Health worker roles in safe abortion care and post-abortion contraception

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Although safe, effective, evidence-based interventions that are simple enough to be provided at primary-care level exist, provision of safe abortion remains restricted to physicians and often only to gynaecologists in many parts of the world. WHO's new guideline *Health worker roles in providing safe abortion care and post-abortion contraception*[1] highlights that moving beyond specialists and enabling a wide range of health workers in safe abortion care promotes a rational use of the available health workforce and facilitates equitable and timely access to care. This is essential in settings where shortages of skilled workers are the most acute, but is also relevant in high-income countries to address subnational imbalances and to promote care that might better meet women's needs.

The guideline was developed from a systematic search, synthesis, and assessment of the evidence. The search identified 36 studies on safety and effectiveness and 204 qualitative studies that looked at acceptability and feasibility. Data came from both high-resource and low-resource settings and included a case study synthesis of five country contexts where abortion-related task shifting has occurred to various degrees (Bangladesh, Ethiopia, Nepal, South Africa, and Uruguay). In keeping with WHO's broad and inclusive definition of health workers, a wide range of health worker types were considered.[2]

The guideline emphasises that abortion and post-abortion care in the first trimester has the greatest potential for expansion of health worker roles. Vacuum aspiration is a primary-care outpatient procedure that can be safely provided by associate clinicians, midwives, nurses, and, in specific circumstances, other workers such as auxiliary nurse midwives. Medical abortion, which uses drugs instead of a surgical intervention, further simplifies the requirements of infrastructure and skills needed and in addition to the health workers listed above, also makes it plausible to consider the roles of providers such as pharmacists and lay health workers who are located outside of a health facility. Although the currently available evidence is not sufficient to recommend independent provision of medical abortion by these cadres, their roles in specific components of care (eg, assessing gestational age and providing information on the appropriate use of drugs) has potential and should be tested under research conditions.

Moreover, the guideline recognises that women themselves are essential actors in managing their own health care. Acknowledging this role as an empowering and active extension of task sharing in health systems, the guideline includes recommendations on women's roles in medical abortion in early pregnancy. Recommendations include women managing the drugs and abortion process outside of a facility, without the direct supervision of a provider and using self-assessment approaches to determining abortion completion. These recommendations are limited to contexts in which women have access to appropriate information and to back-up health care should they need or want it and not an endorsement of women having to resort to clandestine self-use of drugs out of desperation or lack of options.

Although provision of care in later pregnancy remains a more specialised skill, facility-based non-physician health workers can play supportive roles—for example providing cervical priming before dilatation and evacuation or in caring for women in the interval between administration of medications and completion of the abortion process.

Post-abortion contraceptive methods such as intra-uterine devices and implants can also be provided by a range of facility-based health workers. In addition, pharmacists and, in specific circumstances, lay health workers and pharmacy workers can provide injectable contraceptives. The guideline also supports self-administration of injectable contraception in specific circumstances.

The recommendations assume that the assigned health workers will receive task-specific competency-based training and that the interventions will be implemented in accordance with existing WHO clinical care guidance.[3,4] Implementation also requires functioning mechanisms of monitoring, mentoring, and support to health workers taking on these additional roles. Implicit in the implementation is decentralisation of early abortion care to the primary care level, creating

referral linkages and the development of training materials, tools, and mechanisms for a supply of good quality drugs within a regulated and monitored health systems context. These are in fact basic requirements of a health system irrespective of the level of specialisation of providers. Ironically, though, it is often in contexts with dysfunctional or disrupted health systems that task shifting is most needed to reach vulnerable women.

The options in the guideline are intended to be inclusive and to facilitate evidence-based adaptation to the context of local health workforce dynamics, resources, and public health needs. One or more legal grounds for providing safe abortion exist in most countries, and the management of incomplete abortion is a signal function of emergency obstetric care. Additionally, provision of care for post-abortion complications is universally allowed, hence the scope for expansion of health worker roles and the implementation of these recommendations exists everywhere.

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