SUMMARY BRIEF

World Health Organization

Task sharing to improve access to Family Planning/Contraception

Summary information

Problem:

Poor access to family planning services due to inadequate numbers of health workers or their uneven distribution

Option:

Enabling additional cadres of health workers to provide family planning services through competency-based training

Comparison:

Method delivered by other 'higher' clinical cadres or no method delivered

Setting:

Lower level and community/primary health care settings

Benefits of task sharing of contraceptive services:

- Offering contraception through a wide range of providers enables access and availability
- Evidence and experience support that various types of providers can safely and effectively provide contraception
- Sharing routine tasks with lower level cadres allows higher cadre clinicians more time to use their specialized skills.
- Access to contraception is part of a comprehensive sexual and reproductive health and rights package for women and men
- Policies are enforced to allow effective use of defined skills and competencies of the health workforce

RECOMMENDATIONS ON FAMILY PLANNING RELATED TO CADRES OF PROVIDERS

- The WHO recommends that family planning services and methods can be safely and effectively provided by different health worker cadres, under specified circumstances.
- Community health workers can safely and effectively provide the following contraceptive services: education and counselling, information on SDM, 2Day Method, and LAM; oral contraceptives and condoms; and hormonal injectables, under targeted monitoring and evaluation.
- Auxiliary nurses and auxiliary nurse midwives can safely and effectively provide education and counselling, information on SDM, 2Day Method, and LAM, oral contraceptives, condoms, hormonal injectables, and contraceptive implants; and (for auxiliary nurse midwives) IUDs.
- Nurses and midwives can safely and effectively provide education and counselling, information on SDM, 2Day Method, and LAM, oral contraceptives, condoms, hormonal injectables, contraceptive implants, and IUDs.
- WHO recommends further research on the safety and effectiveness of nurses and midwives delivering tubal ligation and vasectomy.
- Operators of retail outlets such as drugs shops and pharmacies and can safely and effectively provide contraceptive services commensurate with their clinical qualifications according to the cadres listed in this document.

Background

Globally, governments, civil society, multilateral organizations, donors, the private sector, and the research and development community have committed to enable 120 million more women and girls to use contraceptives by 2020. Furthermore, the Sustainable Development Goals (SDGs) aim to meet 75% of the global demand for contraception by 2030. To meet these goals, national programs will need to bring together many components, including social and behavior change, a gender and rights perspective, commodities, and quality service provision by adequately trained health providers.

However, in many countries, the numbers of properly trained health providers are not sufficient to address the need for contraception , and their distribution can mean women living in remote or hard to reach areas may lack access. Human resource shortages in the health sector are widely acknowledged as threats to the attainment of health related Sustainable Development Goals (SDGs).

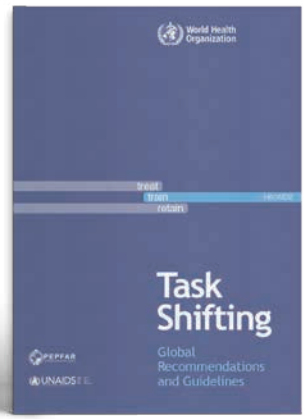
Contraception is an inexpensive and cost-effective intervention, but health workforce shortages and restrictive policies on the roles of mid- and lower-level cadres limit access to effective contraceptive methods in many settings. Expanding the provision of contraceptive methods to other health worker cadres can significantly improve access to contraception for all individuals and couples. Many countries have already enabled mid- and lower-level cadres of health workers to deliver a range of contraceptive methods, utilizing these cadres either alone or as part of teams within communities and/or health care facilities.

The WHO recognizes task sharing as a promising strategy for addressing the critical lack of health care workers to provide reproductive, maternal and newborn care in low-income countries. Task sharing is envisioned to create a more rational distribution of tasks and responsibilities among cadres of health workers to improve access and cost-effectiveness.

The WHO recommendations on task sharing FP services are based on the identified priority questions and critical outcomes, and the retrieval, assessment and synthesis of evidence. These are presented in the two documents: *Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting (published in December 2012) and Health worker roles in providing safe abortion care and post-abortion contraception* (published in July 2015), both of which have recommendations on task sharing for contraceptive services by different cadres. These guidelines documents made 48 recommendations on which contraceptive methods can be delivered safely and effectively by various health worker cadres.

The processes of enabling additional cadres to provide a specific health intervention is referred to here as 'task shifting' and 'task sharing', which are defined below:

Task shifting – refers to a process of delegation or rational distribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications to make more efficient use of the available human resources for health. Reorganizing the workforce in this way through task shifting usually presents a viable solution for improving health care coverage by making more efficient use of the human resources already available and by quickly increasing capacity while training and retention programmes are expanded.



http://www.who.int/healthsystems/TTR-TaskShifting.pdf?ua=1

Task sharing – refers to an expansion of the levels of health providers who can appropriately deliver health services. The term is used to emphasize the common performance of the entire clinical task, or key components of it, among teams of different cadres of health workers. Tasks are not taken away from one cadre and given to another, but rather that additional cadres are given the capacity to take on identified tasks. Task sharing enables this expansion to lay and mid-level healthcare professionals – such as nurses, midwives, clinical officers and community health workers– to safely provide clinical tasks and procedures that would otherwise be restricted to higher level cadres. It can be a vital strategy in overcoming the shortage of higher level providers in many settings. Even in well resourced health systems, task sharing can offer a means of providing services more efficiently, more cost effectively and in a less medicalized environment.

http://www.ghspjournal.org/content/3/3/327

They both reflect the same intention – to include cadres who do not normally have competencies for specific tasks to deliver them and to thereby increase levels of health care access. Both emphasize the need for training and continued educational support of all cadres of health workers in order for them to undertake the tasks they are to perform. The recommendations stated in this document generally would apply to task sharing or task shifting programmes.

Cadres of health workers included in the Task Sharing Guidelines

The health worker types considered in the guidelines are described in Table 1. The descriptions draw on a variety of sources including definitions used in the OptimizeMNH task-shifting guideline (1), and Health worker roles in providing safe abortion (2) and other WHO publications (3–8). Descriptions have been adapted to be generic enough to apply across settings (see Annex 1). They are indicative and illustrative and are not intended to substitute formal definitions of professional bodies or those used in specific countries and are not official WHO definitions.

Table 1. Summary table of cadres included in task shifting/sharing guidelines

Health Worker Type	Illustrative examples
Specialist doctor	Gynaecologist, obstetrician
Non-specialist doctor	Family doctor, general practitioner
Advanced associate and associate clinician	Assistant medical officer, clinical officer, medical licentiate practitioner, health officer, physician assistant, surgical technician, non-physician clinician, medical assistant, nurse practitioner
Midwife	Registered midwife, midwife, community midwife, nurse-midwife
Nurse	Registered nurse, clinical nurse specialist, licensed nurse, BSc nurse
Auxiliary nurse midwife (ANM) and auxiliary nurse	Auxiliary midwife, auxiliary nurse, ANMs, family welfare visitor
Doctor of complementary systems of medicine (mainly in South Asia)	Ayush doctor, Ayurvedic physician, non-allopathic physician
Pharmacist	Pharmacist, chemist, clinical pharmacist, community pharmacist
Pharmacy worker	Pharmacy assistant, pharmacy technician dispenser, pharmacist aide
Lay health worker	Community health worker, village health worker, traditional birth attendant, female community health volunteer
User / self	Woman, client

There are many variations in terms and definitions used for various cadres of providers of contraception. For any report or research on task sharing or human resources in health, these standard terms can be used, based on the local context, and can provide definitions of usual standards of practice, and if possible, descriptions of the prior training and accreditation procedures, whenever applicable. This would allow some flexibility in determining which guideline recommendation to follow, and for comparability across other reports and research.

Drug shops, pharmacies and other retail outlets:

Retail outlets such as drugs shops have been identified as important points of service provision in many settings, and can usually provide commodities including contraceptives. Drug shops are operated by a variety of cadres of providers for these services, ranging from physicians, nurses, midwives, pharmacists, pharmacy assistants, to lay health workers. The recommendations for providing contraception in these outlets are determined by the cadre of provider delivering the service, not the nature of the outlet.

Table of guideline recommendations for task sharing of contraception

FP Methods and Services Typically Offered by Cadre of Service Provider

National policies and service delivery guidelines dictate which cadres of providers can offer specific FP services. The chart below shows the FP methods that are typically offered by these cadres of providers based on recommendations from WHO.

Contraceptive Service	Lay Health Workers (e.g., CHWs)	Pharmacy Workers	Pharmacist	Auxiliary Nurse	Auxiliary Nurse Midwife	Nurse	Midwives	Associate/ Advanced Associate Clinicians	Non-specialist doctors	Specialist doctors
• Informed choice counselling • Combined oral contraceptives (COCs) • Progesterone-only oral contraceptives (POPs) • Emergency contraceptive pills (ECPs) • Standard Days Method and TwoDay Method • Lactational amenorrhea method (LAM) • Condoms (male & female), barrier methods, spermicides	✓*	✓*	✓*	✓*	✓*	✓*	✓*	✓*	✓*	✓*
• Injectable contraceptives (DMPA, NET-EN or CICs)	✓	✓	✓	✓	✓	✓*	✓*	✓*	✓*	✓*
• Implant insertion and removal	R	✗	✗	✓	✓	✓	✓	✓*	✓*	✓*
• Intrauterine device (IUD)	✗	✗	✗	R	✓	✓	✓	✓*	✓*	✓*
• Vasectomy (male sterilization)	✗*	✗*	✗*	R	R	R	R	✓*	✓*	✓*
• Tubal ligation (female sterilization)	✗*	✗*	✗*	✗*	✗*	R	R	✓*	✓*	✓*

✗* **Considered outside of the typical scope of practice; evidence not assessed.**	✗ **Recommended against**	R **Recommended in the context of rigorous research**	✓ **Recommended in specific circumstances**	✓ **Recommended**	✓* **Considered within typical scope of practice, evidence not assessed.**

All of the recommendations above assume that the assigned health workers will receive task specific training prior to implementation. The implementation of these recommendations also requires functioning mechanisms for monitoring, supervision, and referral.

The recommendations are applicable in both high- and low- resource settings. They provide a range of types of health workers who can perform the task safely and effectively. The options are intended to be inclusive, and do not imply either a preference for or an exclusion of any particular type of provider. The choice of specific health worker for a specific task will depend upon the needs and conditions of the local context.

Adapted from the WHO World Health Organization guidelines: *Optimizing health worker roles to improve access to key maternal and newborn interventions through task shifting* and *Health worker roles in providing safe abortion care and post-abortion contraception*.

Summary of guideline recommendations for task sharing of contraception

The following lists the recommendations from the Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting (published in December 2012) and Health worker roles in providing safe abortion care and post-abortion contraception (published in July 2015).

- **General counselling and sharing information on contraception**
- **Distribution of condoms (male and female), other barrier methods.**
- **Initiation and distribution of combined oral contraceptives, progestin only oral contraceptives, and emergency contraception**
- **General instructions for using Standard Days Method, TwoDay Method®, and Lactational Amenorrhea**

- Can be provided by all cadres within their established competencies. This includes the lay health workers. No additional reviews were performed or needed.

NOTES:

Provision of contraception by doctors of complementary systems of medicine is recommended only in contexts with established health system mechanisms for their participation in other tasks related to maternal and reproductive health. This option is feasible and may promote continuity of care for women and can increase access in regions where such providers form a significant proportion of the health workforce.

Provision of Emergency Contraception is not yet specified in these recommendations. Although emergency contraceptive pills are very safe and have few restrictions, evidence on their provision by lay health workers is lacking or has not been reviewed.

- **Delivery of injectable contraceptives using a standard syringe with needle for IM injection or for subcutaneous injection**

- Can be provided by nurses, midwives, associate clinicians and doctors, as part of their established competencies

- Recommended that these may be provided by auxiliary nurses, auxiliary nurse midwives

- Recommended that these may be provided by doctors of complementary medicine in specific circumstances

- Recommended that pharmacists may provide injectable contraceptives
  - Administering injections is within the typical scope of practice of pharmacists, and would require minimal additional training needs.

- Recommended that pharmacy workers may provide injections in specific circumstances
  - Administering injections is within the typical scope of practice for trained pharmacy workers, and thus would need minimal additional training needs. This practice could be under the direct supervision of pharmacists.

- Recommended that lay health workers may provide this with targeted monitoring and evaluation
  - There needs to be more rigorous evidence about the effectiveness or acceptability of lay heath workers providing injectable contraceptives in various contexts or conditions, especially when being considered for implementation and scaling up. Particular attention must be given to specific issues such as risks or harms for which little or no relevant information is available.

- If to be given by the woman or client, self-injection is recommended only in specific circumstances, particularly in contexts where mechanisms to provide the woman with appropriate information and training exist, referral linkages to health care providers are strong, and where monitoring and follow-up can be ensured.

NOTES:

The administration of an injectable involves using a standard syringe and may be intramuscular or subcutaneous. Compact pre-filled auto-disable devices are still not widely available.

For self-injection, the following are important considerations when making the self-injection option available:

+ adequate arrangements for storage and for keeping sharps safely at home;
+ training in and the provision of mechanisms for the safe and secure disposal of used injectable contraceptives (especially in settings with high HIV prevalence);
+ ensuring a way to procure injectable contraceptives on a regular basis without needing to repeatedly visit a health-care facility.

• Insertion and removal of IUDs

- Can be provided by associate clinicians and doctors as part of the established competencies *

- Guidelines recommend that these can be provided by auxiliary nurse midwives, nurses and midwives

- Guidelines recommend that these can be provided by auxiliary nurses only in the context of rigorous research

- Guidelines recommend that these can be provided by doctors of complementary systems of medicine in specific circumstances

- Guidelines do not recommend that these be provided by LHWs, pharmacists and pharmacy workers

- **Insertion and removal of contraceptive implants**

- Can be provided by associate clinicians and doctors as part of the established competencies *

- Guidelines recommend that these can be provided by nurses and midwives

- Guidelines recommend that these can be provided by auxiliary nurses and auxiliary nurse midwives under monitoring and evaluation

- Guidelines recommend that these can be provided by doctors of complementary systems of medicine under specific circumstances

- Guidelines do not recommend that these be provided by pharmacists and pharmacy workers