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IMAP Statement on Task Sharing in Sexual and Reproductive Health

Introduction

Task sharing – or task shifting as it is sometimes called – is a process in which specific clinical tasks are shared at more levels. Where appropriate, tasks that are normally performed solely by highly qualified health workers are also undertaken by health workers who have had less training and have fewer qualifications. Task sharing can be a viable solution to increasing access to sexual and reproductive health services for all people, particularly those who are poor, marginalized, socially excluded and under-served; it is a promising strategy for improving cost-effectiveness within health systems. It also ensures that skills are not lost when staff are replaced or rotated in roles.

The World Health Organization has acknowledged that attempts to optimize the potential of the existing health workforce are crucial to achieve the Millennium Development Goals.[1] It has therefore introduced global recommendations and guidelines for task shifting which define conditions and systems required for its safe, efficient, equitable and sustainable implementation. Detailed guidelines have been produced on task shifting for HIV service provision and for maternal and newborn health interventions.

Based on existing evidence from the World Health Organization and from the field, IMAP[2] has developed recommendations to guide the implementation of a task sharing approach for key interventions of IPPF's 'Integrated Package of Essential Services' – a package of eight essential sexual and reproductive health components. These eight components are contraception, safe abortion care, reproductive tract infections/sexually transmitted infections, HIV, gynaecology, prenatal and post-natal care, sexual and gender-based violence, and counselling.

IMAP acknowledges that task sharing is already being implemented to varying degrees as a pragmatic response to health workforce shortages in a number of countries. These recommendations aim to promote a formal framework that can support task sharing to increase access to an integrated package of sexual and reproductive health services.

[1] World Health Organization (2012) WHO Recommendations: Optimizing Health Worker Roles to Improve Access to Key Maternal and Newborn Health Interventions Through Task Shifting.

[2] IMAP is IPPF's International Medical Advisory Panel.

Who is this Statement intended for?

This Statement is primarily intended for use by IPPF Member Associations. It is also aimed at all organizations, activists and researchers, and policy and decision makers who are working to improve sexual and reproductive health coverage in resource-poor settings by making use of existing human resources for health.

Why tasks need to be shared in sexual and reproductive health services

- **The global health workforce crisis:** Widespread crises in the health workforce are having an impact on achieving the right to health and other sexual and reproductive rights, and on achieving health outcomes prioritized by development frameworks such as the Millennium Development Goals. These crises are characterized by human resource shortages in the health sector. According to 'The World Health Report 2006: Working Together for Health', 57 countries face chronic human resource shortages in the health sector. The report describes imbalances in the distribution of the health workforce across countries: for example, 36 of the 57 countries currently facing health-related human resource crises are in sub-Saharan Africa. There are inequalities reported in the distribution of the health workforce within countries: estimates indicate that only 24 per cent of physicians and 38 per cent of nurses work in rural communities even though half the world's population live in rural areas. The report also points to the lack of specialized health workers such as surgeons, obstetricians and anaesthetists – most countries still have too few specialist clinicians relative to the health needs of their population.
- **The need to accelerate and optimize the delivery of key sexual and reproductive health interventions:** Further investments are needed to scale up high impact and evidence-based interventions that can lead to accelerated progress to achieve the Millennium Development Goals, and the commitments agreed at the International Conference on Population and Development (1994), the World Conference on Women (1995) and the London Summit on Family Planning (2012).

  Family planning is an essential investment in maternal and newborn health, as well as in poverty reduction and national development. However, 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, particularly for the most vulnerable groups such as girls and women who are unmarried, young or poor, as well as migrants and rural women. This is particularly so for the most vulnerable groups such as girls and women who are unmarried, young or poor, as well as 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.[3] Scaling up the training and redeployment of existing health providers, including community-based and mid-level health workers, could lead to accelerated progress.

General recommendations to implement a task sharing initiative

- **Regulatory frameworks**
  - Assess existing regulations to identify opportunities and obstacles to implement task sharing; for example, regulations that require intrauterine devices to be inserted solely by medical clinicians; regulations that establish medical liability in cases where complications arise; and other regulations.
  - Advocate for less restrictive regulations to enable different groups of skilled health workers to practise an extended scope of work.
- **Programme planning**
  - Undertake or update a human resource analysis that will provide information on the demography of current human resources for health in your organization. This should identify the gaps in service provision, the extent to which task sharing is already taking place, and the existing human resource quality assurance mechanisms.
  - Involve and/or consult relevant stakeholders right from the start to facilitate the adoption of task sharing. It is particularly important to engage health workers in the discussion about roles and competencies, changes in workload, and incentives to expand the scope of work or to share tasks with other groups of health workers. Communities and individual clients also play an important role in ensuring that task sharing initiatives are implemented successfully: for example, in some contexts there is confidence in the competence of less highly trained health care providers, while in other contexts recipients may prefer care from specialized health professionals.
  - Implement task sharing alongside other efforts, such as just and timely remuneration and public recognition of contributions, to maintain an effective, productive and motivated workforce.
- **Training**
  - Ensure that providers develop the skills and competencies required to perform their duties through pre-service and in-service training and through continuous learning activities that support the development of competencies.
  - Provide supportive supervision and clinical mentoring to all health workers taking part in task sharing initiatives.
- **Quality**
  - Define the roles and the associated competency levels required for all groups of health workers participating in task sharing initiatives. These standards should form the basis to establish criteria for recruitment, training and performance evaluation.
  - Develop quality assurance mechanisms to support the task sharing approach, such as monitoring services: this includes the quality of services such as counselling and care, complication rates, client satisfaction, and others.
- **Sustainability**
  - Task sharing initiatives should be appropriately costed and adequately financed so that services are sustainable. Resources need to be allocated to ensure continuous training, supportive supervision and quality assurance, and to provide incentives to health workers who take on new and increased responsibilities.
  - Ensure that all groups of health providers have continuous access to the commodities and supplies required to perform the tasks assigned to them. This is particularly important in cases where tasks are being shared with community health workers.

Who is involved in task sharing?

Tasks can be shared among different groups of health workers, such as:

- physician clinicians
- non-physician clinicians (different job titles include medical assistant, nurse practitioners)
- nurses
- auxiliary nurses
- midwives
- auxiliary nurse midwives
- community health workers (different job titles include lay health worker, treatment supporter, village health worker)
- pharmacy workers

[3] World Health Organization (2012). Op. cit.

Task sharing across the components of the Integrated Package of Essential Services[4]

ESSENTIAL INTERVENTIONS	LEVEL OF CARE WHERE THE INTERVENTION CAN BE PROVIDED (COMMUNITY LEVEL OR PRIMARY CARE)	HEALTH WORKERS WHO CAN IMPLEMENT THIS INTERVENTION	COMMENTS
Contraception			
Counselling	All levels of care	All groups	
Provision of oral contraceptives	All levels of care	All groups	
Provision of condoms	All levels of care	All groups	
Provision of emergency contraception	All levels of care	All groups	
Provision of injectables	All levels of care	All groups	Recommendation: monitoring and evaluation targets should be in place for community health workers
Insertion and removal of intrauterine devices	Primary care level	Clinicians, non-physician clinicians, nurses, auxiliary nurses, midwives, auxiliary nurse midwives	All providers, regardless of pre-service training, require in-service competency-based training for intrauterine device insertion and removal
Insertion and removal of implants	Primary care level	Clinicians, non-physician clinicians, nurses, auxiliary nurses, midwives, auxiliary nurse midwives	Recommendation: monitoring and evaluation targets should be in place for auxiliary nurses and auxiliary nurse midwives All providers, regardless of pre-service training, require in-service competency-based training for implant insertion and removal
Safe abortion care			
Pre- and post-abortion counselling	All levels of care	All groups	
Surgical abortion	Primary care	Clinicians, non-physician clinicians, nurses, midwives	Evidence available for non-physician clinicians, nurses and midwives refers to performance of first trimester abortions
Medical abortion	Primary care	Clinicians, non-physician clinicians, nurses, midwives, auxiliary nurse midwives	Evidence available for nurses and auxiliary nurse midwives refers to performance of abortions up to nine weeks

[4] Sources of information: Aziz et al (1999); Callaghan et al (2010); Dinshaw et al (2007); Garcia et al (2003); Harrison et al (2000); Jennings et al (2011); Kim et al (2002); Malarcher et al (2011); Prata et al (2011); Sanjana et al (2009); Sankaranarayanan et al (2005); Selke et al (2010); Shah et al (2007); Warriner et al (2006); Warriner et al (2011); World Health Organization (2012). Op. cit.; World Health Organization (2012) Optimizing the Health Workforce for Effective Family Planning Services; World Health Organization (2007) Task Shifting, Global Recommendations and Guidelines.

ESSENTIAL INTERVENTIONS	LEVEL OF CARE WHERE THE INTERVENTION CAN BE PROVIDED (COMMUNITY LEVEL OR PRIMARY CARE)	HEALTH WORKERS WHO CAN IMPLEMENT THIS INTERVENTION	COMMENTS
Reproductive tract infections/sexually transmitted infections			
Syndromic case management	All levels of care	All groups	Evidence for community health workers and pharmacy workers only available from Peru and Pakistan
Tests	Primary care	Clinicians, non-physician clinicians, nurses, auxiliary nurses, midwives, auxiliary nurse midwives	Recommendation: screening and treatment for syphilis should only be done in primary care facilities and by trained health professionals Tests should only be requested by trained health professionals
Provision of condoms	All levels of care	All groups	
HIV			
Pre- and post-test counselling	All levels of care	All groups	
Testing	All levels of care	All groups	Community health workers are not advised to request CD4 testing or to take and prepare blood for a CD4 test
Provision of condoms	All levels of care	All groups	
Gynaecology			
Manual pelvic examination	Primary care	Clinicians, non-physician clinicians, nurses, auxiliary nurses, midwives, auxiliary nurse midwives	
Manual breast examination	All levels of care	All groups	
Pap smear	Primary care	Clinicians, non-physician clinicians, nurses, auxiliary nurses, midwives, auxiliary nurse midwives	
Visual inspection with acetic acid	Primary care	Clinicians, non-physician clinicians, nurses, midwives, auxiliary nurse midwives	Evidence for auxiliary nurses only available from India
Prenatal and post-natal care			
Confirmation of pregnancy	All levels of care	All groups	
Essential prenatal care	Primary care	Clinicians, non-physician clinicians, nurses, auxiliary nurses, midwives, auxiliary nurse midwives	
Essential post-natal care	Primary care	Clinicians, non-physician clinicians, nurses, auxiliary nurses, midwives, auxiliary nurse midwives	

ESSENTIAL INTERVENTIONS	LEVEL OF CARE WHERE THE INTERVENTION CAN BE PROVIDED (COMMUNITY LEVEL OR PRIMARY CARE)	HEALTH WORKERS WHO CAN IMPLEMENT THIS INTERVENTION	COMMENTS
Sexual and gender-based violence			
Screening and counselling	All levels of care	All groups	
Referrals, for example to legal support, shelters, physiological services, and other services	All levels of care	All groups	
Provision of emergency contraception	All levels of care	All groups	
Presumptive treatment for sexually transmitted infections	All levels of care	All groups	
HIV post-exposure prophylaxis	Primary care	Clinicians, non-physician clinicians, nurses, auxiliary nurses, midwives, auxiliary nurse midwives	
Counselling			
Sexuality counselling	All levels of care	All groups	
Relationship counselling	All levels of care	All groups	

Useful resources

World Health Organization (2007) *Task Shifting, Global Recommendations and Guidelines*.

World Health Organization (2009) *Community Based Health Workers Can Safely and Effectively Administer Injectable Contraceptives*.

World Health Organization (2012) *Optimizing the Health Workforce for Effective Family Planning Services*.

World Health Organization (2012) *WHO Recommendations: Optimizing Health Worker Roles to Improve Access to Key Maternal and Newborn Health Interventions Through Task Shifting*.

Conclusion

Task sharing is essential in order to tackle high unmet need and increase access to sexual and reproductive health services, particularly for those who are poor, hard to reach or vulnerable. This can be achieved by adequately resourcing the supply side of the health service delivery system. This requires a systemic paradigm shift in institutional attitudes in relation to classic service delivery models, in order to achieve universal and effective task sharing implementation within the Federation.

Task sharing is already being implemented as a pragmatic response to health workforce shortages to varying degrees in a number of countries, and there is good evidence in the literature that some forms of task sharing have been adopted informally in response to human resource needs throughout history. There is also a growing body of evidence that demonstrates the effectiveness, safety and acceptability of task sharing in relation to the sexual and reproductive health services outlined in IPPF's 'Integrated Package of Essential Services'. In addition, evidence demonstrates that task sharing has been studied in relation to services and procedures that are more complex than those outlined in the 'Integrated Package of Essential Services'. For example, community health workers can safely carry out HIV treatment and care. At the far end of the sexual and reproductive health tasks that require substantial training, evidence shows that non-physicians and physicians do not differ significantly in key outcomes for caesarean sections (Wilson 2011). However, the scope of task sharing is not restricted to sexual and reproductive health service delivery alone – it has implications for other essential health services and offers strong potential for wider health systems strengthening.

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