

2011

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Recommended Citation

Population Council. 2011. "Expanding access to safe abortion and post-abortion care: Recommendations of a South Asia regional consultation." New Delhi: Population Council.

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Expanding access to safe abortion and post-abortion care

Recommendations of a South Asia Regional Consultation

In March 2011, a South Asia Regional Consultation was held in New Delhi, India, with representation from governments and key stakeholders of Bangladesh, India, Nepal and Pakistan to discuss ways of expanding women's access to safe abortion services and this publication is the result of the deliberations of the participants in that Consultation. The recommendations made in this publication represent the collective views of participants and do not necessarily represent the views of the organisations that they represent.

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Suggested citation: Population Council. 2011. *Expanding access to safe abortion and post-abortion care: Recommendations of a South Asia Regional Consultation*. New Delhi: Population Council.

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Acknowledgements

The Population Council acknowledges support from The David and Lucile Packard Foundation for its generous financial support for the South Asia Regional Consultation and for the four National Consultations that preceded it. We are grateful to Lester Coutinho, Programme Officer (South Asia), Population and Reproductive Health Program, The David and Lucile Packard Foundation, for valuable inputs and suggestions over the course of the consultation process. Earlier versions of the document were reviewed by all participants of the Regional Consultation and we are grateful to them for their patience, collegiality and thoughtful comments. Jyoti Moodbidri's editorial contributions have been significant and we thank her for her meticulous attention to detail. We would also like to acknowledge the contribution of Komal Saxena, who was responsible for preparing the manuscript for publication and ably managed its publication. M. A. Jose was responsible for managing the administrative and financial aspects of the project, and we are grateful to him for ensuring the smooth and efficient functioning of the project.

The Context

WHO's most recent estimates¹ highlight that deaths due to unsafe abortion accounted for as much as 13 percent of all maternal deaths in South-Central Asia, a region that encompasses the four large South Asian countries of Bangladesh, India, Nepal and Pakistan. In 2008, for example, a total of 14,000 such deaths—entirely preventable—took place in the region. Moreover, almost one-third—6.82 million—of the estimated 21.6 million unsafe abortions worldwide occurred in the region; the overall abortion rate was as high as 17 unsafe abortions per 1,000 women aged 15–44 years.

Underlying these dismal statistics is women's limited access to safe abortion services in this region. There is serious concern in Bangladesh, India, Nepal and Pakistan that without concerted efforts to enhance access to safe abortion, unsafe abortion and related mortality will persist. A key strategy for overcoming inadequate and inequitable access to safe abortion is to expand the provider base for first trimester abortion services, and many in the region have articulated the need to enable such health care professionals as nurses, midwives and physicians trained in alternative (non-allopathic) systems of medicine to conduct first trimester abortions, as well as to provide services for the management of incomplete abortion and complications of unsafe abortion, as appropriate in the country's legal context.

With the intent of deliberating on this expressed need, consultations were held at the national level in each of the four countries, followed by a South Asia Regional Consultation with representation from these countries. The National Consultations were coordinated by the Population Council in Bangladesh, India and Pakistan and by the Centre for Research on Environment Health and Population Activities (CREHPA) in Nepal; the Regional Consultation was coordinated by the Population Council India. Participants at all these consultations were key stakeholders representing government and non-governmental organisations, the private sector and development partners. Each country arrived at a national consensus statement on the feasibility of expanding

¹ World Health Organisation. 2011. *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008*. Geneva: World Health Organisation.

the abortion provider base and made national-level recommendations. The Regional Consultation, held in March 2011, deliberated further on these issues from a regional perspective, and, informed by the national recommendation statements, agreed on a set of recommendations for expanding the provider base for safe abortion to include nurses, midwives, and physicians trained in alternative (non-allopathic) systems of medicine (as appropriate in each country's context). We reproduce here the recommendations made by the Regional Consultation against the backdrop of the abortion situation in the four participating countries.

Annex 1 provides a list of the participants who attended the National and Regional Consultations and shared their perspectives on expanding the abortion provider base.

Expanding access to safe abortion and/or post-abortion care (PAC) in South Asia: Is expanding the provider base a feasible option?

Introduction

A South Asia Regional Consultation, with representation from governments and key stakeholders of Bangladesh, India, Nepal and Pakistan, was held in New Delhi, in March 2011, to discuss ways of expanding women's access to safe abortion services. The Consultation deliberated on ways of expanding the provider base for safe induced abortion so as to overcome inadequate and inequitable access to safe abortion, as well as to services for the management of incomplete abortion and complications of unsafe abortion that persist in the region and, thereby, to reduce morbidity and mortality resulting from unsafe abortion. Specifically, the deliberations focused on the feasibility of expanding the provider base for first trimester abortion services [including Medical Abortion (MA) and Manual Vacuum Aspiration (MVA) and Menstrual Regulation (MR) services], and Post-Abortion Care (PAC) services. More specifically, the Consultation discussed the feasibility of including, over and above obstetrician-gynaecologists and allopathic physicians certified to provide abortion, various categories of nurses and midwives, and physicians trained in alternative (non-allopathic) systems of medicine as abortion providers, hereinafter described as "other competent providers". The literature has, thus far, tended to refer to these "other competent providers" as "midlevel providers"; given the increasing recognition of the inadequacy of the term, this statement refers to these providers, more appropriately, as "other competent providers" and recognises that the range of health care professionals included under this term differs across the four countries.

The Consultation was attended by a range of stakeholders, including policy makers, programme managers, researchers, and representatives from non-governmental organisations, civil society, professional organisations, the private sector and development partners, from the participating countries. It was preceded by country-level consultations in each of the four countries, with participants representing a similar spectrum of stakeholders from within each country.

This Statement is informed by recommendations made at the four country-level consultations as well as by the deliberations of this Regional Consultation to which participants from the four countries contributed.

Rationale

It is estimated that over half of all abortions conducted in developing countries are unsafe.¹ The most recent estimates published by the World Health Organization suggest that 21.6 million unsafe abortions take place worldwide every year, of which 21.2 million, or 98 percent take place in developing countries. South-Central Asia is the region with the largest number of unsafe abortions, estimated at more than 6.8 million annually, despite the broad legal parameters for induced abortion in Nepal and India as well as the widespread availability of MR services in Bangladesh. Deaths as a result of unsafe abortion in developing countries are estimated at 47,000 annually, that is, 220 deaths per 100,000 abortions with South-Central Asia accounting for 200 deaths per 100,000 abortions.² Specifically, available estimates of safe and unsafe abortions in the four countries represented at this Consultation follow:

- In Bangladesh, about 800,000 women undergo MR annually^{3,4}—mostly unreported (official estimates suggest a much lower number of 200,000).⁵ While MR is largely safe, evidence from the large number of PAC admissions in facilities reiterates that large numbers of unsafe abortions—estimated at another 150,000 to 200,000—do indeed take place in Bangladesh (Director MCH, Directorate General of Family Planning, personal communication).
- In India, more than 5.5 million of the 6.5 million abortions that take place annually are conducted by uncertified providers or in unregistered facilities;⁶ unsafe abortion accounts for 8 percent of all maternal deaths.⁷
- Estimates suggest that, in total, approximately 890,000 abortions, both safe and unsafe, are conducted in Pakistan annually, with an estimated abortion ratio of 20 per 100 live births; about 197,000 women are treated for post-abortion complications annually.⁸
- In Nepal, an estimated 165,000 abortions, both safe and unsafe, take place annually, and unsafe abortion is the third major cause of maternal deaths in the country.⁹

In all these countries, poor women's access to safe abortion services remains, in practice, limited. A large percentage of rural women are at risk of abortion-related complications: they delay their abortions into the second trimester, seek abortion from untrained providers or in unregistered facilities, and travel long distances to obtain abortion services. In large part, unsafe abortion remains a problem because there are too few providers of safe abortion in these countries. In view of the fact that 'other competent providers' are generally more likely than physicians to work in remote and underserved areas of developing countries in Asia, empowering them to provide abortion services would go a long way in improving access to safe abortion.

Laws governing access to abortion in the four countries of South Asia represented at this Consultation vary. For example:

- In Pakistan, abortion is permitted to save the life of the mother or in order to provide "necessary treatment".¹⁰
- In Bangladesh, MR (by vacuum aspiration, conducted to bring on menstruation and not as a method of pregnancy termination) is legally permitted within 8 weeks of the last menstrual period by a paramedic and up to 10 weeks by a physician;^{5,11} while abortion is legally permitted only to save the life of the mother.¹²
- India permits abortion for a range of social and physical reasons, including contraceptive failure, mental and physical health of the mother, foetal problems and rape; abortions are permitted up to 20 weeks of pregnancy and at any time during pregnancy to save a woman's life, but must have the consent of two providers if the pregnancy is more than 12 weeks.¹³
- In Nepal, abortion is permitted up to 12 weeks of pregnancy on request, up to 18 weeks in the case of rape and incest, and at any time during pregnancy to save a woman's life, if the physical and mental health of the mother is affected and in case of foetal abnormalities.^{9,14}

All four countries provide PAC services in the context of the wider definition of reproductive health.

Laws governing who can provide abortion services also vary:

- In Bangladesh, aside from trained allopathic physicians, Family Welfare Visitors (FWVs), Sub-assistant Medical Community Officers (SACMO) and paramedics, that is, those who have had at least 18 months of formal

training, are permitted to provide MR (up to 8 weeks following the last menstrual period); only trained allopathic physicians are permitted to provide MR and abortion services beyond 8 weeks, as well as PAC services. Physicians trained in non-allopathic systems of medicine (e.g. Ayurveda, Homoeopathy) are not permitted to provide MR or abortion services.⁵

- In India, abortions can be conducted by all obstetrician-gynaecologists, and by other allopathic physicians who have undergone abortion-related training and are certified to conduct abortions; nurses, midwives and physicians trained in non-allopathic systems of medicine (e.g. Ayurveda, Homoeopathy) are not permitted to provide abortion (although they may assist certified physicians in doing so).¹³
- In Nepal, aside from trained allopathic physicians, staff nurses and Auxiliary Nurse Midwives (ANMs) with Skilled Birth Attendance (SBA) training are permitted to provide MA; staff nurses, in addition, are permitted to provide MVA for post-abortion care. Homoeopaths and Ayurveds are not permitted to provide abortion services.⁹
- In Pakistan, only trained allopathic physicians are permitted to provide abortion to save the life of the woman or in order to provide “necessary treatment”.¹⁵

Task shifting from physicians to other competent health care professionals and task sharing between these two categories of health care providers represents an important option in these circumstances, provided that safety and efficacy can be assured. In general, task shifting or sharing is clearly warranted in procedures in which the required skills can be transferred to other competent providers and where such trained providers can deliver the services instead of relying on the skills of highly trained personnel who are in short supply. Experiences from both low and high income countries suggest that such task shifting has been successful in expanding services as well as in improving outcomes for patients without compromising on patient safety and satisfaction.¹⁶

While governments may favour task shifting and expanding the provider base to include ‘other competent providers’, the need for evidence about the safety and efficacy of abortions provided by these providers has often been articulated by governments of the region.

Defining other competent providers

Participants agreed that other competent providers comprise, in general, a range of provider categories:

- ANMs/lady health visitors and/or community midwives with training in skilled birth attendance (SBA).
- Nurse-midwives and nurses holding diplomas or degrees and/or their equivalent.
- Physicians trained in non-allopathic systems of medicine, including Ayurveds, Homoeopaths etc.

However, each country elected to encompass, in its definition of other competent providers, those best suited for each country's own context and legal situation, and pursue the expansion of the abortion provider base to include these providers only.

Recommendations

In order to provide women safe, accessible and acceptable abortion care services, the Consultation strongly recommended that other competent providers should be legally permitted, following due training, to independently provide comprehensive abortion care (CAC), including MR, first trimester abortion services [both MVA and MA (that is, using mifepristone-misoprostol)], and/or PAC services, as appropriate, within each country's legal context. The Consultation also agreed that other competent providers must be given the responsibility of providing post-abortion contraceptive counselling. Participants representing medical and nursing associations in all four countries, further, endorsed this recommendation to expand the provider base.

The Consultation also noted that in order to expand access to safe abortion, several other complementary measures are necessary, as appropriate within each country's legal context. These include efforts to:

- Include specific drugs (mifepristone and misoprostol) in the essential drugs list and MVA equipment in the essential equipment list.

- Equip facilities with infrastructure, equipment and regular supply of drugs and other supplies, to ensure effective provision of abortion and PAC services.
- Ensure a strong, effective, supportive and functional supervision and monitoring system.
- Support NGOs already providing abortion and PAC services by way of training, equipment and drugs.
- Ensure universal access to abortion and PAC services, with special initiatives to reach the poorest; intensify efforts to raise community awareness about the legal aspects of abortion within each country's legal context, and dispel misperceptions that abortion is not legally available or that it is not accessible.

The Consultation unanimously agreed, however, that the main focus of its recommendations would be on the provision of abortion and PAC services by other competent providers.

The recommendations made by the Consultation are listed below:

1. Act upon available evidence on the safety and efficacy of abortion services provided by 'other competent providers'

Evidence is now available from several countries in the South Asia region that confirms the safety, efficacy and acceptability of abortion and/or MR services provided by other competent providers. For example:

- Evidence from Nepal confirms that nurses and ANMs who have had SBA training can provide medical abortion up to 9 weeks of pregnancy as safely as trained allopathic physicians.¹⁷
- Evidence from India shows that nurses and Ayurveds can provide MA just as safely and effectively as trained allopathic physicians, to women with gestational ages up to 8 weeks.¹⁸
- Evidence from India also shows that nurses can provide MVA as safely and effectively as trained allopathic physicians, to women with gestational ages up to 10 weeks.¹⁹

- Evidence from Bangladesh highlights that FWVs can provide MR safely and effectively to women whose last menstrual period took place up to 8 weeks prior to the MR.²⁰
- Experiences from all four countries, including Pakistan,¹⁵ highlight that other competent providers can provide PAC services and post-abortion contraceptive counselling.

Findings from these studies, as well as the study showing the safety of MVA conducted by nurse-midwives in Vietnam and South Africa,²¹ collectively and strongly confirm that abortion services given by other competent providers are as safe and effective as those given by trained allopathic physicians. In this context, the Consultation recommended that:

- Available evidence on abortion, MR and/or PAC specific to the socio-legal context in each country is collated and updated.
- A coalition is established that works in conjunction with other partners working for women's health and rights to advocate for amendments and changes in the law, rules, regulations and policies to promote the provision of abortion, MR and/or PAC services by other competent providers.

The Consultation highlighted the need for governments and country stakeholders to act upon this evidence and to take steps to include other competent providers among those legally permitted to provide abortion, MR and PAC services.

2. National governments and ministries of health must amend laws, rules, regulations and policies for expanding the provider base for safe induced abortion and post-abortion care

Safe abortion services and/or MR, as appropriate in each country's legal environment, and PAC services must be widely accessible, including to women in remote rural settings. In this context, national laws and policies relating to the provision of abortion and PAC services by other competent providers must be amended accordingly. Specifically, governments and Ministries of Health in each country must:

- Express commitment to expanding the provider base for abortion, MR and/or PAC services, review and/or amend existing laws, rules, regulations and/or policies for expanding the provider base to ensure widespread access

and availability of safe abortion/MR and/or PAC services, as appropriate, in each country's legal context.

- Take steps to amend existing laws, rules, regulations and/or policies so that appropriately trained other competent providers are permitted to independently provide abortion/MR and/or PAC services so as to ensure widespread access to these services, as appropriate, in each country's legal context.
- Take steps to introduce and/or make readily available mifepristone-misoprostol for medical abortion/MR, as appropriate, in each country's legal context.
- Take steps to amend rules governing the prescription of allopathic drugs so that other competent providers are legally authorised to dispense drugs for abortion/MR and/or PAC services, as appropriate, in each country's legal context, for medical abortion.

3. Enhance the skills of other competent providers: address comprehensive training needs and certification procedures

The Consultation acknowledged that expanding the skills of other competent providers to include first trimester abortion and PAC and/or CAC services will require attention to training, both pre-service and in-service, and advised the following:

- Review and revise the pre-service curriculum for other competent providers to include competency-based training in MVA, MA and/or MR, and CAC services as appropriate, in each country's legal context, and in PAC; training in EMoC (Emergency Obstetric Care) should include the use of MVA for PAC, with the objective of institutionalising the use of MVA for PAC.
- Provide in-service and refresher training options to develop the skills of other competent providers in the provision of MR, abortion and PAC services, as appropriate, in each country's legal context, and encourage them to pursue such training.
- Explore the feasibility of including other competent providers working in the private or NGO sector in training and certification procedures, in view of the fact that a large number of abortion seekers obtain their abortions from facilities in these sectors.

- Develop a pool of trainers to train other competent providers in the provision of MVA, MA, MR, CAC and PAC services, as appropriate, in each country's legal context.
- Make arrangements for appropriate training facilities to be integrated into existing service systems, including arrangements for the provision of adequate mentoring and support for other competent providers.
- Outline certification and registration procedures for other competent providers. Set standards governing the certification or accreditation of providers, as well as for post-training follow-up and supportive supervision, and ensure that they are effectively maintained; ensure, as well, that documentation, monitoring and evaluation, and audit, are regularly undertaken.
- Ensure that the job descriptions of certified other competent providers include the provision of MR, abortion (MVA/MA), CAC and/or PAC services as appropriate in each country's legal context.

4. Review the content of revised training programmes: address the content of curricula, protocols, manuals and guidelines

- Prepare appropriate competency-based training curricula, protocols, manuals and demonstration kits, as well as operational guidelines and materials on MR, abortion (MVA/MA), CAC and/or PAC services, as appropriate, in each country's legal context; update national guidelines on a regular basis to reflect the latest evidence.
- Revise pre- and in-service training curricular content to include abortion service provision as appropriate, including training in pelvic examination, STI screening, gestation age estimation, assessment of abortion completion status, recognition and treatment of abortion-related complications, as well as training in pre-abortion and contraceptive counselling techniques, making appropriate referrals, and a gender and rights perspective. Training should also cover accurate and complete reporting of the abortion and PAC services provided.
- Ensure that the training of other competent providers includes values clarification, along with sensitisation on attitudes and behaviour towards all abortion clients, so as to respect the client's right to confidential and caring services.

- MVA is important for both CAC and PAC services, and hence, training should be viewed as an essential aspect of all training programmes for other competent providers in all settings, including those in which abortion services are not legally permitted, because of its importance in PAC.

5. Establish appropriate guidelines for abortion service provision and referral

The Consultation made a general recommendation that guidelines for abortion, MR and PAC service provision are prepared that are applicable to all abortion providers that is, including but not limited to other competent providers.

Participants made the following suggestions for inclusion in these guidelines:

- The minimum infrastructure required at facilities (government facilities, NGO facilities, private facilities) in which abortion providers are based.
- Identification of an appropriate back-up facility, including a telephone referral system and transport services for easy referral in the event of serious adverse events, and the basic equipment required in these referral facilities.
- Links with other reproductive health services including family planning services.
- Provision for ensuring client privacy and confidentiality, including private post-abortion recovery facilities.
- Provision of contraception, basic medication and pain control.
- Adequate systems for infection prevention and waste disposal.
- Inclusion of indicators to track abortion service provision in the health management information system (HMIS).

6. Expand the evidence base

The Consultation underscored the fact that available evidence is robust enough for governments to take immediate steps to enable the provision of first trimester abortion (MA and MVA) and/or PAC services by other competent providers. At the same time, it recognised the need to build evidence on related matters to ensure that governments have the necessary evidence not only to bring about amendments to existing laws, rules and regulations, as relevant to each country setting, but also to enable a smooth transition to the provision of abortion and PAC services by other competent providers, and to document

implementation issues arising from the provision of such services once initiated. The following next steps were highlighted:

- Evidence is now available from India and Nepal that establishes the feasibility of the provision of MA^{17,18} and MVA¹⁹ by other competent providers, and from Bangladesh establishing the feasibility of the provision of MR²⁰ by these categories of providers. Next steps with regard to research on the provision of abortion services by ‘other competent providers’ require filling country-specific information gaps, including, for example, those relating to provider category, facility type and women’s perspectives.
- Undertake a situation analysis to understand the positive or enabling factors that already exist within each country to support other competent providers in providing abortion/MR/PAC services and learn from these on-the-ground experiences.
- Undertake operations research in different contexts in the region. Such research is needed in order to provide a better understanding of various health system level implications for expanding the provider base for abortion to include other competent providers, as also to understand the acceptability and feasibility of abortion/MR/PAC service provision by them. Topics may include, for example, a comparison of: MR services provided by nurses versus physicians in Bangladesh, PAC services provided by nurses versus community midwives in Pakistan, abortion services provided by nurses in the public sector compared to those in the NGO sector in Nepal, and services provided by different AYUSH* doctors in India.
- Once systems are in place, undertake operations research to assess the provision of CAC and PAC services. Topics may include such issues as: access (availability, affordability, inequity) and specifically, how to operationalise service delivery in difficult-to-reach populations, quality of service provision and care, acceptability of the provision of services by other competent providers among women, especially poor women; costing and cost-effectiveness, counselling practices, post-abortion contraception uptake among clients of other competent providers, and safety and acceptability of

* AYUSH encompasses physicians trained in Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy; a separate Department of AYUSH has been set up in Ministry of Health and Family Welfare, Government of India; for the provision of services relating to these officially recognised Indian systems of medicine.

abortion provided by other competent providers in private and NGO versus public sector facilities.

- Undertake qualitative studies to better understand the experiences of other competent providers in providing abortion and PAC services, and their perspectives on factors enabling them to sustain service provision (for example, monetary incentives, supportive supervision, job satisfaction).
- Assess the extent to which expanding the provider base to include other competent providers can increase the uptake of post-abortion contraception.
- Assess the feasibility of outreach or in-community provision of abortion/MR/PAC services versus the provision of these services at facility level.
- Assess the role of “new providers” such as chemists or pharmacists and the role they can play in providing information, assessing gestation cut-off points, or referring women to appropriate facilities.

7. Strengthen the role of civil society and professional associations in facilitating the expansion of the provider base for abortion and post-abortion care services

The consultation appreciated the role that civil society organisations, including abortion advocacy groups, NGOs and professional associations have played and can play in expanding the provider base, and highlighted several areas in which further efforts are needed, as follows:

- Civil society groups can play an important role in advocating for changes in government policies relating to the provision of abortion and PAC services by other competent providers.
- There is need for an alliance of different stakeholders to build a consensus with regard to ways of expanding access to safe abortion/MR/PAC services (as appropriate, in each country’s legal context), including by other competent providers. Such an alliance can play a key role in enabling countries of the region share experiences, emerging issues and new evidence on the one hand, and in mapping, at country level, the full range of stakeholders and including their perspectives in efforts to increase the provider base, on the other.

- There is a need to allay misgivings that persist among some physicians and other health care professionals about the feasibility of the provision of abortion and PAC services by other competent providers, and convey to them that task sharing with regard to the provision of abortion and post-abortion services by other competent providers complements rather than competes with the responsibilities of physicians.
- There is a need for closer linkages between various professional bodies, notably physician and nursing-midwifery associations.
- Civil society groups can play a significant awareness-building role in informing communities about the legal situation with regard to abortion and, more specifically, about the importance of seeking early abortion and of seeking abortion from a qualified provider, the dangers of unsafe abortion and the conditions under which abortion services are available (where restricted) and the availability of PAC services. At the same time, they can raise awareness of the role of other competent providers in providing abortion and PAC services (where their services are already legal) or assisting in the provision of abortion services (where their services are not yet legal).
- Civil society groups and health serving NGOs should contribute to efforts to train or orient other competent providers with regard to counselling techniques and respect for women's rights.
- There is concern about possible misgivings among some women's health advocates about the provision of abortion and PAC services by other competent providers. In this context, efforts are needed that apprise this important constituency about the feasibility of the provision of these services by other competent providers. At the same time, it is important that efforts are made to address the concerns of this important constituency about compromised quality of care or the possible effect on sex selective abortion.

8. Until such time as legislation is passed, focus on involving other competent providers in abortion services within the current legal context

The Consultation recognised that passing legislation may not take place with immediate effect, but stressed the need to immediately initiate other activities, within the scope of existing legislation that may facilitate the transition to

independent provision of abortion services by other competent providers once legislation is passed. These activities may include, for example, the following:

- Other competent providers may be involved in all permissible roles in assisting the provision of abortion, for example pre- and post-abortion counselling, assessment of eligibility through pelvic examination, PAC including treatment of incomplete abortion as part of the EMOc package.
- Efforts to revise pre- service training materials to include theory on MR, abortion (MVA/MA), CAC and/or PAC services, as appropriate, in each country's legal context, for other competent providers, as described in Recommendation 2 above, should be put into practice in anticipation of eventual changes in laws, rules, regulations and/or policies.

9. Support and fund the shift to the provision of abortion services by other competent providers

Recognising that resources will need to be allocated for training and monitoring of service provision by other competent providers and conducting operations research, the Consultation recommended that participants and governments explore ways of raising the necessary resources. More specifically, the Consultation recommended that governments:

- Allocate greater resources for training, supervision and monitoring of abortion service provision by other competent providers and for operations research in priority areas.
- Make adequate preparations for the roll out of service provision by other competent providers once appropriate amendments are made to laws and policies.

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PARTICIPANTS

Expanding access to safe abortion and/or post-abortion care (PAC) in South Asia: Is expanding the provider base a feasible option?

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