Task shifting is expanding the roles of family planning providers

Allowing lower-level providers to take on some of the responsibilities of higher-level providers could improve services

Key points

- Lower-level healthcare providers with appropriate training can provide some of the same services as higher-level providers.
- Sharing family planning tasks has the potential to free up time for higher-level providers, improve the quality of care, increase the use of contraceptives, and reduce the costs of providing services.
- Nurses and other mid-level providers can safely provide clinical methods of contraception, such as intrauterine devices, implants, and female sterilisation.
- Community health workers can provide high-quality services for a range of methods including progestin-only injectables and the Standard Days Method.

On a busy weekday at a rural family planning clinic in Senegal, a young woman enters the newly built facility. She announces that she is interested in birth control and would like to meet with a healthcare provider. The clinic is staffed by two registered nurses, a community nurse, and a doctor. But the doctor splits his time between this clinic and another one in a more urban area. Today he is at the urban centre.

After a short wait, the woman meets with one of the nurses. Upon learning about all the contraceptive methods for which she is eligible, the woman decides to try an intrauterine device (IUD), because she wants to prevent pregnancy for at least a few years and prefers a nonhormonal method that requires no daily or monthly upkeep. Unfortunately, the nurse says that she is not allowed to insert IUDs. She also tells the woman that the doctor who inserts them will not be back until next week. Discouraged and unwilling to try another method, the woman leaves for her long journey home—unprotected from an unintended pregnancy. Maybe she will be able to return to the clinic next week. Maybe she won't.

Incidents like this are common in parts of sub-Saharan Africa, especially in settings where only doctors are allowed to provide clinical methods of contraception. The region is experiencing a severe shortage of healthcare providers, including doctors trained in family planning.

The World Health Organization (WHO) recommends a minimum of 20 doctors per 100 000 people, yet many countries in sub-Saharan Africa have far fewer. In Senegal, for example, the latest statistics show only six doctors per 100 000 people.[1] Furthermore, most doctors work in urban areas, leaving rural women and couples in great need of services such as family planning.

Kerry Aradhya, Senior Science Writer, Family Health International, Research Triangle Park, NC, USA

Sharing tasks

Task shifting – allowing lower-level healthcare providers to perform some of the tasks normally reserved for higher-level providers – has been proposed as one way to overcome this shortage. The concept has been spreading rapidly and with intense urgency among providers of HIV prevention, care, and treatment services in many regions of Africa. Studies consistently show that task shifting in the provision of HIV services (such as distributing antiretroviral therapy) and other areas of healthcare can increase access, improve the coverage and quality of health services, and reduce the costs of providing services.[2]

Task shifting is not new. It has been occurring informally for decades within family planning programmes, especially to increase access to contraception for women and couples living in remote areas.

'A growing number of organisations including the World Health Organization, the US Agency for International Development, and many nongovernmental organisations are really interested in scaling up task shifting,'

A variety of healthcare workers stand outside a clinic offering family planning services in Ghana.

In July 2011, FHI became FHI 360.

FHI 360 is a nonprofit human development organization dedicated to improving lives in lasting ways by advancing integrated, locally driven solutions. Our staff includes experts in health, education, nutrition, environment, economic development, civil society, gender, youth, research and technology – creating a unique mix of capabilities to address today's interrelated development challenges. FHI 360 serves more than 60 countries, all 50 U.S. states and all U.S. territories.

Visit us at www.fhi360.org.

says John Stanback, the deputy director of PROGRESS, a project of Family Health International (FHI) that has a mandate to improve family planning and reproductive health in developing countries. 'Because of the global shortage of clinicians, they all recognise the necessity of making good use of other types of health workers.'

Empowering nurses

According to WHO, Africa has the highest ratio of nurses to doctors in the world.[3] This suggests an important opportunity to train nurses and other mid-level providers to offer clinical methods of contraception such as IUDs, implants, and female sterilisation. Decades of evidence show that nurses and other mid-level providers can safely deliver these long-acting and permanent methods (LAPMs), although the practice is not yet widespread (see 'Nurses ready for more: worldwide evidence').

Ghana, Tanzania, Nigeria, Uganda, and Kenya are among the African countries where mid-level providers routinely deliver long-acting, reversible methods of contraception. Although more countries are allowing nurses, nurse-midwives, and clinical officers to provide LAPMs, in general the policies have been slow to change.

'Nurses actually form the main cadre for providing both IUD and implant services in Kenya,' says FHI's Marsden Solomon, a physician who provides technical assistance to the Division of Reproductive Health within the Kenya Ministry of Public Health and Sanitation. 'Unfortunately, it is a different story with regard to permanent methods.'

Kenya's medical board allows only doctors to provide female sterilisations and vasectomy. As in other African countries, many doctors in Kenya are uncomfortable with the thought of mid-level staff providing surgical services.

Demanding clinical methods

Another common problem countries face in shifting tasks to mid-level providers is maintaining demand for LAPMs.

'In sub-Saharan Africa, the growth of modern contraceptive use is dominated by injectables,' says Barbara Janowitz, a senior research advisor at FHI. 'As a percentage of the method mix, long-acting and permanent methods have lost substantial ground in recent years.'

According to data from demographic and health surveys in Namibia, for instance, the percentage of female contraceptive users who are married or in a union and chose injectables rose from about 8% in 1992 to 22% in 2007. During the same period, the percentage who chose LAPMs rose from about 10% to only 12%.[4] Other countries have experienced similar trends.

©Dan nSalasatta

More nurses, like this one in Uganda, are beginning to provide clinical methods.

Although rates of use are still low in most countries, recent efforts to promote LAPMs could help. For instance, in June 2009, Kenya launched a national strategy to improve the uptake of LAPMs. Uganda is also taking steps to promote more task shifting. It is one of the few African countries that is making progress in allowing mid-level providers to perform female sterilisations and vasectomy.

'We recently changed our national sexual and reproductive health policy guidelines and service standards to allow mid-level providers, including clinical officers, to provide permanent methods of contraception if they are properly trained,' says Miriam Sentongo, a senior medical officer at the Uganda Ministry of Health. The policy can be fully implemented once a legal review of it has been conducted, supervision and monitoring tools have been developed, and interested mid-level providers who meet the

selection criteria for training have been identified.

'We have reached this decision because the unmet need for permanent methods is very high in Uganda, yet the doctors skilled in these methods are few, and they are not available in the rural areas where they are needed most,' Sentongo says.

Janowitz believes that more provision of LAPMs by mid-level providers is inevitable, especially given the shortage of doctors in rural areas.

'If women are demanding them and their availability is increasing, there is just no choice but for mid-level providers to deliver these methods. Need will determine function despite all the barriers,' she says. 'Plus, mid-level providers can specialise and provide the methods as well as or better than doctors and are often better at counselling. So as long as doctors can back them up on difficult cases, why not?'

Reaching communities

Shifting family planning tasks from doctors to nurses and other mid-level providers is only one way to address unmet need for family planning. To reach even more rural women and men, tasks are also being shifted from mid-level providers to community health workers (CHWs).

Community-based family planning programmes in Africa have traditionally provided only oral contraceptive pills and condoms. That is changing as years of evidence demonstrate that properly trained members of a community can safely and effectively provide a broader range of family planning methods.

In response to the growing popularity of injectables, FHI and Save the Children assessed the safety and feasibility of adding the injectable depot-medroxyprogesterone acetate (DMPA) to the mix of methods provided by CHWs in the Nakasongola District of Uganda in 2004 and 2005. Results from their pilot study of 945 first-time DMPA users showed that injections given by CHWs and clinic-based nurses were equally safe, that clients from both groups were satisfied with their services, and that about 88% of women from each group received a second injection of DMPA.[5]

Independently, but based in part on the evidence from Uganda, the Madagascar Ministry of Health, Family Planning, and Social Protection (MOHFPSP) changed its national norms and standards for reproductive health to include community-based access to DMPA. The next year, in 2007, the MOHFPSP partnered with FHI, Population Services International, and the local health project SantéNet on another pilot programme for integrating DMPA services into existing community-based family planning programmes. It was the first time that CHWs in Madagascar provided DMPA – and one of the first times that CHWs in Africa provided DMPA with public-sector support.

Sixty-two CHWs from 13 rural communities were trained to offer DMPA alongside the other methods they provided. After just 6 months, 1662 clients had accepted DMPA from a CHW. An evaluation showed that the CHWs provided high-quality DMPA services and that the workers, their supervisors, and their clients all found

Task shifting can also occur when pharmacists and drug shop operators take on some of the typical responsibilities of clinic-based providers. Here, a drug shop operator sells pharmaceutical drugs and contraceptives in upper Guinea.

community-based access to DMPA highly acceptable.[6]

The Standard Days Method (SDM) is another contraceptive that has only recently been introduced in community-based programmes. Operational research conducted by Georgetown University's Institute for Reproductive Health (IRH), where scientists developed the method, has shown that even low-literacy CHWs can provide high-quality SDM services.[7]

IRH is working in countries like Mali, Rwanda, the Democratic Republic of Congo, Guatemala, and India to introduce the SDM in a variety of community-based programmes. Other nongovernmental organisations have helped add the method to community-based programmes in countries such as Ethiopia, Zambia, Kyrgyzstan, Nigeria, and Senegal.

'Community-based distribution remains a relatively minor source of family planning services in places like Africa, but it reaches some of the women with the greatest need,' says Stanback. 'It's the addition of new methods to the community-based programmes that really has people interested, and this is important because the new methods are the ones that people want,' he says.

Gathering support

According to Stanback, as more countries expand their support of task shifting to include new types of providers and new contraceptive methods, it will be important to have the support of clinically trained providers, because they are the ones who will be supervising new cadres of paramedicals.

Although some providers still resist task shifting, support for the concept is growing. On February 28, 2008, six global professional organisations – among them the International Council of Nurses, the International Confederation of Midwives, the International Pharmaceutical Federation, and the World Medical Association – signed a joint health professions statement on task shifting.[8] The statement reads in part:

We, the representatives of more than 25 million health professionals, are committed to providing safe, accessible healthcare to the world's people. We understand all too well the impact of shortage of personnel, supplies and equipment on patients, families and providers. . . . We struggle with the dilemma of resource restrictions and meeting the needs of everyone – and the evidence that shows that better health outcomes occur when higher numbers of professionals are engaged in direct care.

References

1. World Health Organization. Global Health Atlas. Data query. Available: http://apps.who.int/globalatlas/dataQuery/default.asp.
2. Lehmann U, Van Damme W, Barten F, Sanders D. Task shifting: the answer to the human resources crisis in Africa? *Hum Resour Health* 2009; 7: 49.
3. World Health Organization. Working Together for Health: The World Health Report 2006. Geneva, Switzerland: World Health Organization, 2006.
4. Measure DHS. Statcompiler. Available: http://statcompiler.com/.
5. Stanback J, Mbonye A, Bekiita M. Contraceptive injections by community health workers in Uganda: a nonrandomized community trial. *Bull World Health Organ* 2007; 85: 768–73.
6. Hoke TH, Wheeler SB. *Safety, Feasiblity, and Acceptability of Community-based Distribution (CBD) of Depot Medroxy Progesterone Acetate (DMPA) in Madagascar*. Research Triangle Park, NC: Family Health International, 2008.
7. Personal communication, Susan Igras, Director of Field Programs, Institute for Reproductive Health, Georgetown University, June 25, 2009.
8. Joint Health Professions Statement on Task Shifting. February 28, 2008. Available: http://www.icn.ch/Statement_12_principles.pdf.

Nurses ready for more: worldwide evidence

IUDs: In a Brazilian study of 1,711 women requesting an IUD, the women who had an IUD inserted by a nurse were more likely to report a pain-free insertion than those who had an IUD inserted by a doctor.[1] A study of 367 IUD users in Nigeria, Turkey, and Mexico found similar results.[2] However, the studies also found that nonphysicians have more trouble inserting IUDs in nulliparous women and that their patients may have higher rates of expulsion or removal because of pain or bleeding. Competency-based training may help alleviate these risks.

Implants: In Indonesia, a study of 828 women who accepted Norplant from a physician or a nonphysician found that it took the two types of providers about the same amount of time to insert and remove the device. No significant differences were identified in terms of complication rates, which were low for both physicians and nonphysicians.[3]

Female sterilization: A study in Thailand compared the results of approximately 300 postpartum tubal ligations by minilaparotomy performed by doctors and by trained nurse-midwives. The nurse-midwives, who had at least one year of operating-room experience before the trial began, took longer than the doctors to complete the procedure. However, rates of postoperative complications were low for both groups—a finding that has been confirmed by subsequent studies.[4] More recent data suggest that nurse-midwives may be more thorough than doctors in counseling their patients about the procedure.[5]

References

1. Lassner KJ, Chen CH, Kropsch LA, et al. Comparative study of safety and efficacy of IUD insertions by physicians and nursing personnel in Brazil. *Bull Pan Am Health Organ* 1995; 29: 206–15.
2. Farr G, Rivera R, Amatya R. Non-physician insertion of IUDs: clinical outcomes among TCu380A insertions in three developing-country clinics. *Adv Contracept* 1998; 14: 45–57.
3. Affandi B, Prihartono J, Lubis F, et al. Insertion and removal of Norplant contraceptive implants by physicians and nonphysicians in an Indonesian clinic. *Stud Fam Plann* 1987; 18: 302–6.
4. Dusitsin N, Satayapan S. Sterilization of women by nurse-midwives in Thailand. *World Health Forum* 1984; 5: 259–62.
5. Kanchanasinith K, Piyapinyo P, Pitaktepsombati P, et al. Postpartum sterilization by nurse-midwives in Thailand. *Int Fam Plann Perspect* 1990; 16: 55–58.

Web resource

HRH Global Resource Center
www.hrhresourcecenter.org/taxonomy/term/67
Supported by the Capacity Project, this digital library is designed to strengthen human resources for health in developing countries. A collection of resources on task shifting is included.