Virtual Expert Group Meeting to Review Competency-Based Pre-Service Curriculum and Training Resources for Safe Abortion

19 – 21 May 2021, New Delhi, India

A Virtual Expert Group Meeting to Review Competency-Based Pre-Service Curriculum and Training Resources for Safe Abortion was held from 19 – 21 May 2021. The meeting was organized by WHO-CC for Research in Human Reproduction, Department of Obstetrics & Gynecology, AIIMS, New Delhi in collaboration with WHO SEARO.

The Objective of the meeting held was to orient the Experts from South-East Region on the draft competency-based pre-service training tool in CAC, finalize and plan for rollout.

Day 1: 19 May 2021

Prof. Sunesh Kumar, Director in charge of WHO-CCR, AIIMS, gave the welcome address to all participants of the meeting and thanked them for taking time out and being there. He spoke on how in spite of liberal laws in the member country states, we continue to lose a large number of young women due to complications related to abortions. Making liberal laws, availability of abortion facilities in government health facilities have saved many a life *but* a large number of women continue to die due to three abortion-related complications viz., Infections, Haemorrhage and Uterine Perforations. The Department of UHC/ Family Health (FGL), WHO SEARO has been making a concerted effort to make "Abortions Safe and Avoid related morbidity and mortality". He then informed the group on collaboration with WHO SEARO in developing teaching and a training module targeted at Final year MBBS students and interns to impart knowledge about "Safe Abortion Practices and Early Identification of Complications". The modules have been pretested at AIIMS, Kathmandu and Seva Gram (Maharashtra). He requested the experts from Medical Councils of the Member States and Medical Universities to deliberate on the tool and give suggestions since the aim was to introduce this Teaching-Training Resource Material in the final year MBBS teaching curriculum.

After the welcome address, Dr Meera Upadhyay, Technical Officer-Reproductive Health introduced all the participants to the Group and gave a brief outline of the objectives of the meeting. This

meeting was planned to strengthen pre-service training in CAC, share the draft training resources and receive input on the syllabus with relevant stakeholders. Strengthening the preservice training is important and cost-effective for the country to improve access and quality SRHR services. Service providers with sound knowledge, appropriate skills and a good attitude towards abortion, availability of methods of safe abortion services, standardized health facilities to provide abortion and post-abortion services are important to reduce complications due to unsafe abortion.

Following this, Dr Neena Raina, Senior Advisor- Reproductive, Maternal, Newborn, Child & Adolescent Health and Ageing (MCA) delivered her Opening Remarks and the idea behind the need to update the MBBS Curriculum. She said that amidst the Covid Pandemic world over, there are some achievements done over the last few years in SEAR Region that need to be highlighted. Some of them are -Reduction in Maternal Mortality, a significant reduction in fertility rates due to investment in safe motherhood, a decrease in the number of adolescents giving birth and a reduction in the rate of unintended pregnancies. Maternal mortality although showing reductions needs to be brought down further. Unsafe abortion is the cause of serious complications and disability for millions of women each year and is a prominent cause of maternal death. India, for example, spends a lot of resources on training, especially in-service training. The time has come to instill the updated guidelines of WHO (which are followed by the government also) in the medical undergraduate Curriculum. Strengthening the preservice curriculum of undergraduate medical courses by incorporating teaching on different aspects related to abortion, post-abortion care and family planning services will help to expand evidence-based safe abortion practices. Subsequently, it will contribute to the reduction of maternal morbidity and death due to complications of abortion. She ended her talk by saying that she hopes to see in the next year that the curriculum has been updated.

After this, Dr. Sumita Ghosh, Additional Commissioner MOHFW, India gave a small presentation on Comprehensive Abortion Care (CAC) in India: Present Situation and Future Plan. She spoke on the Amendment of the MTP Act of India which took so many years to happen and now will benefit so many women. The key components of CAC are -Health Facility preparedness, List of Trained Providers and availability of district Level committees and Permanent Medical Boards. In India, more than 10 lakh women have been provided abortion care services -out of which spontaneous and induced abortions were 51 and 49% respectively. Presently, more than 6300 Health Facility preparedness is there in India. Capacity Building related to CAC is being imparted to MBBS Doctors

Presently 15457, MBBS doctors, 50469 Nurses and 2,66,158 ASHA's have been trained. Currently, there are 665 district Level committees and 172 Permanent Medical Boards in India. She highlighted the Key amendments of the new Medical Termination of Pregnancy (Amendment) Act 2021 which expands access to safe and legal abortion services on therapeutic, eugenic, humanitarian and social grounds to ensure universal access to comprehensive care.

i) Increasing the upper gestation limit from 20 to 24 weeks for special categories of women, including survivors of rape, victims of incest and other vulnerable women (differently abled women, minors, among others).
ii) The opinion of one provider needed for the termination of pregnancy up to 20 weeks of gestation. Requirement of the opinion of two providers for the termination of pregnancy from 20-24 weeks of gestation.
iii) Upper gestation limit to not apply in cases of substantial fetal abnormalities diagnosed by a Medical Board.
iv) Confidentiality clause. The name and other particulars of a woman whose pregnancy has been terminated cannot be revealed except to a person authorized by law.
v) Extended MTP services under the failure of the contraceptive clause to unmarried women to provide access to safe abortion based on a woman's choice, irrespective of marital status.

The Future Plan of MOHW is to form

i) Rules under the new Medical Termination of Pregnancy (Amendment) Act 2021 and disseminate the learnings of the Act all over India. The plan involves improving the facility preparedness, Training of Providers, quality of Training being given and increasing no of facilities providing CAC.
ii) Review of draft competency-based pre-service training tool in CAC which was tested on interns posted in Obstetrics and Gynaecology department in two medical Colleges by Expert Group from South-East Asia Curriculum on Abortion & Post-abortion care in countries of SEAR.
iii) Expert Group Consultation (National and International experts) to update and Plan a roll out Program on teaching and detailed learning materials on Comprehensive abortion care as part of undergraduate MBBS curriculum, duration and schedule of training

After the talk by Dr Sumita Ghosh was the Session on- Situation in SEAR Countries: Magnitude of Problem: Abortion related maternal morbidity and mortality and MBBS Curriculum and Interns training in various countries with respect to abortion. The Chairpersons were Prof Sunesh Kumar and Prof Manju Puri, HOD Department of O&G, LHMC. In the Session, the Experts from different Counties spoke about -Magnitude (Regional and Country) of abortion and Abortion related maternal morbidity and mortality and impact on maternal health; Laws and /acts /policies related to abortion(Country specific); Discuss the country's legal context and its implications of safe and unsafe abortion; MBBS Curriculum and Interns training in various countries with respect to abortion; Abortion taught when; Practical exposure and Identified gaps ??

Dr Firdousi Begum from Bangladesh gave the first presentation about the prevailing MTP Act and the changes being made in Medical Curriculum. Menstrual Regulation has been a part of Family planning in Bangladesh since 1979. Abortion is responsible for 7% of maternal deaths in Bangladesh (2016). CAC is there in Curriculum but needs to be emphasized especially the post-partum contraception and care. She informed the group that they are in the process if updating Undergraduate MBBs Curriculum and will update accordingly.

Dr K Aparna Sharma then presented the Situation in India. The total No of abortions in India in 2015 were 15.6 million out of which 5% were unsafe abortions The no of illegal abortions is almost similar across SEAR In 2007-11 in India 4.8% of all pregnancies were abortions, out of which 67.1% were unsafe and contributed to 0.3% of all maternal deaths She then presented the current teaching program related to abortion in India which showed that it needs updating. This was followed by a presentation by Dr Jumailath Begum from Maldives. She informed the group that medical school has started in Maldives in 2019 and is affiliated with Malaysia. The maternal deaths recorded in 2017 were 7 and in 2019 were nil and none were related to abortion. Abortion is legal only in certain conditions in Maldives.

Then Dr Chanda Karki from Nepal then gave the presentation. She said that abortion is legally liberal in Nepal up to 12 weeks of pregnancy and up to 28 weeks in special conditions. Medical Abortion presently is 50 % of all cases and appropriate training for medical abortion needs to be given right from undergraduate days. They are planning to have Skill evaluation and computer-based training for undergraduates. The last presentation was from Sri Lanka by Prof. Vajira H. W. Dissanayake, President- Sri Lanka Medical Council. In his presentation, he highlighted that

contraceptive prevalence is 67%. The maternal deaths in absolute numbers were 93 in 2019 and only one case was due to abortion. Post-abortion care is given in Sri Lanka and women are very well informed. There is a strong health system in Sri Lanka. After the last session, there was a discussion that Interns should be trained on providing medical abortion.

The sessions then ended for the day.

Day 2: 20 May 2021

At the beginning, Dr Meera Upadhyay gave a recap of the previous day. This was followed by a Session chaired by Prof Sunesh Kumar and Dr Manju Puri In the Session there was an overview of the Situation of Abortion in Major Cities and Medical Colleges of India and the Previous 5 Years' Experience by experts from different medical colleges of the country. **Prof Papa Dasari** from JIPMER, Pondicherry gave the presentation first. She gave her experience of the last three years. A total of 640 MTPs done in the last 3 years (in their medical college) making 1.22% of all pregnancies with an almost equal no of first and second-trimester pregnancies. The no of MTPS in the year was only 110 in number. The main indication of MTPs was congenital anomaly risk (38.28%) followed by 7.99% due to socio-economic reasons. The reason for saving the health of the mother was17.38%. In the second trimester the majority of the reason was congenital anomalies. About 40 % MTP was done by medical methods with only 9.5% by surgical methods. In about 48.9% both medical and surgical methods were used.

This was followed by a presentation from Dr Vinita Suri from Chandigarh. A total of 1655 MTPs done in the last 5 years with 691 and 964 first and second trimester MTPs respectively. PGI being a tertiary center caters to second trimester MTP cases which are referred. The majority of the indication was congenital anomaly followed by mental and physical stress to the mother. Out of a total of 691 MTPs first trimester, the medical methods used were 62.9% and surgical 38.9%. Out of total 964 MTPs second trimester, medical methods used were 94.7 % and hysterotomy in special conditions approximately 3% and combination of Prostaglandin, intraamniotic saline infusion and oxytocin drip in 2.3% approximately. Post-abortion contraceptives were mainly barrier (79.6%), CuT in 12.4% and permanent methods in 5.35 only. The rate of septic abortions was 12.6 and 9.1% in 2016 and 2020 respectively. Maternal mortality due to abortions was 1.4and 5.1 % in 2016 and 2020 respectively. The cause of post-abortion maternal death was 92.8 % due to sepsis and 1.25 %

due to post-abortion hemorrhage. She summarized that young doctors need to be trained properly because if abortions are done properly they are safe and no risk to women.

Dr Uma Singh from KGMU Lucknow then gave her presentation. In her area over the last few years, they noticed a dip in unsafe abortions and abortion-related complications but following Covid again the rates have increased. The total no of abortions was 460(0.51%) and 140(0.37%) of total Gynaecology OPD cases in 2016 and 2020 respectively. The MTP was 76.7 and 62.14 % of all abortions in 2016 and 2020 respectively. Out of all MTPs, the medical and surgical methods were 30.3 and 69.7% in 2016 and 60.9 and 39.1% in 2020 respectively. The rate of septic abortions was 16 and 14.3% in 2016 and 2020 respectively. The rate of laparotomy following abortions was 7.8% each in 2016 and 2020 respectively.

Her talk was followed by a presentation by Dr Manika Agarwal from NEIGRIHMS, Shillong. She told about the demographics of Shillong where most people considered abortion as a sin. A total of 280 and 279 abortions were recorded in 2018 and 2019 respectively where incomplete abortions were 51.07 and 53.7 % respectively. As per her opinion interns presently observe 10-15 D&C E procedures. They need to be taught the skill and role of medical abortion during their training

The session ended and was followed by a Presentation on Draft Pre-Service Training Tools for Undergraduate Medical Course on Comprehensive Abortion Care (CAC) by Dr Meera Upadhyay. She talked about the Regional situation and efforts being made towards SRHR.

In SEAR maternal mortality has reduced by 57.3% from 2007 to 2017. Unintended pregnancy rates and abortion rates are still high (2015-19). Abortion-related deaths as a percent of maternal mortality have fallen from nearly 12 to less than 4% over the last 10 years. The goal of the training of the MBBS undergraduates was to improve both knowledge and skill development on comprehensive abortion care. The objectives of the training will be to develop the competency and attitude of service providers. The training tool being developed is of interactive methodology including lectures, tutorials, role plays, videos, hands-on training. The Facilitator and Learner’s Guide have been prepared and also a logbook for the students to complete during training. She highlighted that training would cover all the topics related to CAC. The pilot training has been completed by AIIMS New Delhi, Kathmandu Medical College and MGIMS Wardha and has to be done in KGMU Lucknow

Dr K Aparna presented the experience of two-day training held for interns at AIIMS in August 2020. Interactive Methodology was used. There was a short lecture on Introduction to objectives, an overview of training methodology and training norms. A Pre-test assessment questionnaire was used for Knowledge assessment and then a Skill-based assessment was done on a model using the Skill assessment Checklist and scoring was done

The trainees were then divided into 4 groups with 2 facilitators on each table keeping a ratio of Trainer: Intern as 1:4.
The topic of Definition of Abortion & Demography, statistics was taught using power points. Ethical, medico-legal and social aspects of abortion with a brief focus on laws related to abortion with respect to countries were also taught using a PowerPoint. Then diagnostic scenarios related to types using Flip charts were held. Pre-abortion assessment and Counselling of a woman seeking a first-trimester abortion was taught by PPT and table discussion. The skill of history taking, general physical examination, and gynecological examination was taught under the supervision
Roleplay was used to teach counseling. The interns then did an Examination on anatomical models-Zoe simulator, different uterine sizes under supervision.
Different methods of abortion, discussion about the etiology and management of abortions including threatened, incomplete, inevitable, missed and septic abortion, Medical methods of abortion were initially discussed in small groups using PPT and a video was also shown. The doses, indications and prerequisites of medical abortion, the symptoms experienced by clients and the follow-up procedure were discussed. Surgical methods of abortion using PPTs were taught. The Facilitators discussed and demonstrated the technique on models. clinical hands-on experience done by all interns under the supervision of Facilitators. Post-abortion care was taught using role-play Complications of abortion and its management were discussed in small groups. There was a PPT and then a Case-based discussion. Post-abortion Contraception and counseling Practice with peers in simulation using role plays was done. Infection prevention was taught using PPTs
This was followed by a Post-test Questionnaire where knowledge gained was assessed. A hands-on skills session was then done by interns and the facilitators used the checklist to assess the skills
This was followed by a Focus Group Discussion. Everyone was asked to give their opinion on the teaching methods and asked for any suggestions and their view on having this type of training included in the MBBS Curriculum. It was very interactive, and all the interns agreed that the method

was really useful and skill-based teaching on the topic of Abortion should be included in the Final Year of MBBS

Dr Rachana Saha from Kathmandu College Nepal gave her experience. The training was held in two batches with a total duration of 24 days. Each day pre and post-test questionnaire was used for knowledge assessment. She summarized that in the training -MVA should be taught. The total duration of training for interns should be 10 days and pain management should be included also.

Dr Poonam Shiv Kumar from Wardha shared her Experience of Piloting Pre-Service Training Tool in Comprehensive Abortion Care – MGIMS. The training was held in two batches with 2 weeks in each batch. The training tool was used -pre and post-test questionnaires, case discussions, role-plays, and videos were used. She summarized that interns were very happy with the training and the training tool developed is very interactive and skill-based and should be included in the curriculum. After this, there was a small discussion and the sessions ended for the day.

Day 3: 21 May 2021

Dr Meera Upadhyay gave a recap of the topics covered on the previous day. The first presentation was by Sophia Sadinsky, MPP, Senior Global Policy Manager Guttmacher Institute. She took the session on -Investing in sexual and reproductive healthcare to prevent unsafe abortion in Southeast Asia. Unintended Pregnancies and abortions are experiences shared by millions of women all over the world. The rates are higher in low-income countries than in high-income ones. Over the period from 2015 to 2019, 61% of all unintended pregnancies ended in abortions. She gave an overview of rates of unmet needs of contraception in different countries of SEAR. In Myanmar, Bangladesh and Thailand the unmet needs of contraception were 23,26 and 9%. The most common method of contraception in Myanmar, Bangladesh and Thailand were injectables (41%), pills/patches/Rings (36%) and pills/patches/Rings (38%) respectively

She gave the link for more information on countries regarding abortion and contraceptive methods. After her talk was the Session on Further Course of action and how to integrate the changes in current MBBS Curriculum with the aim to bring down Maternal Mortality due to abortion. The Chairpersons were Prof Sunesh Kumar and Dr Alpesh Gandhi. -Dr Jaydeep Tank from India spoke first. He said that to bring down Maternal mortality due to abortions undergraduates need to be aware of public Health, taught soft skills, be aware of the prevailing laws and know about medical abortion. Currently, for abortion related skills, there is low demand and awareness from the students.

There is no glamour for them for the subject and a bit of altruism for the subject. At the same time, amongst the public, there is stigma related to abortion and limits the ability of providers to give abortion care. We need to bring up both demand and supply. The undergraduates should be given incentives related to work done on abortion like prizes /certificates/medals etc. we need to have a standard language related to abortion like using the term self-care rather than self-use etc. And the community has to be made aware of the facilities available. After his talk, Dr Chanda Joshi from Nepal gave her presentation. She said in the Curriculum we should know what to teach, how to teach and whom to teach and what to teach. First of all, the Curriculum has to be finalized, content has to be developed. The curriculum development team should make systemic decisions about learner's characteristics, intended outcomes, methodology and how to evaluate knowledge developed. Then pilot testing has to be done followed by evaluation again. The curriculum materials have to be developed and then volunteer training needs to be done. The Medical schools, Medical Boards and Nursing schools will have to be involved. After her talk, Dr Jumailath Begum from Maldives gave her opinion on further course of action. In Maldives, they are very new to medical school and the training modules are affiliated to universities in Malaysia. But they can work with their National Board and make necessary changes as per local requirements. After this Dr Ferdousi Begum from Bangladesh gave her presentation. She said that in Bangladesh there is a structured medical curriculum that is updated every 6-8 years. For the last two years the curriculum is being updated and they will finalize it after incorporating the changes essential for CAC. They will focus on Medical abortion and post-abortion care also.

After her talk, the next session was started. This was a panel discussion on How to Scale up the CAC. The Moderator was Prof Neerja Bhatla, Department of O&G AIIMS, New Delhi and discussants were members of Obstetrics & Gynaecology Society of countries participating in the meeting. Prof Neerja Bhatla welcomed everyone to the last session and invited everyone to give their points of view to how to scale up the incorporation of the new curriculum. Dr Mangala Dissanayake from Sri Lanka said that there is a challenge, they will have to prepare a Module to include abortion care and post-abortion family Planning in the training module in Sri Lanka. Ms Suria Begum from Bangladesh said that Midwifery is being promoted and is active in health promotion and an updated curriculum for midwives is also necessary. Dr Ganesh Dangal from Nepal said that there is a PG Training center and the provision of abortion care in the training needs to be included. Dr Jaydeep Tank was of the opinion that there is an overlap between old and new curricula.

Whatever extra should be incorporated, and pilot testing can be done on the extra additions. The training has to be updated for both under and postgraduates, especially the second-trimester topic has to be updated. Dr Vanita Suri from India said that the module for the second trimester has to be updated especially the indications, decision making, the role of the supervisor has to be included. Dr Achala Batra from SJH agreed to update of PG Curriculum. She also said that abortion care provided should not be necessarily be associated with mandatory contraception. Dr Ferdousi Begum said that the topic of unintended pregnancies and the role of contraceptives have to be included. The second-trimester module in their country will be specific to their national guidelines and law. Dr Preeti Kumar from India said that both under and postgraduates need to be trained. In post-graduation, PGs take this topic very casually and that needs to be changed. The scaling up of pilot training in India should be done and then extended to other countries as well. Mrs Momtaz Begum from Bangladesh said that nurses need to be trained as well since are equally involved in abortion care. Dr Manika from India said that abortion care can be taught to those undergraduates who want to pursue O& G training in the future. However, Dr Neerja said that it has to be comprehensive for everyone since all doctors need to know about abortion care since they might have to deal with this as they become seniors and also within the family. Dr Jaydeep Tank said that in the training has to be emphasized that women s choice has to be respected. After this Dr Neena Raina gave Closing statements. She thanked everyone for participating. She stressed three points. Firstly, the updated training package to be tested on a pilot basis by all countries and give suggestions. Secondly to participate in preparing a second-trimester training module. Thirdly to meet at least once a year for experience sharing and to document all their findings so that we can have evidence
After this the meeting ended and Prof Sunesh thanked everyone for active participation.

Recommendations

Phase I: Consolidating the Curriculum

Step 1: Validating the Curriculum Content

The CBC-CAC content should be validated by the expert group members for completeness and consistency with the available WHO guidelines and the country-specific requirements in relation to the existing laws and policies prevailing in various countries of the SEAR region.

Step 2: Augmented Piloting of the Curriculum Across Countries

The CBC-CAC needs to be piloted at various levels in different SEAR countries to include undergraduates and interns to assess the feasibility of implementation with special emphasis on inculcating the soft skills of communication and counseling related to abortion services. how soft skills could be taught with this tool.

Step 3: Development of Modules for Postgraduate Training and for Second Trimester Abortion

Separate training modules need to be developed for second-trimester abortion and the present module needs to be modified to address the postgraduate training.

Phase 2: Dissemination of Curriculum

1. ***Close Liaison with The Medical Councils***

   A close liaison with National Medical Councils for integration into undergraduate curriculum is required for the implementation of the CBC-CAC curriculum into routine undergraduate training

2. ***Evidence Generation***

   The work-related to pilot testing and implementation should be documented meticulously and collated to provide evidence for continued use and implementation and any subsequent changes if required.

3. ***Creating A Minimum Standard of Training for Offering Abortion Services for In-Service Health Care Providers***

The current curriculum can be used to operationalize the creation of a cadre of health care providers trained in offering (at least) medical abortion services from among the currently practicing health care workers. This needs to be country-specific based on the current guidance on levels of health care workers providing abortion.

4. ***Review Meeting for Dissemination and Experience Sharing***

A yearly review meeting should be conducted to understand the implementation and acceptance of the curriculum and the lacunae and challenges faced during the same.

5. ***Incorporation of the CAC-CBT in popular undergraduate textbooks***

There is a need to incorporate the content of the curriculum into the undergraduate textbooks of obstetrics and gynecology, to ensure uniform and compulsory exposure of all undergraduates to this curriculum.