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Expanding Roles for Family Planning Providers

This issue explores the progress made in allowing nonphysicians to provide selected family planning methods.

Sub-Saharan Africa is experiencing a severe shortage of health care providers, especially doctors. 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 Kenya, for example, the latest statistics show only 14 doctors per 100,000 people. Most of these doctors work in urban areas, leaving rural women and couples in great need of services such as family planning.

Allowing lower-level providers to perform some of the tasks normally reserved for higher-level providers has been proposed as one way to overcome this shortage.

According to WHO, Africa has the highest ratio of nurses to doctors when compared with other parts of the world. This suggests an important opportunity to train nurses and other mid-level providers to offer clinical methods of contraception such as intrauterine devices, implants, and female sterilization.

Opportunities also exist to allow trained community health workers to provide methods typically provided by mid-level providers. For example, an increased demand for injectable contraceptives has led several African countries to explore nonclinic-based mechanisms for providing this method.

In an effort to inform future policies and programs, WHO, the U.S. Agency for International Development, and FHI convened a technical consultation on expanding access to injectable contraception, held in Geneva in June 2009. The consultation concluded that there is sufficient evidence to support the introduction, continuation, and scale-up of community-based provision of progestin-only injectable contraception.

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.

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IN DEPTH

Sharing Family Planning Tasks

KEYPOINTS

- Lower-level health care providers with appropriate training can provide many of the same services, with equal quality, as higher-level providers.
- Sharing family planning tasks has the potential to clear time for higher-level providers, improve quality of care and contraceptive use, and reduce the costs of service provision.
- Support for this concept is growing but is not yet universal.

International organizations recognize the potential to improve services.

Task shifting (also known as task sharing) has been spreading rapidly and with intense urgency among providers of HIV prevention, care, and treatment services in Africa and other parts of the world. In these settings, lower-level health care providers are taking on many of the responsibilities, such as distributing antiretroviral therapy, typically reserved for higher-level providers. The lower-level providers are performing these tasks with equal quality and positive health outcomes, and collectively the different levels of providers are serving more patients.

Although less evidence has been gathered on the effects of task shifting on family planning services than on HIV services, policymakers are beginning to give the strategy the attention it deserves. Task shifting has actually been occurring for decades within family planning programs, especially to increase contraceptive access for women and couples living in remote areas.

"A growing number of organizations, including the World Health Organization, the U.S. Agency for International Development, and many nongovernmental organizations, are really interested in scaling up task shifting," says John Stanback, the deputy director of FHI's PROGRESS project, which has a mandate to improve family planning and reproductive health in developing countries. "Because of the global shortage of clinicians, they all recognize the necessity of making good use of other types of health workers."

Types of task shifting

Barbara Janowitz, a senior research advisor at FHI, suggests that there are two types of task shifting. The first type occurs within a clinic or other health facility, such as when a physician shares responsibilities with a nurse, nurse-midwife, or clinical officer. Demand for certain contraceptive methods (particularly long-acting methods like intrauterine devices

ADVANTAGES OF TASK SHIFTING . . .

- Task shifting frees time for higher-level providers. For example, if nurses and other paraprofessionals provide long-acting methods, doctors have more time to handle more complicated tasks.
- Lower-level providers can provide high-quality care. Because they are responsible for fewer tasks than higher-level providers, they may be more technically competent in those tasks. They may also know individual clients better and be able to spend more time with them.
- Increased access to contraception could lead to more contraceptive choice and higher rates of contraceptive use and continuation.
- Lower-level providers earn less, so task shifting could lower the costs of service provision. This may be especially true when tasks are shifted from a clinic to a community-based program.

. . . AND CONCERNS TO CONSIDER

- Although task shifting may free time for higher-level providers, providers may not use this time productively unless demand for other services is high.
- Giving lower-level providers too many responsibilities may overstretch their ability to provide high-quality care. Placing excessive demands and time constraints on community health workers could impair job performance.
- Task shifting may require additional supervision and training for lower-level providers, which increases costs. However, training needs may differ depending on the strength of a particular program and should be considered during cost-benefit analyses.

or implants) combined with overworked doctors may encourage this type of task shifting to reduce the amount of time doctors spend providing these methods.

The second type, designed to improve contraceptive access, occurs between two different supply outlets. An example is providers in a clinic sharing tasks with providers in a community-based program.

"By reducing the time and money clients spend trying to reach a clinic, the provision of contraceptives by community health workers can facilitate uptake and continued use of contraceptive methods," says Janowitz.

This type of task shifting can also occur between providers in a clinic-based program and those in a pharmacy or drug shop. Pharmacists and drug shop operators are quickly gaining popularity as providers of contraceptive methods, especially oral contraceptives. In many countries, they also provide a safe outlet for women seeking emergency contraception.

Supportive providers

When deciding whether and how to introduce and scale up task shifting, managers of family planning programs must consider a variety of issues. According to Janowitz, these include higher-level providers' use of newly freed time, additional training and supervision for lower-level providers, the effects on quality of care, and cost-effectiveness. Political barriers and resistance by higher-level providers must also be addressed.

"More countries are expanding their support of task shifting to include new types of providers and new contraceptive methods, but we still have a long way to go. It will be especially important, for instance, to have the support of clinically trained providers, since they are often the ones who will be supervising new cadres of paramedicals," says Stanback.

Although some providers still resist task shifting, support for the concept is growing. On February 28, 2008, six global professional organizations signed a joint health professions statement on task shifting. The International Council of Nurses, the International Confederation of Midwives, and the World Medical Association were among those that signed.

"We, the representatives of more than 25 million health professionals, are committed to providing safe, accessible health care to the world's people. We understand all too well the impact of shortage of personnel, supplies and equipment on patients, families and providers," say the signers of the statement. They continue, "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."

Resources

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 (such as the joint health professions statement on the topic) is included.

Community-Based Health Workers Can Safely and Effectively Administer Injectable Contraceptives: Conclusions from a Technical Consultation.
http://www.fhi.org/en/research/projects/progress/gtl/concba2i.htm
This short policy brief summarizes the conclusions from the recent consultation held by the World Health Organization, the U.S. Agency for International Development, and FHI. Background documents are also available.

A drug shop operator sells pharmaceutical drugs and contraceptives in upper Guinea.

FIELD RESEARCH REPORT

Nurses Ready for More

KEYPOINTS

- Nurses and other mid-level providers can safely provide long-acting and permanent methods of contraception.
- National policies allowing the provision of long-acting methods are more widespread than those allowing the provision of permanent methods.
- Demand and availability of the methods also affect their provision by mid-level providers.

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

Mid-level providers break through barriers.

Decades of evidence show that nurses and other mid-level providers can safely provide long-acting and permanent methods (LAPMs) of contraception including intrauterine devices (IUDs), implants, and female sterilization. However, despite strong examples of its feasibility and success, the provision of these methods by mid-level providers is not yet commonplace.

Ghana, Tanzania, Nigeria, Uganda, and Kenya are among the African countries where mid-level providers already deliver long-acting, reversible methods of contraception on a routine basis. But 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."

According to the medical board in Kenya, only doctors are allowed to provide female sterilizations and vasectomy. As in many African countries, doctors in Kenya are often uncomfortable with the thought of mid-level staff providing surgical services.

Demand for services

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 contraceptive users who chose injectables rose from about 8 percent in 1992 to 22 percent in 2007. During the same period, the percentage who chose LAPMs rose from about 10 percent to only 12 percent.

Although rates of use are still low in most countries, recent efforts to promote the methods may be helping. For example, Kenya launched a national strategy to improve the uptake of LAPMs in June 2009. And, Uganda is one of the few African countries that is making progress in allowing mid-level providers to perform female sterilizations 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. Once a legal review of the policy has been conducted, supervision and monitoring tools have been developed, and interested and trainable mid-level providers have been identified, then the policy can be fully implemented.

"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.

An example from India also shows how demand for LAPMs can influence who provides them. In rural India, most primary health centers are staffed by auxiliary nurse-midwives and their supervisors, known as lady health visitors. IUDs have become very popular at the health centers, but many of the staff are not trained to provide IUD services. In early 2008, with support of the chief medical officers and civil surgeons in

five districts of the state of Bihar, doctors from Pathfinder India trained more than 80 auxiliary nurse-midwives and lady health visitors to provide these services. More facilities in rural Bihar are now offering IUDs, and word is spreading through the communities that these services are available.[1]

Availability of methods

A similar scenario occurred in Kenya when, in 2002, the Kenya Ministry of Health changed its national family planning guidelines to allow nurses and clinical officers to insert and remove Norplant. Demand for the method was high, and over a four-month period 400 mid-level providers were trained to safely provide the method. They subsequently inserted more than 40,000 devices.[2] Unfortunately, stock outs of Norplant became frequent, as they are today for the simpler implants Implanon and Jadelle. However, the availability of implants is expected to increase because a low-cost alternative to Jadelle (known as Sino-implant) has recently been registered in Kenya and several other African countries.

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 specialize and provide the methods as well as or better than doctors and are often better at counseling. So, as long as doctors can back them up on difficult cases, why not?"

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Resource

Checklist for Screening Clients Who Want to Initiate Contraceptive Implants.
http://www.fhi.org/en/RH/Pubs/servdelivery/checklists/implants/index.htm
FHI's newest provider checklist is designed to help nurses and other health care providers screen women who have been counseled about their contraceptive options and have chosen to use implants.

WORLDWIDE EVIDENCE

IUDs. In a Brazilian study among 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 among 367 IUD users in Nigeria, Turkey, and Mexico found similar results.[2] But the studies also suggest 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 among 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 regardless of who provided the implant.[3]

Female sterilization. A study from Thailand compared the performance of doctors and trained nurse-midwives in performing approximately 300 postpartum tubal ligations by minilaparotomy. 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 in 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]

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PROGRAM DISPATCH

Contraceptives on the Road

KEYPOINTS

- Adding new contraceptive methods to community-based family planning programs can attract new contraceptive users.
- Recent data from Madagascar demonstrates the safety, feasibility, and acceptability of the provision of injectables by community health workers.
- Research from several countries shows that community health workers can provide high-quality services for the Standard Days Method.

Community health workers provide new methods.

Community health workers (CHWs) have been providing family planning services—particularly oral contraceptives and condoms—to rural women and men worldwide for decades. These community-based programs are gaining momentum as years of evidence demonstrate that properly trained members of a community can safely and effectively provide a broader range of methods.

"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 John Stanback, the deputy director of FHI's PROGRESS project, which has a mandate to improve family planning and reproductive health in developing countries. "It's the addition of new methods to the community-based programs that really has people interested, and this is important because the new methods are the ones that people really want," he says.

Adding injectables

In 2004 and 2005, FHI and Save the Children embarked on a pilot project to assess 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. Results among 945 first-time DMPA users showed that injections from CHWs and clinic-based nurses were equally safe, clients from both groups were satisfied with their services, and about 88 percent of women from each group received a second injection.[1]

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 program for integrating DMPA services into existing community-based family planning programs. 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.

HOW TO ADD A NEW METHOD TO AN EXISTING COMMUNITY-BASED PROGRAM . . .

- Assess the need to provide the method through the community-based program.
- Evaluate the cost of adding the method to the program.
- Consider how to incorporate the provision of the method into national regulations and service delivery guidelines.
- Advocate and mobilize communities to create and sustain demand and support for provision.
- Establish a logistics system to ensure a steady supply of commodities.
- Assess the capacity of existing CHWs to offer the method.
- Train the CHWs to competently provide the method.
- Enhance mechanisms to assure high-quality provision of the method.
- Monitor and document the outcomes of providing the method.

. . . AND ITS ANTICIPATED EFFECTS

- The effects of adding a method depend on the complexity of the method, the motivation and capacity of CHWs to provide it, the strength of training and retraining, the quality of supervision, the supply and resupply of the method, and efforts to inform the community that a new method exists.
- As more methods are added to a community-based program, clients will have more family planning choices. An improved selection of methods may attract new users and could increase client satisfaction and continuation rates.
- As more complex methods are added, the structure of the program may shift. Some countries are considering several types of CHWs—those who are educated and trained to provide clinical methods such as injectables and implants; those who are less educated but can provide nonclinical methods such as oral contraceptives, condoms, and the Standard Days Method; and those who work solely to promote better health, including family planning.

Sixty-two CHWs from 13 rural communities were trained to offer DMPA alongside the other methods they provided. After just six months, 1,662 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 community-based access to DMPA highly acceptable.[2]

"One of the other great results from both pilot projects is that the addition of injectables to the community-based programs seems to attract new contraceptive users," says Kirsten Krueger, a senior technical officer at FHI who coordinates advocacy and scale-up of the practice in Africa.

Adding a fertility awareness method

Research from Georgetown University's Institute for Reproductive Health (IRH) suggests that the addition of the Standard Days Method (SDM) to community-based programs is also attracting new family planning users.

"Our studies show that 60 percent to 70 percent of SDM users are first-time family planning users," says Susan Igras, the director of field programs at IRH. "Although the SDM brings new family planning users to both community-based programs and facility-based programs, these studies indicate that it brings relatively more new users to family planning at the community level."

The SDM is a natural and modern method of family planning developed by scientists at IRH to help women with menstrual cycles that are between 26 and 32 days long avoid unintended pregnancy. To use the method, most women rely on CycleBeads—a color-coded string of beads that helps them identify the days when they are most likely to become pregnant (cycle days 8 through 19) and avoid unprotected intercourse on those days. When used correctly, the method is 95 percent effective.

In the past few years, IRH has worked with several community-based programs to help introduce the SDM. Most of these efforts were part of operational research that showed that even low-literacy CHWs can provide high-quality SDM services.

In India, for example, IRH provided technical assistance to CARE India, the Community Aid and Sponsorship Program (CASP), and the Centre for Development and Population Activities (CEDPA) to introduce the SDM to community-based programs in both urban and rural programs. The most significant results were in the rural programs, where interviews revealed that 91 percent of the women were able to identify their fertile days by using the method after it was introduced (compared to 0 percent before the introduction). Moreover, contraceptive prevalence increased from 24 to 41 percent (with 7.5 percent of women using the SDM) over a one-year period.[3]

IRH continues to work in Mali, Rwanda, the Democratic Republic of Congo, Guatemala, and India to introduce the SDM into more community-based programs. Other nongovernmental organizations have helped add the method to community-based programs in countries such as Ethiopia, Zambia, Kyrgyzstan, Nigeria, and Senegal. Like the pilot projects that introduced injectables in Uganda and Madagascar, these efforts are reaching a relatively small population—in this case because the SDM remains new to community-based programs.

"In spite of all the evidence, decision makers are still reluctant to rely on the experiences of other countries when deciding whether to introduce new methods into existing community-based programs," says Krueger. "Unfortunately, at least in my view, countries will continue to want their own pilot projects until we reach that ultimate 'tipping point'—which is on the horizon now, I believe."

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Resources

Provision of Injectable Contraception Services through Community-Based Distribution: An Implementation Handbook.
http://www.fhi.org/en/rh/pubs/booksreports/cbd_dmpa_imp.htm

Offering CycleBeads: A Toolkit for Community Health Workers.
Find out more about IRH's soon-to-be-released publication by e-mailing: irhinfo@georgetown.edu.

A man and woman in Benin demonstrate CycleBeads to each other during a community discussion about the Standard Days Method.

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Lime juice not a viable microbicide

Many women in Nigeria believe that the intravaginal application of lime juice can protect them from HIV, other sexually transmitted infections, and pregnancy. However, a recent clinical trial by scientists at CONRAD and FHI suggests that the juice causes cell damage and is not safe when applied at concentrations of 50 percent or more. The findings were published in November 2008 in the *Journal of Acquired Immune Deficiency Syndromes*.

Forty-seven women were randomly assigned to apply either lime juice or water to their vaginas twice daily for two six-day intervals. Tissue examinations revealed deep disruptions of the epithelial surface in the vaginas of nine women who used a 50-percent or higher concentration of lime juice. Such damage could actually increase a woman's risk of HIV infection and transmission, according to the scientists who conducted the study.

Reducing child marriage

Child marriage—in which the female partner is often younger than 18 years old—can reduce a woman's reproductive choice, according to a recent survey from India.

The survey of 124,385 ever-married women, published in May 2009 in *The Lancet*, found that more than two-fifths of the women were married before the age of 18. Almost half were married before the age of 16. Women who married young were more likely to have more children and less spacing between them. The data also showed associations between child marriage and unwanted pregnancies, abortion, and sterilization.

This connection between child marriage and lack of reproductive choice indicates a need for more family planning interventions tailored to married adolescents. The study was conducted by scientists from Boston University's School of Public Health and its partners in the United States and India.

A global fund for family planning?

The field of family planning needs a global fund to help address the reproductive health needs of people in developing countries, according to the chair of sexual and reproductive health at University College London.

At the annual conference of the Optimum Population Trust, held in London in March 2009, Professor Judith Stephenson called for the dedication of more resources to improve family planning programs around the world. Because of the "long shadows" cast by coercive family planning programs in the 1970s and 1980s, many governments have neglected the importance of family planning, she says.

Establishing an international family planning fund similar to the Global Fund to Fight AIDS, Tuberculosis and Malaria would be one way to redirect international attention to this issue.

Intrauterine devices for use by adolescents

Clinicians should offer the intrauterine device (IUD) as a first-line contraceptive method to all women, including adolescents, say the authors of a recent systematic review published in June 2009 in the journal *Contraception*.

Scientists from the University of North Carolina and FHI evaluated the published evidence on adolescent use of IUDs, which consisted of six cohort studies and seven case-series reports.

Adolescents who used the IUD had low rates of pregnancy—ranging from 2 percent after six months of use to 11 percent after 48 months of use. Two studies compared use of the IUD to use of combined oral contraceptives; continuation rates for the IUD were similar to or better than those for pills.

Concern about impairing fertility has limited IUD use in young women in the past, but research in recent decades shows that prior IUD use is not associated with a significant increase in tubal infertility.