by CHW, Nurse, Midwife, Doctor across six WHO regions and across the 7 technical areas of service provision.

–WHO/USAID 2007 Family Planning: Global Handbook for Providers did not use categorical nomenclature in the definition of who can provide family planning services: "Many different people can learn to inform and advise people about family planning to provide family planning methods. Countries and programs have various guidelines about who can offer which methods and where…" Then listed the types of people who commonly provide family planning including nurses, nurse-midwives, nurse practitioners, auxiliary nurse-midwives, midwives, physicians (specialist/non-specialist), physician assistants, pharmacists, community health workers, community members serving as community-based distributors, trained TBA, shopkeepers/vendors, volunteers (experienced users, peer educators, community leaders). Referenced training, quality criteria then provided a table with specific services and who can provider. For example, for COC, "all providers with brief specific training," and for vasectomy, "anyone with specific training in the procedure, including MDs, medical officers, nurse-midwives, nurse practitioners, midwives, physician assistants/associates."

–ICM 2011 Draft Guidelines for Midwives in providing safe abortion care. Competency #7: Competency in facilitation of abortion-related care: Midwives provide a range of individualized, culturally sensitive abortion-related care services for women requiring or experiencing pregnancy termination or loss that are congruent with applicable laws and regulations and in accord with national protocols.

–WHO Social Science Policy Brief: What health-care providers say on providing abortion care in Cape Town, South Africa: findings from a qualitative study (Kabiru et al): described characteristics of abortion providers in terms of overall numbers, type of setting, training, service provider category (counselor, enrolled nurse, RN, nurse-midwife, doctor, management), sex, religious affiliation.

–Recent empirical research on nurses in abortion care: McLemore MR, Kools S, Levi AJ. Calculus Formation: Nurses' Decision-Making in Abortion-Related Care. Res Nurs Health. 2015 Mar 27. PMID: 25820100: PMC2891150.
McLemore MR, Levi A, James EA. Recruitment and Retention Strategies for Expert Nurses in Abortion Care Provision. Contraception (DOI: 10.1016/j.contraception.2015.02.007).

3) Assumptions underlying reframing and revised provider definitions:

- The evidence for using an imprecise categorical term such as midlevel provider although appealing as a shorthand term is contrary to internal and conclusion validity necessary for program evaluation purposes.
- Unit of analysis is the standard of care not the clinician/provider which are core competencies (knowledge/attitudes/skills) and education/training standards
- Maximize capacity and value of existing health care personnel who don't consider themselves to be "midlevel providers"

Christian Fiala
Conscientious objection really is an important issue by itself and also in relation to stigma. We will not be able to overcome stigma as long as CO in RH is widely accepted. Unfortunately the debate is frequently dominated by political correctness and the willingness to grant what is misleadingly called 'a right to conscience' for health care providers.

Two aspects need to be highlighted in the debate: the huge damage CO does to women's health and accessibility to health care services. For the European context this was put together in the publication: "Conscientious objection and induced abortion in Europe" http://informahealthcare.com/doi/pdf/10.3109/13625187.2013.819848

The second aspect which we need to highlight is the fact that CO is unworkable. We discussed this and other aspects in the following 3 articles, which are freely accessible:

'Dishonourable Disobedience': Why Refusal to Treat in Reproductive Healthcare Is Not Conscientious Objection
http://www.sciencedirect.com/science/article/pii/S2213560X14000034

'Why We Need to Ban 'Conscientious Objection' in Reproductive Health Care
http://rhrealitycheck.org/article/2014/05/14/why-we-need-to-ban-conscientious-objection-in-reproductive-health-care/

The CO debate: 'Conscientious Objection' is still dishonourable disobedience.
http://www.reproductivereview.org/index.php/rr/article/1606/

Emily Freeman
Thanks for sharing the links to these important papers, especially Dishonourable Disobedience. They highlight an important point – that in many laws CO doesn't actually *mean* anything. For example, the Zambian Termination of Pregnancy Act allows CO – but only if the abortion isn't necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman. So given the law on reasons for an abortion, practitioners are only actually allowed to CO is if an abortion has been requested *only* to prevent risk of injury to the physical or mental health of any existing children of the pregnant woman or if there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped. That's not many cases!

Heini Vaisanen
Many thanks for the comment and links. I found these very useful and I'm sure many others did too. CO is under debate in Finland at the moment, and I have seen many arguments for and against it, but rarely has anyone discussed it from the perspective of power and stigma, although these aspects should not be ignored.

Diana Taylor
Conscientious Provision and Objection–two sides of professional code of ethics

The exercise of conscience in health care is generally considered synonymous with refusal to participate in contested clinical services, especially abortion. This depiction neglects the fact that provision of end of life care, infertility care, contraception, and abortion is also conscience-based. The persistent failure to recognize this care as "conscientious" has resulted in laws that do not protect caregivers who are compelled by conscience to provide services and contributes to the ongoing stigmatization of health professionals who are committed by their conscience to provide abortions based on deeply held, core ethical beliefs related to women's reproductive autonomy and self-determination of childbearing decisions.

Therefore, the discussion of Conscientious Objection or professionals' refusal to provide care needs to be broadened to include Conscientious Commitment to provide care in the context of politically contested and stigmatized areas of practice (e.g., end of life care, HIV/AIDS, and sexual and reproductive health care, specifically infertility, contraception and abortion care). Most health professional codes of ethics reference end of life care, they are silent on other areas of nursing or medical practice that are stigmatized. These ethical codes should acknowledge the conscientious commitment to care for patients requiring sexual and reproductive health services, most of whom are poor women or ethnic minorities who are choosing legal interventions in the face of extreme political and social pressure.

Bioethics has focused on defining conditions under which conscientious refusals are acceptable but have neglected to make the ethical case for protecting the conscientious provision of care. Violations of negative claims of conscience are considered ethically worse than violations of positive ones. This ethical asymmetry thesis does not provide adequate ethical justification for current conscience law, which protects only conscience-based refusals.

While health care providers have always had the legal right to abstain from performing abortions or providing abortion care, conscience clauses (now extending to all cadres of health professionals and frontline workers) have become an increasingly salient and powerful political tool of groups restricting access to end of life care, AIDS and SRH care. These clauses protect not only individuals but also institutions, which often impose ideologically based restrictions on the health care that clinicians in their system can legally (and should ethically) provide.

The current public discourse about refusal clauses and restrictions is poised as an ethical contest between the providers' "rights of conscience" vs. the autonomy and self-determination of patients (specifically women). This discourse takes place in a theoretical and ideological framework without a full understanding of the impact on individual's health, and without due regard for health care quality and patient well-being.

Furthermore, the equation of conscience with non-provision of care contributes to the stigmatization of all health professionals choosing to provide care. Such a bias reinforces stereotypes of the 'abortionist' or 'Dr. Death' as unethical and deters professionals from providing care which reduces patient access to quality services.

Respect for conscience requires accommodation of both objection to participation in services and commitment to their delivery. Conscientious commitment may call for courage when treatment is provided that contradicts non-clinical directives such as those by religious institutions. Healthcare providers' professional ethics require mutual tolerance and accommodation, and resistance to forces of intolerance.

As professional societies update their ethical codes of conduct, it is important that refusal clauses and denials of care, as well as religious affiliated institutional policies be evaluated using the same metrics used to evaluate quality generally:

- Evidence-based: Health care decision making is based on the best scientific evidence available, and ensuring that patients receive treatments (including prevention interventions) known to be effective.
- Patient-centered: Patients are provided culturally appropriate care, treated with dignity and respect, given complete and scientifically accurate information so that patients can give fully informed consent to their treatment options, with care coordinated in a manner that result in high quality outcomes.
- Prevention-focused: Access to information and services that allows patients to optimize their health outcomes and well-being before the onset of disease or health condition.

The International Federation of Gynecology and Obstetrics (FIGO) issued revised ethical guidelines for conscientious objection related to the practice of reproductive and women's health; these may be useful in standardizing professional codes of ethics. In Guideline 4 of the FIGO Ethical Guidelines on Conscientious Objection, they state that "practitioners have a right to respect for their conscientious convictions in respect both of a undertaking and not undertaking the delivery of lawful procedures, and not suffer discrimination on the basis of their convictions" (FIGO, 2009).

References:

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- FIGO Committee for the study of ethical aspects of human reproduction and women's health. Ethical issues in obstetrics and gynecology. London: FIGO. http://www.figo.org

Sarah Jane Holcombe
Thank you for these great resources and thoughts. Medical professionals' refusal to provide care on the basis of religion/philosophy can have even greater consequences in contexts where there are very few medical professionals and/or where medical facilities are geographically dispersed (especially in rural areas). Viable referral systems can be very hard to set up in these contexts. When there is only on health professional at a health post, and this professional refuses to provide care, referring a woman for abortion care elsewhere becomes a meaningless exercise.

Ernestina Coast
Thinking about how this would play out in terms of "impact" on women's ability to access resources (whether a high income or low income country), then this leads me to think that – in addition to "simply" measuring the amount of conscientious objection, it's also important to understand the relative impact. For example, 1 conscientious objector in a setting where there are 100 who are conscientiously committed (see Diana's post), would have a very different potential impact on the "density" of service availability compared to a setting where there is only 1 provider, and they are a conscientious objector. Is anyone aware of work that attempts to measure the relative density/impact of conscientious objection?

Ernestina Coast
A really thoughtful summary (with lots to read and follow up on). The concept of conscientious commitment is certainly one that needs foregrounding. Just musing on comments made elsewhere in this forum – about how care providers' perspectives might change dependent upon e.g.: gestational age or method of abortion – we can also think about how, for one provider, their attitude might shift from commitment to objection dependent upon circumstance. And then I was further musing about whether there is also a space "in between" for something I'll call conscientious ambivalence. As I said, a musing, but would be interested in others' reactions.

Christian Fiala
Task shift is also a question of technology. The example of pregnancy testing is illustrative. Until the 1960s you needed toads to do a pregnancy test: http://en.muvs.org/topic/the-frog-test-en/ and http://en.muvs.org/contraception/pregnancy-tests/

So everything was in the hands of doctors. With the availability of chemical pregnancy tests task shifting took place towards lab personnel and family planning associations. And with the invention of self home tests another task shift took place towards women doing pregnancy tests themselves without asking anyone for approval or paying anyone to provide the service.

Similarly we currently see a task shift with the availability of medical abortion as compared to surgical abortion. Obviously one does not need a trained medical doctor to hand out a few pills. This can be done by midlevel providers. But actually it can also be done by pharmacists. Because that is what they are being trained for: handing out pills.

Consequently the future will most probably see the task shift towards self-abortion by women just as they already perform the pregnancy tests themselves.

Emily Freeman
This point about technology and who can use it also feeds into what can be considered safe and unsafe abortion of course. For those who haven't seen it, this paper in the WHO Bulletin summarises the issue neatly: http://www.who.int/bulletin/volumes/92/3/14-136333/en/

Amy Levi
Thank you for chiming in! I'm a big fan of your work, and interested in opening up the CO discussion here in the US. It is a difficult conversation to have! BTW, I emailed you and Joyce about a commentary I wrote for the Journal of Midwifery and Women's Health, and it has been accepted! I will let you know when there is a publication date.

Amy Levi
Thanks for this interesting perspective on "task-shifting" (what I would prefer to call "task-sharing"!), Christian. I think it is always a goal for us to include women in our processes of care, so even in this instance, task-sharing is the appropriate approach. The international voices in this discussion also remind me of the complexity of the systems in which we support women: systems that have control of access to care, belief systems that are deeply ingrained (or part of the national constitution!), and the educational processes that produce the providers who control the care that women receive. Stigma needs to be addressed at each of these levels if we are to ensure access to safe abortion care. I am curious to see what impact the inclusion of misoprostol on the WHO Essential Medicines list has on self-administration of medication abortion…

Emily Freeman
Just to chime in on your point about the educational processes that produce providers, we were recently reminded during some training we ran for young parliamentarians in Zambia that the educational processes that produce law makers is also key. A group of undergraduate law students discussed how their lecturer had introduced them to the TOP Act but had told them that it should be interpreted narrowly, with the example that "mental health" should only include physiological changes to the brain ('brain damage') and not depression or anxiety disorders.

Emily Freeman
Further to our conversations yesterday about stigma directed to healthcare practitioners, I found this newly published open access literature review on providers' perceptions of and

attitudes towards abortions in Africa and Asia really helpful:
http://www.biomedcentral.com/content/pdf/s12889-015-1502-2.pdf.

Ferdousi Begum
http://www.sciencedirect.com/science/article/pii/S0020729214001544

Araceli Fernandez
In Mexico City, where first trimester abortion was fully liberalized in 2007, nurses are providing medical abortion after a randomized trial proved they could provide it as safely, effectively and acceptably as physicians.

Here is a link to the article in the WHO Bulletin:
http://www.scielosp.org/pdf/bwho/v93n4/0042-9686-bwho-93-04-249.pdf

Diana Taylor
In response to Ernestina, Emily and Heini's query: We should stop talking about task shifting and start talking of "interprofessional workforce" What do you think?:
Posting 1 of 2:
Some collaborative work we are doing in the US out of health workforce centers suggests the need for common terminology (especially for research and implementation interventions) that does not impose unnecessary boundaries or political hierarchies such as "professional" or "mid-level" categories.

We might want to consider these priorities and questions for improving the abortion care workforce and reducing the burden of unsafe abortion:
1. Using an expanded definition of PROVIDER, what are the effective capacities, components and processes of a PROVIDER TEAM to prevent unwanted pregnancy and decrease the burden associated with unsafe abortion within the context of community, culture, politics and healthcare systems?

2. Consider a proposed definition of an expanded PROVIDER TEAM— a range of front-line health workers (healthcare professionals/workers, informal caregivers) and healthcare delivery systems/settings—which care for women, children, and families across varying locales worldwide to provide teaching-learning opportunities on interventions for/with populations and communities as well as to inform, advise, and engage policy makers.

- More specifically, PROVIDERS as the unit of analysis include people (generalist and specialist physicians and nurses, midwives, community health workers, skilled birth attendants, relief workers, social workers, allied health workers, informal caregivers) and systems/settings (hospitals, clinics, community centers, homes, pharmacies).
- Example: Evidence-based workforce resources for utilization of such an expanded provider team include global, national and local models: WHO Global Workforce Alliance , National Center for Interprofessional Practice and Education—a public-private partnership (US based) , and the regional/state health workforce centers (e.g., California Center for the Health Professions http://www.futurehealth.ucsf.edu)

3. What are the PROVIDER capacity-building strategies to improve provider team communication and skills needed to improve uptake of abortion care improvement interventions?

- Examples: Provider capacity-building to improve provider team communication and skills might include, team-based teaching/learning in collaboration with communities organized on a push-pull framework to maximize impact, behavioral change models, collaboration with local opinion leaders, audits and feedback, case management and care coordination. See ITECH tools/Everyday Leadership model (taken from HIV/AIDS methods), intersectionality methods, and women's empowerment/gender equity models since women predominate in the front-line provider groups.

4. What are the strategies, communicative processes and infrastructure necessary for PROVIDER implementation of abortion care improvement interventions? How can knowledge transfer/exchange strategies, communicative processes and infrastructure elements be adapted from a variety of successful global and local programs focused on PROVIDERS?

Global examples include instructional and institutional reforms (Lancet Commission) ; use of technology for training/learning (asynchronous online/e-portfolio) and communication (mHealth) across provider team and healthcare settings; and Global-Local knowledge transfer/exchange: 1) In-service training and outreach education adapted for practice-based and community collaborations that focuses on provider-community exchange; 2) Audits and feedback adapted for collaborative and team-based training; 3) Tailored interventions for providers/teams, health care systems by culture, global, local communities; 4) Computerized reminders but focused on front-line health workers; 5) competency-based and service-based provider training programs like the WHO/UK model for sexual and reproductive health for all public health and primary care providers.

5. How to evaluate the effectiveness of programs and the extent to which the program engages and empowers all relevant providers (health care workers, informal caregivers, healthcare systems) in team-based care that is community engaged or directed, including change management, empowerment and collective action skills that will lead health improvement for clients/patients, populations, and communities affected by unsafe abortion?.

To be effective, provider capacity-building must be sustained until local providers develop the capacity in teaching-learning for team-based care and prevention. Train-the-trainer methods have been very successful in HIV care. Tested models of service-based teaching/learning of a collaborative team across settings using a wide range of technology and teaching-learning models could be readily adapted/expanded for abortion care within the context of existing primary care and maternal-child health services.

Selected References:

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- The International Training and Education Center for Health (I-TECH), a collection of videos and curriculum materials suitable for use in classroom trainings, distance learning programs, and as tools for self-reflection.
- Provider, Community and Advocacy methodologies, http://www.CoreAlign.org; Roberts D & Jesudason S (2013)
- Women's empowerment and leadership development: http://www.who.int/kobe_centre/publications/womens_empowerment2005.pdf?ua=1 ; Empowering women and strengthening health systems: http://www.nap.edu/download.php?record_id=19005 ; Literature review: Upadhyay et al, June 2014. Women's empowerment and fertility: A review of the literature. Social Science & Medicine 115(2014):111-120.

Diana Taylor
In response to query, We should stop talking about task shifting and start talking of "interprofessional workforce" What do you think?
Posting 2 of 2 (much shorter than my first posting! :)

It will be important to consider the unintended consequences and lessons learned from global experience with health professional interventions for preventing and treating pre-term birth and HIV/AIDS.

For example, vertical programs lead by professionals (vs community lead or integrated programs) have focused on technology and disrupted the traditional informal care provider education. Evaluation of interventions in Rwanda/Uganda found that family beliefs, myths and cultural norms outweighed the value of professional-driven interventions no matter how scientifically based. Community-based evaluations using focus groups found important concerns regarding professional driven interventions (vs team based interventions that did not include community systems)–decreased respect given by health care professionals with predetermined judgment by providers.

Conclusions from these global models:
- New (or adapted) models of abortion care workforce need to be studied in local contexts within a culture of humility and would be relatively easy to supplement existing provider-focused educational programs. In some locales/settings, provider education is routine, but evidence-based methods from other health sectors could contribute significantly to improved practice, uptake of interventions, and health outcomes.
- Competency and service based provider training in communication, patient-centered care, and SRH/abortion messaging, in collaboration with communities, to policy makers could transform care in selected locales, at the same time help foster a provider team-based approach to abortion care and prevention. Such work is also deeply embedded within communities of science, practice, environment, and culture since it requires the

collaborations among people (all stakeholders), systems (political, clinical) settings (community, institutions) and technology (education innovators, communications and digital technology experts).

References to inform program and provider knowledge transfer/exchange for MCH/Preterm Birth prevention include: Maternal, Newborn and Child Health in Rwanda: http://uwo.ca/projects/mnchr/; Canadian Maternal Health Project in Rwanda: http://www.acdi-cida.gc.ca/cidaweb/cpo.nsf/vWebCSAZEn/76FCFF9FF271322B8525796F003B568D; Healthy Newborn Network Kenya; http://www.healthynewbornnetwork.org/partner/kenya-association-maternal-neonatal-health-kamaneh; Kenyan Centre for Maternal and Newborn Health: http://www.mnhu.org/about-cmnh/map-of-activity/kenya/; Partners in Health: http://www.pih.org/blog/all-babies-count-caring-for-newborns-in-rwanda
Global Male Partnership: http://www.men-care.org/Blog/?id=76