What is Task Sharing?

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FP2020 Goals

- There is a plan to add 120 new users of modern contraceptives by 2020.
- This is to address the unmet need for contraception.

- There are many factors to ensure meeting this goal, including providing commodities, providing quality of care services, within a gender and rights perspective by adequately trained health providers.

- However, the numbers of properly trained health providers are not enough to address the needs.
Background

- Lack of health providers who can provide services in countries or in selected hard to reach regions
- Human resource shortages in the health sector are widely acknowledged as threats to attainment of health related SDGs
- 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.
**Definitions**

- **Cadres** – levels or categories of providers in RMNCH
  - May be called different things in different areas, e.g. Community health worker, lay health worker, health volunteer

- **Task sharing** – usual providers retain task but involve or expand to other cadres

- **Task shifting** – delegate the task to other cadres
  - Highly contextual
  - Based on laws and policies
  - May need specific statements related to detection and referral/management of problems and complications
Why task-sharing?

- One response to the critical lack of health workers to deliver reproductive, maternal and newborn care, including FP/Contraceptive or abortion services

- Which tasks for these services can be moved/shared from higher level to lower level health workers?

- Need for guidance
WHO GUIDELINES AND DOCUMENTS

WHO recommendations

Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting

Health worker roles in providing safe abortion care and post-abortion contraception

Task shifting to improve access to contraceptive methods

OPTIMIZE MNH

Strengthening the capacity of community health workers to deliver care for sexual, reproductive, maternal, newborn, child and adolescent health

Technical brief by the H4+ (UNAIDS, UNFPA, UNICEF, UN Women, WHO and the World Bank)
Optimizing health worker roles to improve access of to Key Maternal and Newborn health Interventions through Task shifting/sharing

- A project supported by USAID, NORAD, Gynuity and others to look into the preparation of practice guidelines on the **effectiveness of using specific cadres of health providers and lay workers** in delivery of services on maternal and newborn health, **including family planning**

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**Health worker roles in providing safe abortion care and post-abortion contraception**

- This guideline thanks the Norwegian Knowledge Centre for the Health Services, Oslo, Norway, for their work in evidence synthesis and assessment, and the Norwegian Agency for Development Cooperation for supporting the staff’s time to work on this project.
  - Standardized operating procedures in accordance with the process described in the *WHO Handbook for guideline development.*
The Guideline Development Process

- WHO has internal regulations and standards for developing guidelines: *WHO Handbook for guideline development*
- WHO Guidelines Review Committee (GRC) monitors the guideline development process and ensures that the relevant regulations and standards are applied

\[
\text{proposal} \xrightarrow{} \text{content development} \\
\text{technical unit} \rightarrow \text{GRC} \rightarrow \text{technical unit} \rightarrow \text{GRC} \rightarrow \text{final approval}
\]
### Health worker category descriptions

<table>
<thead>
<tr>
<th>Broad category</th>
<th>Illustrative description for the purpose of the tasks covered in this guideline</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist doctor</td>
<td>For the purpose of this guideline, specialization refers to postgraduate clinical training and specialization in obstetrics and gynaecology.</td>
<td>Gynaecologist, obstetrician</td>
</tr>
<tr>
<td>Non-specialist doctor</td>
<td>For the purpose of this guideline, this refers to a medical doctor who holds a university-level degree in basic medical education with or without further training in general practice or family medicine, but not in obstetrics and gynaecology.</td>
<td>Family doctor, general practitioner, medical doctor</td>
</tr>
<tr>
<td>Advanced associate and associate clinician</td>
<td>For the purpose of this guideline, this refers to a professional clinician with basic competencies to diagnose and manage common medical and surgical conditions and also to perform some types of surgery. Training can vary by country, but generally requires 3–4 years post-secondary education in an established higher education institution. The clinician is registered and his or her practice is regulated by a national or subnational regulatory authority.</td>
<td>Assistant medical officer, clinical officer, medical licentiate practitioner, health officer, physician assistant, surgical technician, non-physician clinician, medical assistant, nurse practitioner</td>
</tr>
<tr>
<td>Midwife</td>
<td>For the purpose of this guideline, this refers to a person who has been registered by a state midwifery or similar regulatory authority and has been trained in the essential competencies for midwifery practice. Training typically lasts 3 or more years in nursing or midwifery school and leads to a university degree or the equivalent. A registered midwife has the full range of midwifery skills.</td>
<td>Registered midwife, midwife, community midwife, nurse-midwife</td>
</tr>
</tbody>
</table>
### Health worker category descriptions

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<tr>
<td>Nurse</td>
<td>For the purpose of this guideline, this refers to a person who has been legally authorized (registered) to practice after examination by a state board of nurse examiners or similar regulatory authority. Education includes 3 or more years in nursing school, and leads to a university or postgraduate university degree or the equivalent.</td>
<td>Registered nurse, clinical nurse specialist, licensed nurse, BSc nurse</td>
</tr>
<tr>
<td>Auxiliary nurse midwife and auxiliary nurse</td>
<td>For the purpose of this guideline, an auxiliary nurse is someone trained in basic nursing skills but not in nursing decision-making. An auxiliary nurse midwife has basic nursing skills and some midwifery competencies but is not fully qualified as a midwife. The level of training may vary from a few months to 2–3 years. A period of on-the-job training may be included, and sometimes formalized in apprenticeships.</td>
<td>Auxiliary midwife, auxiliary nurse, ANMs, family welfare visitor</td>
</tr>
<tr>
<td>Doctor of complementary systems of medicine</td>
<td>For the purpose of this guideline, this refers to a professional of traditional and complementary systems of medicine (non-allopathic physician) whose training includes a 4- or 5-year university degree that teaches the study of human anatomy, physiology, management of normal labour and the pharmacology of modern medicines used in obstetrics and gynaecology, in addition to their systems of medicine. For the purpose of this guideline, these doctors are included with reference to the provision of elements of abortion-related care as per conventional medical practice.</td>
<td>Ayush doctor, Ayurvedic physician, non-allopathic physician</td>
</tr>
</tbody>
</table>
## Health worker category descriptions

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<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacist</td>
<td>For the purpose of this guideline, this refers to a health practitioner who dispenses medicinal products. A pharmacist can counsel on the proper use and adverse effects of drugs and medicines following prescriptions issued by medical doctors/health professionals. Education includes university-level training in theoretical and practical pharmacy, pharmaceutical chemistry or a related field.</td>
<td>Pharmacist (USA), chemist (United Kingdom and the Commonwealth), clinical pharmacist, community pharmacist</td>
</tr>
<tr>
<td>Pharmacy worker</td>
<td>For the purpose of this guideline, this refers to technicians and assistants who perform a variety of tasks associated with dispensing medicinal products under the guidance of a pharmacist. They inventory, prepare and store medications and other pharmaceutical compounds and supplies, and may dispense medicines and drugs to clients and instruct on their use as prescribed by health professionals. Technicians typically receive 2–3 years training in a pharmaceutical school, with an award not equivalent to a university degree. Assistants have usually been through 2–3 years of secondary school with a subsequent period of on-the-job training or apprenticeship.</td>
<td>Pharmacy assistant, pharmacy technician dispenser, pharmacist aide, dispensary assistant</td>
</tr>
<tr>
<td>Broad category</td>
<td>Illustrative description for the purpose of the tasks covered in this guideline</td>
<td>Examples</td>
</tr>
<tr>
<td>----------------</td>
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</tr>
<tr>
<td>Lay health worker</td>
<td>Any health worker who performs functions related to health-care delivery; was trained in some way in the context of the intervention; but has received no formal professional or paraprofessional certificate or tertiary education degree. <em>Traditional birth attendant (TBA)</em>: A person who assists the mother during childbirth and who initially acquired their skills by delivering babies themselves or through an apprenticeship to other TBAs. Trained traditional birth attendants have received some level of biomedical training in pregnancy and childbirth care. In this guidance, trained TBAs are considered within the category of lay health workers.</td>
<td>Community health worker, village health worker, treatment supporter, promotores etc. Community Based Skilled Birth Attendant (Bangladesh); Dai (Pakistan); Bidan Kampong (Malaysia); Skilled Birth Attendants (Bangladesh); Traditional midwives (Guatemala); Dayas (Egypt)</td>
</tr>
</tbody>
</table>

From the Optimize MNH guidelines

From the Safe Abortion guidelines
Problems with cadre categories

- Different studies or reports cite various terminologies
  - Wide variations in the terminologies (and even definitions)
  - Better to look at definitions of provider cadres in the reports and try to fit into existing categories (not always available)
  - Definitions to include training background and existing competencies (but not always clearly stated)
  - Adaptability of guidelines not always feasible because of legal, policy, resource, or training issues.
  - Remuneration, scope of work, additional tasks.
Training Duration* and Remuneration of Community Health Workers (CHWs) Providing Injectables

CHWs receive salaries from the Ministry of Health

CHWs are volunteers and receive incentives, donations, and/or other remuneration.

*Training duration refers to the total amount of training that community health workers (CHWs) who provide injectables receive, and is not limited to CBA2I training.

Map is completed to the best of FHI 360’s knowledge. If you have suggestions or additions, please email: cba2i@fhi360.org

Updated January 2013
# Categories for recommendations

<table>
<thead>
<tr>
<th>Recommendation category</th>
<th>Symbol</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommended</td>
<td><img src="check.png" alt="Green Check" /></td>
<td>The benefits of implementing this option outweigh the possible harms. This option can be implemented, including at scale.</td>
</tr>
<tr>
<td>Recommended in specific circumstances</td>
<td><img src="check.png" alt="Green Check" /></td>
<td>The benefits of implementing this option outweigh the possible harms in specific circumstances. The specific circumstances are outlined for each recommendation. This option can be implemented under these specific circumstances.</td>
</tr>
<tr>
<td>Recommended in the context of rigorous research</td>
<td><img src="cross.png" alt="Red Circle" /></td>
<td>There are important uncertainties about this option (related to benefits, harms, acceptability and feasibility) and appropriate, well designed and rigorous research is needed to address these uncertainties.</td>
</tr>
<tr>
<td>Recommended against</td>
<td><img src="cross.png" alt="Red Cross" /></td>
<td>This option should not be implemented.</td>
</tr>
</tbody>
</table>
Summary of recommendations in OMH

<table>
<thead>
<tr>
<th>Lay Health Workers</th>
<th>Auxiliary Nurses</th>
<th>Auxiliary Nurse Midwife</th>
<th>Nurses</th>
<th>Midwives</th>
<th>Associate Clinicians</th>
<th>Advanced Level Clinicians</th>
<th>Non-Specialist Doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contraceptive delivery</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1.1–1.13 Promotion of maternal, newborn and reproductive health interventions</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>12.2 Initiation and maintenance of injectable contraceptives – standard syringe</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>12.3 Insertion and removal of intrauterine devices</td>
<td>✗</td>
<td>✗</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>12.4 Insertion and removal of contraceptive implants</td>
<td>✗</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>12.5 Tubal ligation</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>12.6 Vasectomy</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✔️</td>
</tr>
</tbody>
</table>

- ✔️ Recommended
- ✗ Consider in context of rigorous research
- ✔️ Recommended with monitoring and evaluation
- ✗ Recommend against

Colors:
- Green: Accepted as within competency
- Light green: Accepted as outside competency

hrp
# Summary of recommendation in Safe Ab HW

## Provision of post-abortion contraception

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Lay health workers</th>
<th>Pharmacy workers</th>
<th>Pharmacists</th>
<th>Doctors of complementary systems of medicine</th>
<th>Auxiliary nurses/ANMs</th>
<th>Nurses</th>
<th>Midwives</th>
<th>Associate/advanced associate doctors</th>
<th>Non-specialist doctors</th>
<th>Specialist doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insertion/removal of intrauterine devices (IUDs)</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✅</td>
<td>✅ (for ANMs)</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
</tr>
<tr>
<td>Insertion/removal of implants</td>
<td>🟠</td>
<td>✗</td>
<td>✗</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
</tr>
<tr>
<td>Initiation/continuation of injectable contraceptives</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
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</tr>
<tr>
<td>Tubal ligation</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
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<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
</tr>
</tbody>
</table>

* considered within typical scope of practice; evidence not assessed.
** considered outside of typical scope of practice; evidence not assessed.
RECOMMENDATIONS

12.0 Distribution of condoms and oral contraceptives – noted to be already within competencies, no review done
   - Issue of Emergency Contraception which needs other components of counseling, especially for those initiating use.

12.2 Delivery of injectable contraceptives using a standard syringe
   - LHW – Recommended with targeted monitoring and evaluation
   - AN / ANM – Recommended with note that monitoring of the standard of counseling should be part of the implementation
   - Nurses, midwives – within competencies
RECOMMENDATIONS

- **12.3 Delivery of IUDs**
  - LHWs – not recommended
  - AN – In the context of rigorous research
  - Others – recommended

- **12.4 Delivery of contraceptive implants**
  - LHWs – In the context of rigorous research and with LHWs with higher appropriate levels of training
    - (e.g. 6 to 12 months – determined at the country level) and who deliver care in a facility with sterile conditions (7 panel members dissented)
  - AN, ANM – with targeted monitoring and evaluation
  - Nurses and midwives - recommended
### Guidance question

12.1 Should LAY HEALTH WORKERS initiate and maintain injectable contraceptives using a compact, prefilled auto-disposable device (CPAD) such as Uniject™?

<table>
<thead>
<tr>
<th>#</th>
<th>Guidance question</th>
<th>Recommendation</th>
<th>Justification and conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.1</td>
<td>Should LAY HEALTH WORKERS initiate and maintain injectable contraceptives using a compact, prefilled auto-disposable device (CPAD) such as Uniject™?</td>
<td>No recommendation has been made for this option.</td>
<td>We concluded that research is needed on the effectiveness of delivering injectable contraceptives using a CPAD such as Uniject™ before a recommendation can be made about which health workers can undertake delivery. The Guidance Panel therefore decided not to make a recommendation. It was also noted that studies on the effectiveness of delivering injectable contraceptives using a CPAD are currently being conducted.</td>
</tr>
</tbody>
</table>

12.2 Should LAY HEALTH WORKERS initiate and maintain injectable contraceptives using a standard syringe?

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>12.2</td>
<td>Should LAY HEALTH WORKERS initiate and maintain injectable contraceptives using a standard syringe?</td>
<td>We suggest considering this option with targeted monitoring and evaluation.</td>
<td>There is insufficient evidence on the effectiveness of this intervention. However, based on programme experience, we concluded that the intervention has the potential to improve equity by increasing access to family planning, and does not appear to have associated safety issues. In many settings, LHWs already deliver some form of contraceptive counselling and use injections for other conditions. We therefore suggest that this option be considered in the context of targeted monitoring and evaluation.</td>
</tr>
</tbody>
</table>

#### General implementation considerations:

- Planners need to consider a number of issues related to task sharing and the expansion of LHW responsibilities. These include the distribution of roles among cadres, regulatory issues, stakeholder involvement, training and supervision, systems for referral, supply chains, and possible changes to payments or other incentives (see Box 1).

#### Additional implementation considerations for this intervention:

- Recipients may find LHWs from their own community particularly acceptable. However, LHWs may also be more vulnerable to blame in instances of incidental death, disease, or other problems during treatment. Systems therefore need to be established to provide help to such health workers. Visible support from the health system, regular supervision, and birth preparedness counselling are examples of possible support strategies.

- Issues related to sexual and reproductive health can be sensitive. Confidentiality may be a concern, especially if providers from the same local communities as recipients. LHW selection needs to be informed by this concern. In addition to training LHWs in confidentiality-related issues and concerns, recipients need to be made aware that their interactions with health workers regarding contraception are confidential.

- Because of the sensitivity of sexual and contraceptive issues, planners may need to consider whether the health workers who promote or deliver reproductive health services to women should also be women. Due to confidentiality issues and cultural sensitivities, it may also be an advantage to ensure that the relevant training of female health workers is conducted.
2. ‘Recommend with targeted monitoring and evaluation’

This rating indicates uncertainty about the effectiveness or acceptability of an intervention, especially with regard to particular contexts or conditions. Interventions classified as such can be considered for implementation (including at scale), provided they are accompanied by targeted monitoring and evaluation. Particular attention must be given to specific issues about which there are concerns (such as risks or harms) and for which little or no relevant information is available. Information about monitoring and evaluation may be obtained from a range of sources, including routine data and survey data (2). The Guidance Panel attempted to specify which aspects of the interventions required monitoring and specified the relevant indicators.

- The Guidance Panel attempted to specify particular monitoring requirements. These included, for example, monitoring for high-risk groups (such as very low birth weight babies) and in instances of harm (such as inappropriate referral or failure to refer). Where possible, the relevant indicators were also specified.

3. ‘Recommend only in the context of rigorous research’

This rating category indicates that there are important uncertainties about an intervention. In such instances, the implementation can still be undertaken at a large scale, provided that it takes the form of research which is able to address unanswered questions and uncertainties related both to the effectiveness of an intervention and its acceptability and feasibility. To assess the effectiveness of an intervention the research should – at least – compare people who are exposed to one option with people who are not, and include a baseline assessment. These comparison groups should be as similar as possible to ensure that the effect of an intervention is assessed rather than the effect of other factors. Randomized trials are the most effective way to do this, but if these are not possible then interrupted time series analyses or controlled before-and-after studies should be considered. Programmes evaluated without a comparison group or baseline assessment are at high risk of bias and may not measure the true effect of an intervention.

Where unanswered questions or uncertainties are linked to the acceptability or feasibility of the intervention, related research should include well-conducted qualitative studies, as well as quantitative designs, such as surveys, to explore these issues.
8. Dissemination of the recommendations

<table>
<thead>
<tr>
<th>Priority actions for dissemination</th>
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</thead>
<tbody>
<tr>
<td>Prepare guidance derivatives for policy-makers, consumers, clinicians and other groups (e.g. a two-page policy brief and a press release for engaging the public via the media).</td>
</tr>
<tr>
<td>Prepare translations of the Executive Summary of this guidance into official United Nations languages.</td>
</tr>
<tr>
<td>Seek endorsement by national and international professional societies, including the International Federation of Gynecology and Obstetrics, the International Confederation of Midwives, and other organizations such as the American College of Obstetricians and Gynecologists, and the Royal College of Obstetricians and Gynaecologists.</td>
</tr>
<tr>
<td>Continue working with The Norwegian Knowledge Centre for the Health Services to develop tools, including educational videos and other audiovisual presentations, to facilitate the formulation of evidence-informed health policies based on the recommendations in this guidance.</td>
</tr>
</tbody>
</table>
WHO/ UNAIDS/ PEPFAR Task Shifting

22 recommendations mainly for providing HIV services

- Task shifting as a public health initiative
- Creating an enabling regulatory environment for implementation
- Ensuring quality of care
- Ensuring sustainability
- Organization of clinical care services
Recommendation 1:
Countries, in collaboration with relevant stakeholders, should consider implementing and/or extending and strengthening a task shifting approach where access to HIV services, and to other health services, is constrained by health workforce shortages. Task shifting should be implemented alongside other efforts to increase the numbers of skilled health workers.

Recommendation 2:
In all aspects concerning the adoption of task shifting, relevant stakeholders should identify the appropriate stakeholders, including people living with HIV, involved and/or consulted from the beginning.

Recommendation 3:
Countries deciding to adopt the task shifting approach should develop a framework that can ensure harmonization and provide stability for the public and non-state sectors. Countries for the exploration of task shifting to meet other critical public health needs.

Recommendation 4:
Countries should undertake or update a human resource analysis to determine the current human resources for health in both the need for HIV services; the gaps in service provision; the extent to which the existing human resource quality assurance mechanisms are being used.

Recommendation 5:
Countries should assess and then consider using existing regulatory approaches, rules and regulations, policies and guidelines where necessary, to enable cadres of health workers to practice scope of practice and to allow the creation of new cadres within the current regulatory frameworks.

Recommendation 6:
Countries should consider adopting a fast-track strategy to produce regulatory approaches to produce regulatory approaches (laws and proclamations, rules and regulations) where necessary. Countries could also simultaneously pursue long-term task shifting on a sustainable basis within a comprehensive and national framework.

Recommendation 7:
Countries should either adapt existing or create new human resource quality assurance mechanisms to support the task shifting approach. These should include processes and activities that define, monitor and improve the quality of services provided by all cadres of health workers.

Recommendation 8:
Countries should define the roles and the associated competency levels required for existing cadres that are extending their scope of practice, and for those cadres that are being newly created under the task shifting approach. These standards should be the basis for establishing recruitment, training and evaluation criteria.

Recommendation 9:
Countries should adopt a systematic approach to harmonized, standardized and competency-based training that is needs-driven and accredited so that all health workers are equipped with the appropriate competencies to undertake the tasks they are to perform.

Recommendation 10:
Training programmes and continuing educational support for health workers should be tied to certification, registration and career progression mechanisms that are standardized and nationally endorsed.

Recommendation 11:
Supportive supervision and clinical mentoring should be regularly provided to all health workers within the structure and functions of health teams. Individuals who are tasked with providing supportive supervision or clinical mentoring to health workers to whom tasks are being shifted should themselves be competent and have appropriate supervisory skills.

Recommendation 12:
Countries should ensure that the performance of all cadres of health workers can be assessed against clearly defined roles, competency levels and standards.
Recommendation 13:
Countries should consider measures such as financial performance-based incentives or other methods as a means of enhancing the performance and increasing the availability of health workers with new or increased available resources in a sustainable manner.

Recommendation 14:
Countries should recognize that essential health services should be provided on a voluntary basis if they are to be sustainable. With the contribution on a short term or part-time basis, trained health workers, including community health workers, should be provided with appropriate and commensurate incentives.

Recommendation 15:
Countries and donors should ensure that task shifting is adequately financed so that the services are sustain

Recommendation 16:
Countries should consider the different types of task shifting practice and select those models that are best suited to the specific country situation (taking into account health workforce demography, disease burden, and analysis of existing gaps in service delivery).

Recommendation 17:
Countries should ensure that efficient referral systems are in place to support the decentralization of service delivery in the context of a task shifting approach. Health workers should be knowledgeable about available referral systems and trained to use them.

Recommendation 18:
Non-physician clinicians can safely and effectively undertake a majority of clinical tasks (as outlined in Annex 1) in the context of service delivery according to the task shifting approach.

Recommendation 19:
Nurses and midwives can safely and effectively undertake a range of HIV clinical services (as outlined in Annex 1) in the context of service delivery according to a task shifting approach.

Recommendation 20:
Community health workers, including people living with HIV/AIDS, can safely and effectively provide specific HIV services (as outlined in Annex 1), both in a health facility and in the community in the context of service delivery according to the task shifting approach.

Recommendation 21:
People living with HIV/AIDS who are not trained health workers can be empowered to take responsibility for certain aspects of their own care. People living with HIV/AIDS can also provide specific services that make a distinct contribution to the care and support of others, particularly in relation to self-care and to overcoming stigma and discrimination.

Recommendation 22:
Cadres, such as pharmacists, pharmacy technicians or technologists, laboratory technicians, records managers and administrators, could be included in a task shifting approach that involves the full spectrum of health services.
Task shifting to improve access to contraceptive methods

The WHO OptimizeMNH guidance contains evidence-based recommendations for the safe provision of key maternal and newborn health interventions by different cadres of health workers. This document summarizes the WHO recommendations on the cadres ranging from lay health workers to mid-level providers that may be trained and supported to provide the following contraceptive methods safely: tubal ligation, vasectomy, intrauterine device (IUD), implants, injectables, as well as promotional activities. The process of enabling additional cadres to provide a specific health intervention is referred to here as “task shifting” but is also widely known as “task sharing.”

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 “white clinical cadres” as opposed to the communities

Setting: Community/public health care settings

Key message: The WHO recommends the use of different non-physician health worker cadres to provide the following family planning services:

- Tubal ligation
- Vasectomy
- IUD
- Contraceptive implants
- Injectable contraceptives
- Education and counseling

Who is this summary for?

- Ministries of health and other decision makers working to access to family planning services

This summary includes:

- All recommendations from World Health Organization OptimizeMNH guidance that relate to family planning

Not included:

- The OptimizeMNH recommendations also cover maternal and newborn health services. Recommendation to these services are not described in this summary but are covered in other summary documents.

Please visit www.optimizemnh.org for further information on:

- Recommendations for task sharing other types of maternal and newborn health care
- The evidence supporting these recommendations
- Glossary of terms used in this report

Background references on this topic are listed on page 4.
From Evidence to Policy: Expanding Access to Family Planning

Optimizing the health workforce for effective family planning services

Family planning services can be most effective if staff are well trained and supported as part of a well-equipped and well-functioning health system.

Key policy and programme actions:
- Implement sound international and national strategies to increase the number of skilled health workers trained and allowed to provide family planning services, with specific focus on underserved areas and populations.
- Adapt WHO guidelines in developing and implementing locally appropriate task shifting policies for family planning counselling and services.
- Undertake a systematic approach to standardized, competency-based training that enables health workers to provide quality family planning services, with adequate supervision and monitoring, and clear protocols for referrals.
- Emphasize quality of care through counselling by all cadres of health providers. All family planning and counselling services should be strongly linked in a rights-based approach that respects individual needs and preferences.
- Carry out social science and implementation research to understand, and strengthen, the dynamics and organization of health systems and contraceptive services delivery.

Background
Family planning is an essential investment in maternal and newborn health, as well as in poverty reduction and national development. Unintended pregnancy constitutes a serious threat to the lives of women and their families. However, despite the known health benefits and cost-effectiveness of family planning, large discrepancies exist in accessing modern contraception. Worldwide, an estimated 222 million couples have an unmet need for contraception. This need is the highest in areas where maternal mortality is greatest.

There is a global shortage of at least 3.5 million health-care workers, including doctors, nurses, midwives and community health workers. The severe shortage of skilled health-care workers trained in family planning and contraception provision is a key constraint to improving access to family planning services for many women, men, girls and their families. The current network of health-care providers fails to reach some of the most vulnerable groups: the unmarried, the young, the poor, migrants and rural women. Increasing access to contraception, family planning and counselling services will require additional numbers of skilled and supported health workers, in both the public and private sectors of national health systems. Scaling up training and redeployment of existing health providers, including community-based and mid-level health workers, is of critical importance. These cadres have the potential, when appropriately trained and supported, to improve access to essential family planning, maternal, newborn and child health services, while containing costs. Expansion of cadres with adequate skills will be critical to increasing access to certain contraceptive methods as well as reducing maternal mortality, as they will be instrumental in providing education, advising on reproductive health, and distributing services to those most in need.

Recommended policy actions
- Undertake rigorous studies to determine the safety and effectiveness of auxiliary nurses performing IUD insertion and removal, and nurses and midwives performing male and female sterilization procedures.
- Undertake studies to evaluate the cost-effectiveness of programmes of various cadres of health providers in family planning service provision.
- Carry out social science and implementation research to understand, and strengthen, the dynamics and organization of health systems and contraceptive services delivery.

Recommended programme actions
- Undertake a systematic approach to standardized, competency-based training that enables health workers to provide quality family planning services, with adequate supervision and monitoring, and clear protocols for referrals.
- Emphasize quality of care through counselling by all cadres of providers. All services and guidance should be centred in a rights-based approach that respects individual needs and preferences.
- Trained health workers, including community health workers, should be supported to ensure access to services.

Recommended research actions
Recommended policy actions

- Implement sound international and national strategies to increase the number of skilled health workers trained and allowed to provide family planning services, with specific focus on underserved areas.
- Adapt WHO guidelines and, as necessary, develop locally appropriate training manuals and guidelines for traditional counselling and service delivery mechanisms. Emphasize the implementation of these guidelines and a paucity of dissemination and use of existing job aids and training materials; training materials must be adapted to local conditions.
- Adopt and strengthen the capacity of health service providers to train and transfer skills to health workers and to ensure the availability of required supplies and equipment.

Recommended programme actions

- Undertake a systematic approach to standardized, competency-based training that enables health workers to provide quality family planning services, with adequate supervision, including periodic refresher courses.
- Emphasize the provision of provider-friendly training and a rights-based approach to training and service delivery, recognizing the preferences of service providers and their clients.

Recommended research actions

- Undertake rigorous studies to determine the safety and effectiveness of auxiliary nurses performing IUD insertion and removal, and nurses and midwives performing male and female sterilization procedures.
- Undertake studies to evaluate the cost-effectiveness of programmes of various cadres of health providers in family planning service provision.
- Carry out social science and implementation research to understand, and strengthen, the dynamics and organization of health systems and contraceptive services delivery.
General considerations for implementation of task sharing programme

- Implementation will be shaped by specific sociocultural and political factors in specific contexts
- National dialogue is required to determine whether:
  - Health worker availability contributes to accessibility/utilization of key interventions
  - There is a willingness to consider task sharing
  - Health care workers need to be supported by other interrelated health systems components
  - The individual recommendations should be considered as ‘packages’, in terms of health worker categories and the condition being addressed. New tasks should be considered in the context of overall health care delivery, rather than being implemented as standalone measures.
Where is task sharing taking place

- Ethiopia / Health extension workers
  - Provide pills, condoms, injectable contraceptives (soon implants) through health posts and doorstep services

- Bangladesh / Bluestar project drug shop staff
  - Provide injectable contraceptives, utilized by nearly a third of clients

- Malawi / Clinical officers
  - Provided over 40K tubal ligations per year in rural facilities
Where task sharing studies are ongoing (2014)
Why task sharing? Why now?

- Offering contraception through a wide range of providers enables access and availability.
- Evidence and experience support that a wide variety of providers can safely and effectively provide contraception.
- Access to contraception is part of a comprehensive SRHR package for men and women.
- Need to improve policies to allow effective use of skills and competencies of the health workforce.
The task shifting approach represents a return to the core principles of health services that are accessible, equitable and of good quality. These recommendations and guidelines on task shifting provide a framework that is informed by all we now know about the ways in which access to health services can be extended to all people in a way that is effective and sustainable. It is for these reasons that I see task shifting as the vanguard for the renaissance of primary health care.

Dr Margaret Chan
Director-General of the World Health Organization
Thank you

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