EFFICIENT FUNCTIONING OF HEALTH SYSTEMS REQUIRES THAT SERVICES ARE TRIAGED TO OFFER THE APPROPRIATE LEVEL OF CARE. SAFE ABORTION IS LARGELY A PRIMARY CARE SERVICE THAT CAN BE SAFELY PROVIDED BY A RANGE OF NONPHYSICIAN HEALTH WORKERS. MANUAL VACUUM ASPIRATION (MVA) AND MEDICAL ABORTION ARE SIMPLE, NONINVASIVE, AND EFFECTIVE INTERVENTIONS THAT CAN BE SAFELY PROVIDED BY TRAINED HEALTH WORKERS, INCLUDING NONSPECIALIST PHYSICIANS, MIDWIVES, NURSES, AND AUXILIARIES AMONG OTHERS.

While the concept of task-sharing is relatively well established in maternal and child health, services related to abortion are often restricted to physicians (and in some contexts, OBGYN specialists) by law, policy, or practice. Following a rigorous process of evidence synthesis and review by the UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), the World Health Organization (WHO) published recommendations on which cadres of health worker could provide which services. The recommendations were based on a review of clinical as well as programmatic evidence on the safety, feasibility, and acceptability of task-sharing in abortion and postabortion care.\(^1\) The recommendations in the guideline are based on the premise that while task-sharing may be a necessary strategy to overcome an absolute or relative shortage of physicians, it is entirely appropriate to include a wider range of cadres of health workers in safe abortion care because there is ample evidence that they can provide care as safely and effectively as physician providers, and in many cases may be preferred by women.\(^1-3\)

Translated the guideline recommendations into national programs requires thoughtful consideration of the country's unique legal and health systems, and political, social, and cultural contexts. As a follow-up to the publication of the guideline and recommendations referred to above, HRP undertook a series of case studies in six diverse country contexts—Bangladesh, Colombia, Ghana, Mexico City (Mexico), Sweden, and Tunisia—to document lessons learned from efforts to implement task-sharing in abortion and/or postabortion care at scale. The case studies included a review of relevant country-level statistics, policy documents and academic literature, and discussions with key informants to validate and supplement the information. The case studies took place over the course of 6–9 months and culminated in presentations at a dedicated dissemination workshop held alongside the 2018 International Conference on Family Planning held in Kigali, Rwanda on November 11–12, 2018. This Supplement offers six standalone articles reporting on the findings from each of the case study country contexts and a seventh article synthesizing the key themes cutting across the six case studies.

The article from Bangladesh is an example of a low-resource context with a long history of including nonphysician health workers in the delivery of healthcare services.\(^4\) In fact, nonphysician health workers have been supported by national policies and technical guidelines as the main providers of their menstrual regulation program since its inception. While abortion is restricted in Bangladesh, menstrual regulation uses MVA or a combination of mifepristone and misoprostol.
to regulate the menstrual cycle when menstruation is absent for up to 10–12 weeks. The service is allowed and provided as part of the government family planning program. The case study on Bangladesh describes the advantages of a context with a strong public health program to provide services and highlights the ongoing challenges of maintaining the quality of the program and meeting the needs of the population despite the widespread implementation of task-sharing.

Colombia provides an example of a private abortion care service operating within a favorable policy environment but where service delivery in public facilities is not yet implemented to the full extent of the law. Abortion was partially decriminalized in Colombia in 2006 to permit abortion under three circumstances: when a woman’s life is in danger, when there is a fetal malformation incompatible with life, and when the pregnancy is due to sexual violence or insemination without consent. In the process of changing the abortion law, stakeholders had the foresight to include a range of health workers in developing the high-level guidelines governing the delivery of abortion care. Precedent was already set in other areas of health care. Regardless, attitudes about abortion from key stakeholders, including providers themselves, hinder full implementation of task-sharing.

Ghana is an example from sub-Saharan Africa and one of collaboration between the Ministry of Health and international nongovernmental organizations. It is also an illustration of building upon task-sharing precedent in other areas of reproductive and sexual health care. Awareness of the critical care gap when there is a shortage of available specialized physicians underpinned support for task-sharing in general. To fill this gap, midwives and other nonphysician health workers were trained to be able to take on specific tasks. Abortion care was eventually included on this list.

First trimester abortion was decriminalized in Mexico City in 2007. Mexico City, Mexico is unique among these contexts, as outside of the capital city, apart from a recent change in the Southern Mexican state of Oaxaca, abortion remains highly restricted. Although the initial guidelines offered a highly medicalized service, the introduction of mifepristone into public facilities has simplified service delivery. Although nonspecialist physicians are now permitted to be involved in care and the services can be delivered at the primary level, there remains resistance to further demedicalization and task-sharing. However, recent evidence of the effectiveness of nurse-led service delivery and a more general movement to (re) include midwives into maternal and sexual and reproductive health care are promising.

Midwives’ prominent role in sexual and reproductive health care in Sweden has been in place for decades. In this context, and with the introduction of medical abortion, this health worker cadre became the natural choice for involvement in service delivery. The authors of the article in this Supplement outline why they believe task-sharing was possible in the context of Sweden and highlight how, despite midwives’ lack of explicit responsibility for abortion care in Sweden, they have had a dominant role. Several of the research studies that have been conducted with midwives in Sweden have been used to support the introduction of medical abortion and task-sharing with midwives elsewhere in the world.

Like Sweden, Tunisia has produced important research on the efficacy of a medical abortion service delivered by midwives. Midwives had been responsible for various aspects of sexual and reproductive health for many decades, becoming involved in the delivery of medical abortion when it was introduced in the country in 2001. However, as the political and social environment of the country has become more conservative, barriers to access to safe abortion have been increasing, largely related to provider attitudes.

An additional paper presents an analysis of the cross-cutting themes and lessons learned across the six case study contexts. The author asks: What features do these six contexts share that have enabled the implementation of task-sharing in abortion care? The strategies highlighted in this article are informative for programs wishing to implement task-sharing in abortion care in their contexts.

In addition to the country case studies, a paper from India describes a participatory process of mapping country gaps, both in the availability of a healthcare workforce and in task-sharing policies/guidelines or practice in place. The exercise allows stakeholders to assess where they may need to invest energies to successfully bring the distribution of tasks among health workers in line with the WHO recommendations.

These case studies and the articles can serve as a valuable tool to facilitate knowledge translation and bridge the gap between the WHO recommendations and their transformation into country implementation.

**AUTHOR CONTRIBUTIONS**

AS and BG co-wrote the Editorial.

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**CONFLICTS OF INTEREST**

Both authors were involved in the development of the WHO guidelines.

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