

Task Sharing in Family Planning

Barbara Janowitz, FHI
John Stanback, FHI

Many developing countries face strains in meeting the demands for provision of health services because of limited medical personnel. This situation has been exacerbated by the continued "brain drain" of highly trained medical professionals, and, more recently, by the increased demand for HIV services, especially in countries with a generalized epidemic. This has led to renewed interest in task sharing, also known as task shifting. A key feature of task sharing is that those with less medical or paramedical training can provide some of the same services with the same quality as those with more training. While the term "task sharing" is new, the concept has been applied for many years in family planning programs as various tasks became shared between doctors and nurses or between nurses and community health workers. The consensus reported in a recent WHO document, 'Task Shifting to Tackle Health Worker Shortages', was that task sharing "will positively affect health outcome... Good management, support, supervision and political commitment," are needed for success. (WHO, 2007)

In family planning, perhaps the most important reason for task shifting is to bring services to women with poor access. Since it is not always cost effective to build clinics in sparsely populated rural areas, women will either be forced to travel long distances for services or non-clinic-based services must be provided in local communities.

There are two main types of task sharing. The first occurs within a facility, when providers share their responsibilities with less credentialed providers, e.g., when nurses perform tasks previously reserved for physicians. For family planning, demand for certain methods, combined with overworked providers, may encourage this type of task sharing to reduce the time that physicians or nurses spend on certain tasks. Failure to task share under these circumstances could restrict service provision. A study from Thailand provides a good example of task sharing within a facility. Physicians in Thailand could not adequately meet the demand for female sterilization given their other responsibilities. Nurse-midwives were trained to do sterilizations thereby freeing up the time of doctors to take on higher level tasks. (Kanchanasinith et al., 1990; Satyapan et al., 1983; Dusitsin & Satyapan, 1984) Similar results were also found in Bangladesh. (S. Chowdhury & Z. Chowdhury, 1975)

The second type of task sharing occurs between two different supply outlets, when providers, such as community health workers share some of the same tasks that are carried out by physicians and nurses based in clinics. This type of task sharing facilitates access to services. For example, women living in remote rural areas have poor access to clinics. Sharing provision of contraceptives between clinics and community health workers ensures that rural women have increased access to family planning services. The presence of a community worker minimizes travel time for clients, and, if the worker makes household visits, reduces client travel time to zero, thereby facilitating uptake and continued contraceptive use. Community health workers

may also have more time to devote to counseling compared to medical and nursing personnel in clinics.

The following arguments have been made in favor of task sharing, and, because the concept remains controversial in some countries (Stanback et al., 2007; McPake & Mensah, 2008), we also consider some of the questions that continue to restrict the scaling up of this practice.

- *Increased access frees up the time of higher level health personnel in clinics.* If nurses and midwives provide long-acting methods, the time of physicians is freed up to handle more complicated cases. Research has shown that nurses and midwives can do female sterilizations and these cadres routinely insert IUDs in dozens of countries. However, while task sharing will free up the time of higher level personnel, downtime could increase if there is limited demand for other services. An important issue thus concerns whether the freed up time is used productively.
- *Specialization promotes quality.* While some might argue that sharing jobs with lower level providers will compromise quality, it may be argued that lower level providers who concentrate on a smaller number of tasks may actually carry out the work with greater technical competence, one of the elements of quality of care defined by Bruce. (Bruce; 1990) A recent paper, drawing on a systematic review of studies, dealt with the question of whether nurse practitioners could substitute for doctors by providing “safe, effective, and economical front-line management of patients.” The paper showed some evidence that their results were equivalent to or even better than those of doctors but quality of the evidence was deemed to be “low or moderate”. The review pertained to high income countries and may not be applicable in low income countries. (Wiysonge & Chopra, 2008)

Other defined elements of quality may also increase by virtue of the fact that lower level personnel may have more time to devote to clients or may live among them, thus improving interpersonal relationships, the quantity and quality of information given, and continuity and follow-up, which are additional elements of quality of care defined by Bruce (ibid). However, a concern is that adding more tasks to the work of community health workers, such as providing injectables, may overstretch their ability or time to provide quality services. A review of community health workers suggests that adding too many tasks that place excessive demands and time constraints on them may reduce job performance. (Bhattacharya et al., 2001)

- *Increased access to methods leads to greater choice and higher contraceptive use.* As early as 1973, the International Planned Parenthood Federation Medical Committee endorsed the community-based distribution of oral contraceptives. (IPPF, 1973) One lingering concern with this approach was that there might be negative consequences on subgroups of women who have possible contraindications to OC use. Research in Mexico was designed to answer this question. Findings from a survey indicated that the health status of program users was similar to that of non-program users regardless of whether non-program users had been examined by a physician. Thus, findings indicated that a clinic visit preceding initiation of pill use was not necessary. (Zavala et al., 1987)

Data from the DHS show that community based provision is important in rural areas of many countries. Even today not all community workers are allowed to provide pills, and when they can, some do not provide the first cycle of pills. In some countries, the major source of OCs is the pharmacy, often with support from social marketing programs. Such programs allow women to obtain this method without visiting a clinic.

While CBD programs have long been providers of pills, only recently has there been renewed interest in CBD provision of injectables. Though CBD provision of injectables has taken place for years in many Latin American countries and in Bangladesh, only a handful of countries in sub-Saharan Africa have introduced it in their programs. Data from the DHS show that CBD programs play a limited role in injectable provision in most countries. A recent study conducted in Nakasongola, Uganda provides support for the introduction and scale-up of injectables in CBD programs in that it showed that CBD agents could safely provide injectables. (Stanback et al., 2007) This practice has now been introduced in Ethiopia, Malawi, Madagascar and plans are to introduce it in Zambia and Rwanda. In Rwanda, policies are already in place in anticipation of introducing this practice.

Whether well trained community health workers can safely provide injectables remains controversial in some countries, and provision of injectables in pharmacies and drug shops might be even more contentious.

- *Lower level workers earn less so that task sharing leads to lower costs of service provision.* Some have argued that provision of injectables in community health programs is less costly than provision in clinics. However, task sharing may require increased supervision and training of community health workers to do the new jobs and these costs need to be considered. Any calculation of what it costs to add a new benefit to a community health program must take into consideration the strength of the program. It may be less costly to add injectables to a strong program with dedicated field personnel and high retention rates as training costs will be lower as there is less need for retraining. Even if costs are high, programs may be more concerned about increasing choice than about increasing costs. (Wiysonge & Chopra, 2008)

The review cited above also concluded that “cost data were of very low quality and inadequate for a robust economic analysis”. (Wiysonge & Chopra, 2008) In the example, data are needed on the costs of additional training for nurses to become nurse practitioners as well as supportive supervision and continuing education. Similar information would be needed for programs in developing countries that were deciding on whether to introduce and scale-up task sharing.

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