

SAAF CASE STUDY

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USING THE TASK SHARING MODEL TO EXPAND ACCESS TO SAFE ABORTION SERVICES TO UNDER-SERVED POPULATIONS IN NEPAL

BACKGROUND

The Safe Abortion Action Fund (SAAF) was established in 2006 as a multi-donor mechanism to support global abortion-related programming. At the time, many organizations committed to addressing unsafe abortion were denied funding as a direct result of the United States government reinstating the Mexico City Policy (known as the 'Global Gag Rule') in 2001. Under this policy, any non-governmental organization that received United States government funds was prevented from performing or promoting abortion services, including with its own funds.

The Safe Abortion Action Fund provides small grants to projects that promote safe abortion and prevent unsafe abortion through advocacy and awareness raising, service delivery and research activities, and has supported such projects for over a decade. There have been three rounds of grant funding since SAAF was set up, supporting 188 projects in 59 countries, with a total grant

commitment of over US\$35 million. Under the third round of funding, which started in 2014 and is due to end in 2017, 103 organizations in 50 countries have been funded, with a total grant commitment of US\$16 million. SAAF is currently funded by the governments of Denmark (Danida), Netherlands, Norway (Norad), the United Kingdom (DFID) and an anonymous donor.

In 2014, the Center for Research on Environment Health and Population Activities (CREHPA) was awarded US\$160,000 to strengthen and expand access to safe medical abortion services in 20 rural municipalities (known as village development committees) across five districts of Nepal (Banke, Bardiya, Pyuthan, Sindhuli and Udayapur). CREHPA supported 20 mid-level provider-led government health posts to increase access to medical abortion and post-abortion contraception services by combining supply-side and demand-side interventions.

"I am very happy to provide medical abortion services because women can get the abortion service in their own village and they do not have to travel so far. They can also open up more easily with me as they know me. Confidentiality and privacy can be maintained here. As it is nearby the woman, she can come here by herself and there is no need to depend on other family members."

SUSHILLA, AUXILIARY NURSE MIDWIFE, BANIYABHAR HEALTH POST

TASK SHARING

What is task sharing?

Task sharing is the process by which specific clinical services and procedures are moved from more highly qualified health workers (for example, doctors) to health workers with fewer qualifications but who have received appropriate training (for example, nurses and auxiliary nurse midwives).

Why is it implemented?

Task sharing can be a viable solution to improve access to health services in low-resource settings by making efficient use of the existing health workforce, in order to meet the health needs of the population.

The role of auxiliary nurse midwives

In Nepal, auxiliary nurse midwives must either have completed 8th grade plus two years of pre-service training or completed 10th grade and School Leaving Certification, plus 18 months of pre-service training.

Auxiliary nurse midwives in Nepal:

- can provide antenatal care, post-natal care, delivery care and contraceptive services (short-acting methods only unless they have received additional training in inserting implants and IUDs)
- can provide primary health services at health and sub-health post level
- are eligible for medical abortion training if they have received either in-service training in post-abortion care, insertion of IUDs or skilled birth attendance
- can provide medical abortion services up to nine weeks of gestation

Adopting task sharing as an approach to increase access to safe medical abortion services has been found to be effective, safe and acceptable.

SAFE ABORTION SERVICES IN NEPAL

Gender inequality, illiteracy and poverty prevent many women and girls in Nepal from realizing their sexual and reproductive rights. Even though the government has made significant strides in reducing its maternal mortality rate, complications related to unsafe abortion still continue to be one of the leading causes of maternal death in Nepal.

Abortion was legalized by the government of Nepal in 2002. The provision of surgical abortion services using manual vacuum aspiration started in 2004, with the government focusing on training physicians in public regional, zonal and district hospitals. In 2008, training in surgical abortion was expanded to include senior nurses who had already received training in post-abortion care. However, even with the rapid scale-up of manual vacuum aspiration services, safe abortion facilities were disproportionately concentrated in urban areas or at district level; this resulted in a lack of availability of safe abortion services in rural and remote areas. In 2009, therefore, medical abortion services were introduced in Nepal together with approval for auxiliary nurse midwives to be eligible providers for medical abortion.

THE ROLE OF TASK SHARING

Adopting task sharing as an approach to increase access to safe medical abortion services has been found to be effective, safe and acceptable.¹

As a result, the decision to allow auxiliary nurse midwives to be trained in medical abortion has helped to support the expansion of safe medical abortion services for rural and under-served populations at community level, where there are often insufficient doctors along with an inadequate infrastructure to provide surgical abortion services. However, lack of expansion of medical abortion services to outreach health centres, particularly at health and sub-health post level (the lowest level of health facility in the government health system), has limited the scale-up of safe abortion services.²

PROJECT OVERVIEW

The Center for Research on Environment Health and Population Activities launched its SAAF-funded initiative in January 2014. The key objective of the project was to support the scale-up of comprehensive abortion care in rural and under-served communities. By leveraging existing partnerships with the Ministry of Health and Population and with local non-governmental organizations, CREHPA aimed to expand access to safe medical abortion services by 1) training mid-level providers (auxiliary nurse midwives) based in rural government health facilities (health post and sub-health post level) to provide medical abortion services; 2) supporting the accreditation of these facilities as certified safe abortion service sites; and 3) training female community health volunteers to increase community awareness, and to facilitate referrals for safe abortion services.

1 World Health Organization (2015) *Health Worker Roles in Providing Safe Abortion Care and Post Abortion Contraception*. Geneva: WHO. Available at <http://apps.who.int/iris/bitstream/10665/181041/1/9789241549264_eng.pdf?ua=1&ua=1>

2 Andersen KL, Basnett I, Shrestha DR et al (2016) Expansion of safe abortion services in Nepal through auxiliary nurse-midwife provision of medical abortion, 2011–2013. *Journal of Midwifery & Women's Health*. 61(2): 177–84. DOI: 10.1111/jmwh.12419.

STEPS TO IMPLEMENT THE TASK SHARING PROCESS

STEP 1: ASSESS LEGAL AND REGULATORY FRAMEWORK

The first step was to assess the existing legal and regulatory framework to identify opportunities and obstacles to implement task sharing for safe abortion service provision. This was a key step in the project planning process as it informed the scope of the intervention design.

The government of Nepal has a comprehensive regulatory framework – known as the legal procedural order – that defines the legislative mechanisms, clinical norms, regulations, roles and responsibilities to deliver safe abortion services. As a result, CREHPA had clear guidelines in relation to **approved clinical procedures for first trimester abortion provision** (manual vacuum aspiration and medical abortion); **providers eligible to deliver safe abortion services** (physicians, nurses and auxiliary nurse midwives); **service fee structure** for clinical abortions performed in public health facilities (500 Nepalese rupees/about US\$5); **in-service training pathway and curriculum** for eligible providers (with training provided by the government’s National Health Training Centre); and criteria for **certification and accreditation of health facilities** as safe abortion centres (led by the Family Health Division of the Ministry of Health and Population).

STEP 2: IDENTIFY KEY STAKEHOLDERS

During the project planning process, CREHPA identified key stakeholders who could support the scale-up of safe medical abortion services in rural and under-served communities. As a result, local non-governmental organizations were selected in the five intervention districts, based on their experience of working on safe abortion issues within the district, as well as their knowledge of the unmet sexual and reproductive health needs of the target population. This included barriers to accessing safe abortion services. CREHPA partnered with the government (specifically its Family Health Division), the National Health Training Centre and district public health offices in order to facilitate the training of auxiliary nurse midwives and support the accreditation of health and sub-health posts in the intervention sites.

STEP 3: CONDUCT NEEDS ASSESSMENT

CREHPA worked with its district-level partners to identify communities with the highest unmet need for safe abortion services within each district – this included Muslim women, Dalits, and hill and Terai Janajatis (indigenous people). Based on the needs assessment conducted by the local partner non-governmental organization and CREHPA, health facilities were selected at community level (health or sub-health post). This shortlist was presented to the district public health offices, who made the final selection of the health or sub-health posts that would be nominated for accreditation as safe medical abortion sites. The government’s Family Health Division is responsible for approving health facilities as safe abortion sites. It is important to note that the accreditation process is a bottom-up approach, which takes approximately six to eight months to complete. As a result, a total of 20 health and sub-health posts were accredited across the five project districts.

STEP 4: BUILD CAPACITY OF MID-LEVEL PROVIDERS

On average, one auxiliary nurse midwife from each of the 20 health and sub-health posts participated in a five-day training on medical abortion service delivery, organized by the National Health Training Centre. The training sessions were conducted over two months in the last quarter of 2014. The training included both theoretical and practical components and was designed to ensure clinical competence in delivering a medical abortion service. The training covered the following topics:

- **Counselling:** informed consent, options for abortion procedure, and benefits and risks of medical abortion.
- **Values clarification:** examining provider beliefs, knowledge and attitudes about abortion.
- **Medical abortion with mifepristone and misoprostol:** mechanisms of action, indications and contraindications, drug regimen, efficacy and routes of administration.
- **Clinical care:** clinical assessment, expected effects of medical abortion, pain management, potential side-effects, signs of complications and post-abortion contraception.

Each auxiliary nurse midwife received a certificate of completion from the National Health Training Centre; the Family Health Division also issued a separate certificate for each auxiliary nurse midwife accrediting them as a safe abortion provider.

“It feels great that we are certified to provide medical abortion services as clients faced barriers in visiting larger facilities.”

PARBATI, AUXILIARY NURSE MIDWIFE, HIRMINIYA HEALTH POST

A government health post, accredited as a safe abortion site.



STEP 5: SELECT AND RECRUIT COMMUNITY HEALTH WORKERS

Within each village development committee, a maximum of 33 female community health volunteers were engaged and trained to increase knowledge about the consequences of unsafe abortion, the availability of legal abortion services in Nepal, and how to conduct community referrals. Because of their access to under-served and marginalized populations, the female community health volunteers played a key role in generating demand and strengthening the referral process to health and sub-health posts. As a result, referrals from the volunteers were responsible for 92 per cent of the medical abortion services provided at health and sub-health posts.

STEP 6: ENSURE ACCESS TO COMMODITIES

CREHPA identified resources to ensure that accredited health and sub-health posts received supplies of Medabon (a combination pack of mifepristone and misoprostol), an essential commodity to ensure safe medical abortion. At the start of the project, CREHPA purchased supplies of Medabon; however, through its partnership with district public health offices, subsequent stock was provided by the government. Contraceptive commodities, supplied by the district public health offices, were already available at the health and sub-health posts.

STEP 7: LAUNCH SAFE ABORTION SERVICES

With all the above steps completed, the project moved into implementation phase.

Community mobilization: The female community health volunteers organized neighbourhood meetings and visited women in their homes to inform the community about the availability of safe abortion services, including information on the legal status of abortion in Nepal, an integral project activity. In addition, they offered urine pregnancy tests and referred women to trained auxiliary nurse midwives for either safe medical abortion or antenatal care. The volunteers also conducted post-abortion follow-up visits which resulted in a high uptake of post-abortion contraception methods within the target population. The volunteers received 100 Nepalese rupees (about US\$1) for every client they referred for safe abortion and antenatal services and 175 Nepalese rupees (about US\$1.75) for post-abortion contraception services.

Reporting: Data on the number of post-abortion care clients, induced medical abortion clients, clients accepting post-abortion contraception (disaggregated by method) and clients with complications were recorded in the Safe Abortion Service Register, a reporting mechanism developed by the government. These indicators were incorporated into the existing health management information system at the health and sub-health posts and the data collected were reviewed by the district public health offices.

Monitoring: CREHPA ran one post-training supportive supervision visit to observe medical abortion service provision by the auxiliary nurse midwives. The local partner non-governmental organizations conducted monthly monitoring visits, during which they reviewed the Safe Abortion Service Register, checked levels of Medabon stock, and supported providers and clinic managers to identify and address any service-related challenges.

ACCREDITATION PROCESS

FACILITY SELECTION

- CREHPA and partner non-governmental organization identify health and sub-health posts with 1) birthing centre; 2) auxiliary nurse midwife trained in skilled birth attendance; and 3) clinic manager (known as Health Post In-charge) and auxiliary nurse midwife interested in providing medical abortion services
- District public health office selects health and sub-health posts to provide medical abortion, based on mapping carried out by CREHPA and partner non-governmental organization



FACILITY ASSESSMENT

- District public health office conducts assessment of selected health and sub-health posts to ensure the facility meets the standards set by the Family Health Division, which include:
 - location: near tertiary facility; for example, 24-hour birthing centre, geographic priority area etc
 - presence of eligible provider: auxiliary nurse midwife trained in skilled birth attendance, post-abortion care or IUD insertion
 - clinical and physical infrastructure to support the provision of medical abortion



TRAINING PROVIDERS

- District public health office sends a request to the Family Health Division to approve training of selected auxiliary nurse midwives in medical abortion
- Nominated auxiliary nurse midwives are trained in medical abortion by the National Health Training Centre (the official government training body in Nepal)
- Six to eight auxiliary nurse midwives are trained per session
- Training duration is five days
- CREHPA covers the training costs

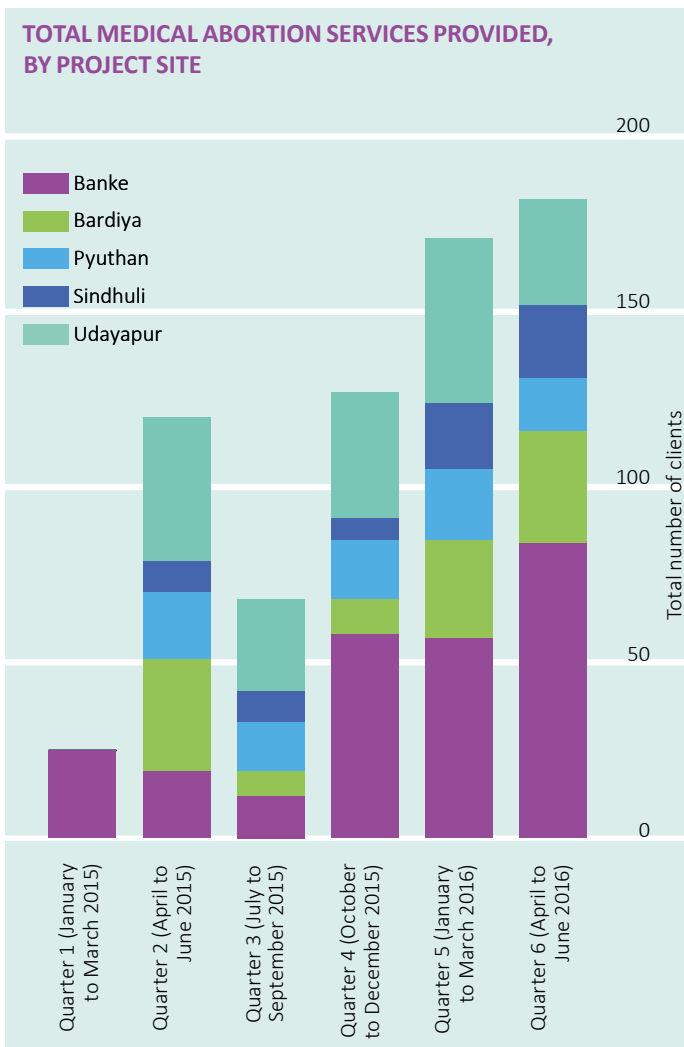


FACILITY ACCREDITATION

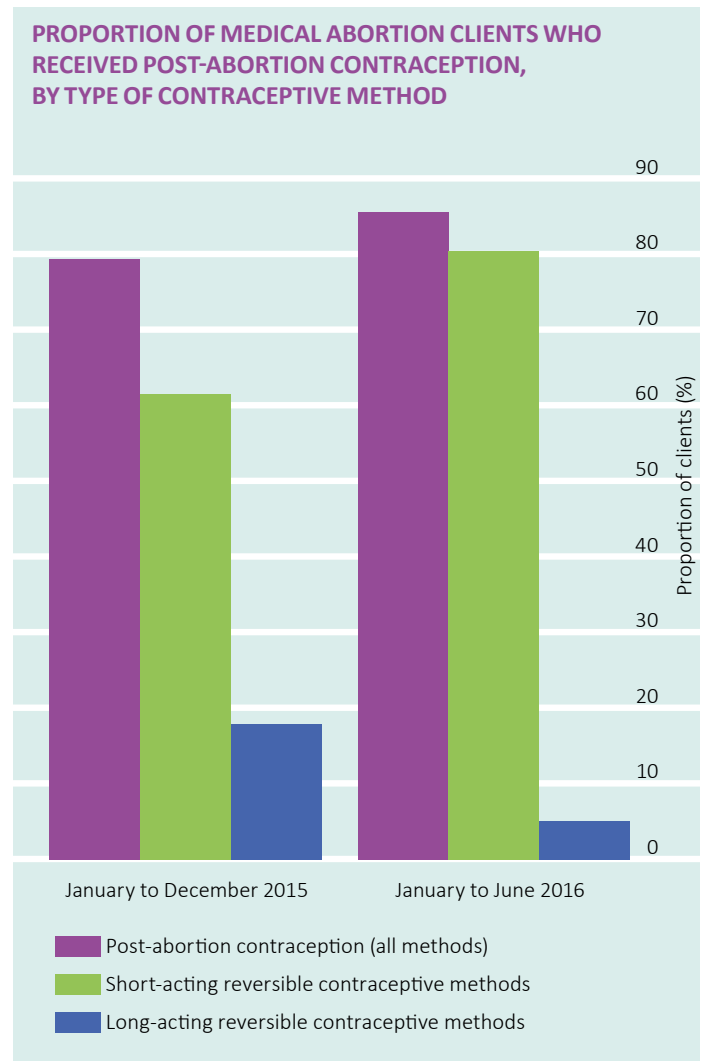
- When the facility assessment and auxiliary nurse midwife training are completed, the district public health office submits an application to the Family Health Division recommending accreditation of the selected health or sub-health post as a safe abortion site
- The Family Health Division provides accreditation for the health facilities as safe abortion sites, and provides certification for the auxiliary nurse midwives as safe abortion providers

ACHIEVEMENTS

The number of medical abortion services provided in the accredited health and sub-health posts increased between 2015 and 2016, with the project sites providing more services in the first six months of 2016 (353) than were provided in the whole of 2015 (340). Furthermore, 86 per cent of clients accepted a post-abortion contraceptive method in 2016 (compared to 79 per cent in 2015). It is important to note that there were differences in the uptake of medical abortion services across the five districts due to 1) geographical location and 2) size of the target population; for example, over a fifth of the total number of medical abortion services were provided in Pyuthan and Sindhuli, which are hilly districts with smaller populations.



It is also important to note that during the first quarter, only three health posts were providing medical abortion services as they were the first facilities to be accredited as safe abortion sites. Overall, while there was a general upward trend in women accessing medical abortion services across the six quarters of the project, there was a significant reduction between quarter two and quarter three. The main reason for this reduction was due to the large number of men within the target communities working as overseas migrant labourers. Migrant workers return to Nepal between September and November to celebrate Nepali religious festivals. As a result, there was a subsequent reduction in the number of women requiring medical abortion services during quarter three due to their spouses working abroad.



The key objective of the project was to support the scale-up of comprehensive abortion care in rural and under-served communities.

“All the medical abortion cases have been successful. I feel good about it!”

AUXILIARY NURSE MIDWIFE, DHADHAWAR HEALTH POST

LESSONS LEARNED

Know your target population. It is important to be clear about which segment of the population you are aiming to target as the entire project design will be built around this decision. A thorough needs assessment is vital in order to understand the unmet sexual and reproductive health needs and the barriers faced by the target population in accessing safe abortion services.

Ensure you are aware of any regulatory restrictions. The ability to deliver the objectives of the intervention and to ensure programmatic sustainability will ultimately depend on the existing national legislative framework. It is important to identify the restrictive and supportive regulations governing safe abortion provision, and ensure that they inform each step of the project design process. In Nepal, for example, auxiliary nurse midwives are not permitted to induce abortions between 10 and 12 weeks of gestation; as a result, referral facilities were identified for each health and sub-health post to ensure women had access to this service.

Select stakeholders who can add the most value to your intervention. It is worth investing the time and resources up-front to select key stakeholders who can support the design and implementation of the intervention, in order to achieve the project goal. The success of the project will ultimately depend on selecting the right partners and maintaining effective relationships with them. For example, CREHPA regularly conducted meetings with both local non-governmental organizations and the government, at both district and national levels. These activities were budgeted for and included in the project design.

Maintaining quality of care requires ongoing resources. While a one-off investment in training and procurement of medical abortion commodities is necessary, this investment in itself is not sufficient to ensure the ongoing provision of quality services. This initial investment must be supplemented with sustainable continued resources to support refresher training, supportive supervision activities and an adequate supply of medical abortion drugs, in order to ensure that quality standards are met. For example, a number of health and sub-health posts experienced stock-out of Medabon, which

meant that medical abortion services could not be offered. The centralized procurement processes, including budget allocation, did not provide sufficient flexibility to address the increased demand for medical abortion services at district level, which had a direct impact on service quality.

Community health workers are key. While investments in the supply-side are crucial, CREHPA found that client numbers increased as a result of greater awareness among the target population of the availability of safe medical abortion. Community health workers therefore played a key role in the success of the intervention.

Provider buy-in is essential. It is vital that providers are involved in discussions relating to the proposed changes to their role, in order to ensure that they accept and have ownership of the intervention. This provides an opportunity to address any negative concerns and to ensure that providers support the introduction of safe abortion services. Ensuring adequate financial compensation for the change in workload was also a key facilitating factor in the success of the intervention: auxiliary nurse midwives received 200 Nepalese rupees (about US\$2) for each client who received a safe abortion service.

Demonstrate the positive impact of task sharing to address unmet sexual and reproductive health needs. Task sharing has been shown to increase access to safe abortion services in both low- and high-resource settings. In order to get governments on board, it is important to document the success of delivering a safe abortion service through a task sharing model. This can help to support advocacy efforts to change restrictive regulations: for example, auxiliary nurse midwives reported that there was a significant need for induced abortion services at 10–12 weeks of gestation. Due to the distance and cost of travelling to district-level health facilities, many women were forced to undergo unsafe abortions. By allowing auxiliary nurse midwives to be trained in manual vacuum aspiration, this would help to address the unmet sexual and reproductive health needs within the target population.

WHO WE ARE

The Safe Abortion Action Fund (SAAF) is working toward a world where women's rights to safe legal abortion are established and women are empowered to exercise these rights, focusing on the needs of the marginalized and most vulnerable women and girls. By visibly funding projects using an international funding mechanism, SAAF works to destigmatize abortion and to legitimize the abortion debate.

ACKNOWLEDGEMENTS

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