USAID FROM THE AMERICAN PEOPLE

HRH2030 HUMAN RESOURCES FOR HEALTH IN 2030

TECHNICAL REPORT | MAY 2020

National Family Planning Guidelines in 10 Countries:

How well do they align with current evidence and WHO recommendations on task sharing and self-care?

Contents

Acronyms ii
Executive Summary 3
Overview 4
Activity Objectives 5
Definition of Terms 5
Methodology 6
Questions Explored 6
Benchmarks 6
Definition of Cadres 8
Country selection 9
Literature scan 9
Summary of Findings 10
Discussion and Recommendations 13
Appendix A. Country Stages of mCPR Growth 15
Appendix B. Country Results 16
Burkina Faso 16
Côte d'Ivoire 17
Kenya 18
Madagascar 19
Malawi 20
Mali 22
Nigeria 23
Philippines 24
Uganda 26
Zambia 27
Appendix C. References 29

ACKNOWLEDGEMENTS

This publication was produced for review by the United States Agency for International Development (USAID). It was prepared by Erin K. McGinn (Palladium) and Sara Stratton (Palladium) as members of the HRH2030 consortium.

May 14, 2020

Cooperative Agreement No. AID-OAA-A-15-00046

DISCLAIMER

This material is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of cooperative agreement no. AID-OAA-A-15-00046 (2015-2020). The contents are the responsibility of Chemonics International and do not necessarily reflect the views of USAID or the United States Government.

Acronyms

AC	Agent Communautaire
ASC	Agent de Sante Communautaire
BHW	"Barangay" (Village) Health Workers
BLT	Bi-tubaligation
CBD	Community Based Distributors
CBDA	Community Based Distribution Agents
CBT	Competency-based Training
CHW	Community Health Workers
CHEW	Community Health Extension Workers
CIP	Costed Implementation Plan
CHV	Community Health Volunteers
CMA	Community Midwife Assistance
COC	Combined Oral Contraceptives
CSM	Contraceptive Social Market
DMPA	Depot medroxyprogesterone acetate
DMPA-IM	Intramuscular depot modroxyprogesterone acetate
DMPA-SC	Subcutaneous depot modroxyprogesterone acetate
ECOWAS	Economic Community of West African
States ECP	Emergency Contraceptive Pills
FP	Family Planning
HRH	Human Resource for Health
HSA	Health Surveillance Assistance
IUD	Intrauterine Device
LAM	Lactational Amenorrhea
LNG	Levenogesteral
MCH	Maternal Child Health
mCPR	Modern Contraceptive Prevalence Rate
MEC	Medical Eligibility Criteria
MCH	Maternal and Child Health
MNCH	Maternal, Neonatal and Child Health
MOH	Ministry of Health
NMT	Nurse Midwife Technician
NSV	No Scalpel Vasectomy
OBGYN	Obstetrics and Gynecology
OCP	Oral Contraceptive Pill
OTC	Over the Counter
PAC	Post Abortion Care
PNP	Policies, Norms and Protocols
PPMV	Patent and Proprietary Medicine Vendors
POP	Progestin-Only Pill
RH	Reproductive Health
SDM	Standard Days Method
SEC	*Soins essentiels dans la communauté* (essential care in the community)
SRH	Sexual and Reproductive Health
SRH/MCH	Sexual and Reproductive Health/Maternal Child Health
STI/HIV	Sexually Transmitted Infection/Human Immunodeficiency Virus
TBA	Traditional Birth Attendant
TS	Task Sharing
VHW	Village Health Workers
WHO	World Health Organization

Executive Summary

This analysis seeks to document the extent to which 10 countries – Burkina Faso, Côte d'Ivoire, Kenya, Madagascar, Malawi, Mali, Nigeria, Philippines, Uganda, Zambia – have adopted policies, service delivery guidelines, or other government documents in-line with current scientific evidence and WHO guidelines on ***task sharing*** and ***self-care*** for family planning. WHO's guidance is summarized in its 2017 *Task Sharing to Improve Access to Family Planning/Contraception* and its 2019 publication *Consolidated Guideline on Self-Care Interventions for Health*.

Through this work, USAID's Human Resources for Health in 2030 (HRH2030) Program documents areas where national FP guidelines remain behind current evidence, and highlights opportunities for advocacy and policy-change at the country level to further reduce medical barriers and ultimately increase access to family planning. Not surprisingly, countries with more recent national FP-related policies or guidelines followed WHO recommendations more closely, which speaks well to the willingness of countries to adopt global guidance when made available. Furthermore, four of the countries have recently developed stand-alone task sharing policies or guidelines to hasten implementation of these important service delivery approaches.

With respect to specific methods, most countries are allowing short acting methods (pills, injectables, etc.) to be provided by lay/community health workers, and several countries have adopted policies allowing self-injection of subcutaneous depot modroxyprogesterone acetate (DMPA-SC). The availability of pills (including emergency contraceptive pills) through pharmacies (or similar service delivery points) was only addressed in about half of the countries, but in some cases, it was unclear as to whether prescriptions were required. Burkina Faso, Côte d'Ivoire, Mali, Malawi, Nigeria have adopted policies allowing provision of implants and IUDs by higher-level community health workers or auxiliary cadres. However inconsistent terms/labels for various cadres made a full comparison difficult. Likewise, vasectomy and tubal ligation were allowed by non-doctors in 4/10 countries, but again, cadre nomenclatures made this challenging to fully assess. For a summary of findings by country, see Table 3, page 12.

The authors noted that inconsistencies within or between national documents, as well as poor definition and delineation of cadres (e.g., different terms, the education and training they received, etc.), made it difficult to make robust comparisons. One area in need of improvement is the fuller incorporation of pharmacies and drug shops into national FP guidelines. Pharmacies and drug shops play a large and often first-contact role in health services in many countries, and with increased emphasis on self-care, their role in FP provision may expand further. Yet most of the documents reviewed only tangentially referred to pharmacies or drug shops.

> ***[International global guidance] confirms that all women can safely use almost any method and that providing most methods is typically not complicated.***
>
> Ellen Starbird, Director, Office of Population and Health, USAID, in "Family Planning – A Global Handbook for Providers" (2018)

Interestingly, Philippines seemed to have embraced task sharing the least. Malawi, a country that has embraced significant task sharing approaches, as well as now self-injection of DMPA-SC, had no mention of which cadre could provide which method in its national FP guidelines; all information had to be obtained through in-country contacts. Uganda's guidelines outlined nurses and midwives as being able to provide sterilization services, however in-country contacts suggest this is not being implemented. These examples suggest that further investigation is needed on whether national FP guidelines are being operationalized to truly assess whether these policies are increasing contraceptive access.

Overview

WHO has issued guidelines on which cadres can provide which family planning methods, and recommendations on self-care models for contraceptive access. Which countries are listening?

For decades, many in the international family planning (FP) community have been concerned with reducing unnecessary medical barriers to contraception, which impede access and undermine women and couples' rights. Medical barriers first appeared in FP literature in 1992, and are defined as "practices, derived at least partly from a medical rationale, that result in a scientifically unjustifiable impediment to, or denial of, contraception."[1] USAID and its implementing partners have been researching and working to reduce unnecessary medical barriers for decades.[2] Through extensive research and advocacy, many medical barriers such as spousal consent and parity requirements have been eliminated from policies and programs. Likewise, the WHO Medical Eligibility Criteria (MEC), first published in 1996 and now on its fifth iteration, is an excellent and well-used resource for countries to ensure clinical guidelines on eligibility for various contraceptive methods are evidence-based. However, access to family planning continues to be challenging for many women and couples in part because of outdated notions of and restrictions on who can provide various contraceptive methods.

The global FP2020 initiative has set a goal to enable 120 million additional women to use modern contraceptives by 2020. Given current strains on developing country health systems, including poor infrastructure, human resources for health shortages, and poor commodity security, achieving the FP2020 goal will be difficult without—among other approaches—exploring safe and proven strategies to safely increase access to family planning in lower level health facilities and through pharmacies and community health workers. Historically, family planning has been overly and unnecessarily medicalized, leading to numerous medical barriers (see definitions, pg. 5). As such, it behooves governments to undertake any legal, regulatory, or service delivery change to remove these medical barriers and improve access to contraception. Efforts to improve access to contraceptives will need to include expanding the cadres authorized, empowered, and trained to provide quality FP services (task sharing), and deregulation of hormonal contraceptives to promote client empowerment and self-care wherever possible.

> ***Governments should make it easier for couples and individuals to take responsibility for their own reproductive health by removing unnecessary legal, medical, clinical and regulatory barriers to information and to access to family-planning services and methods.***
>
> — 1994 ICPD Programme of Action, para 7.20

In 2012, WHO released its publication, *Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting*.[3] This document provides cadre definitions and lists the types of services that can be provided by each cadre, including contraceptive services. In 2017, WHO also released a summary brief *Task sharing to improve access to Family Planning/Contraception* that reinforces key messages specifically on task sharing for FP.[4] Most recently, in June 2019 WHO issued *Consolidated Guideline on Self-Care Interventions for Health* where they recommended self-administration of injectable contraception should be made available, and oral contraceptive pills (OCPs) should be available without a prescription, for women already using OCPs, i.e., "over-the-counter."[5]

Significant operations research, advocacy, and program efforts have validated task sharing and self-care approaches and encouraged dissemination and implementation of international

---

[1] Shelton, J. and R.A. Jacobstein, M.A. Angle. 1992. "Medical Barriers to Access to Family Planning". *Lancet* 340(8831):1334-5.

[2] Solo, J., and M. Festin. 2019. "Provider Bias in Family Planning Services: A Review of its Meaning and Manifestations". *Global Health Science and Practice* 7(3):371- 385.

[3] WHO. 2012. *Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting*.

[4] WHO. 2017. *Task sharing to improve access to Family Planning/Contraception*.

[5] WHO. 2019. *WHO Consolidated Guideline on Self-Care Interventions for Health*.

evidence and WHO guidance. The Ouagadougou Partnership, which emerged from francophone West Africa (where FP provision has historically been particularly highly medicalized), was founded in part to promote expansion of who may provide FP services.[6] In April 2017, the Economic Community of West African States (ECOWAS) adopted a declaration in support of task sharing, the approach prioritized for diversifying service delivery options in West Africa.[7] This officially facilitated the process for countries to formally approve task sharing where there was still domestic resistance to this approach.[8]

Further global evidence supporting task sharing is codified in the *Strategic Planning Guide on Task Sharing* as part of the High Impact Practices (HIPs) initiative[9]. This guide presents five considerations for countries who want to develop or expand a task sharing strategy.

The growing body of evidence and international guidance promoting the expansion of cadres that can provide family planning to improve access to and use of modern contraceptive methods has led several countries to adopt various task sharing policies to increase FP access and streamline responsibilities among various health worker cadres. But these approaches can be controversial at the country level. Countries may claim health worker cadres are not equivalent in education and skills to similarly named cadres in other countries that have adopted task sharing, or stakeholders raise safety concerns or other issues to reject over the counter (OTC) access to hormonal contraceptives. Some countries have implemented task sharing on a pilot basis, but still have not changed national policies. And in some cases, task sharing or OTC access may be happening informally but is still not codified in national guidelines or regulations.

Activity Objectives

This analysis seeks to document the extent to which select countries have adopted policies, service delivery guidelines, or other government documents in-line with current scientific evidence and WHO guidelines on ***task sharing*** the provision of methods to mid- and lower-level cadres, and promotion of ***self-care*** through self-injection and/or OTC provision of hormonal pills. This analysis identifies areas where national FP guidelines remain behind current evidence, and highlights opportunities for advocacy and policy change at the country level to further reduce medical barriers and ultimately increase people's access to family planning.

Definition of Terms

Medical barriers are any contraindications, eligibility requirements (e.g., age, parity, spousal consent), process hurdles (like irrelevant laboratory tests or pelvic exams), the provider of contraception (e.g., limiting FP provision to specialized cadres), provider bias, and regulation that may have had some medical rationale but are scientifically unjustified.[10] Reducing medical barriers to contraception can include undertaking legal, regulatory, or service delivery change that removes barriers to accessing contraception and enables self-care. It seeks to improve contraceptive access or "contraceptive convenience."[11] In the area of family planning, it can include new task sharing policies to increase the number and type of (less-specialized) providers able to offer certain methods, it can include changes in drug regulations to allow hormonal pills to be offered over-the-counter by pharmacists and drug shops, or it may include advance provision of pills or DMPA-SC to allow women to have a year's supply at home for her added convenience and self-administration.

Task shifting refers to moving the responsibility for simple health tasks from a more highly qualified health provider, to health workers with shorter training and fewer qualifications

[6] Ouagadougou Partnership. N.d. *Family Planning: Francophone West Africa on the Move. A Call to Action.*
[7] Health Policy Plus. 2017. "HP+ West Africa Leadership Plays Leading Role on ECOWAS Task Shifting/Sharing Resolutions. *Health Policy Plus,* June 21, 2017
[8] Millogo. T, S. Kouanda, NT. Tran, B. Kobore, N. Keita. et al. 2019. Task sharing for family planning services, Burkina Faso. *Bull World Health Organ*. 2019;97(11):783–788. doi:10.2471/BLT.19.230276.

[9] High-Impact Practices in Family Planning (HIPs). Task Sharing Family Planning Services to Increased Health Workforce Efficiency and Expand Access: A Strategic Planning Guide. 2019. Washington, DC: USAID.
[10] Shelton. J, and R.A. Jacobstein, and M.A. Angle. 1992. "Medical Barriers to Access to Family Planning". *Lancet* 340(8831):1334-5.
[11] Barot. S. 2008. Making the Case for a 'Contraceptive Convenience' Agenda. Guttmacher Policy Review. Vol 11, No 4.

in order to streamline health services and make more efficient use of human resources for health. **Task sharing** means expanding what cadres can perform which tasks, where the tasks are not taken away from one cadre, but rather additional cadres are capacitated to take on new tasks (WHO, 2017). The FP/RH community has adopted task sharing as their standard term, which is used in this document, but this analysis included literature and policies that use either term or concept.

Self-care refers to "the ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a health care provider."[12] It is meant to complement a provider-client model and to be promoted within an enabling environment, such as investment in health literacy, strong quality control of contraceptives available in the market place, and continued access to trained health care workers should the client need them. The focus on self-care in this review was for DMPA-SC and oral contraceptives as that is what is addressed in the 2019 WHO guidance as it relates to contraceptive methods.

Methodology

Questions Explored

The authors undertook this analysis with the following five questions in mind:

1. How close do national guidelines on family planning match WHO guidelines on which cadre can provide which method?
2. Have national guidelines adopted self-care approaches to FP, such as OTC availability of hormonal pills and self-injection of DMPA-SC?
3. Within a country, are there any inconsistencies between policy documents reviewed (e.g., guidelines, laws, SOPs, assuming available via desk review)?
4. Is there a relationship between degree of task sharing in the national guidelines and the current use of FP (modern contraceptive prevalence rate or mCPR—i.e., do countries ranking high on the "S-Curve" also have extensive task sharing policies? (See Appendix A.)
5. Through the review of multiple country national FP guidelines, are there any overarching impressions on content, format, or approach to provide additional conclusions regarding the current state of national FP guidelines, or recommendations for future development of FP guidelines?

Benchmarks

In order to conduct this analysis, the authors first established the benchmarks against which they would be assessing national documents (see Figure 1). Since using contraception is generally safe and most methods do not require complex medical training for them to be provided to clients,[13, 14] they began with the premise that contraception should be available through the most basic service delivery channels possible to facilitate client access and enhance health system efficiencies.

According to WHO guidance,[15,16] lay health workers and pharmacy workers, with some tailored training, can counsel for all FP methods, counsel and support lactational amenorrhea (LAM) and the Standard Days Method (SDM) and Two Day Method, provide condoms and spermicides, and initiate hormonal pills (combined oral contraceptives [COCs], progestin only pills [POPs], and emergency contraceptive pills [ECPs]) and in specific circumstances, injectables. Self-care guidance also recommends hormonal pills be provided over-the-counter, and promotes self-injection of subcutaneous depot modroxyprogesterone acetate (DMPA-SC).[17] Due to research on the safety of ECPs[18] and lack of WHO eligibility criteria to use,[19] the authors included ECPs alongside COCs and POPs as the package of hormonal contraceptive pills that should be available over-the-counter, assuming that the WHO self-care guidelines' reference to OCPs includes ECPs. Depending on a country's public health workforce, lay health workers can encompass community health volunteers, peer educators, social workers, environmental health workers, etc.

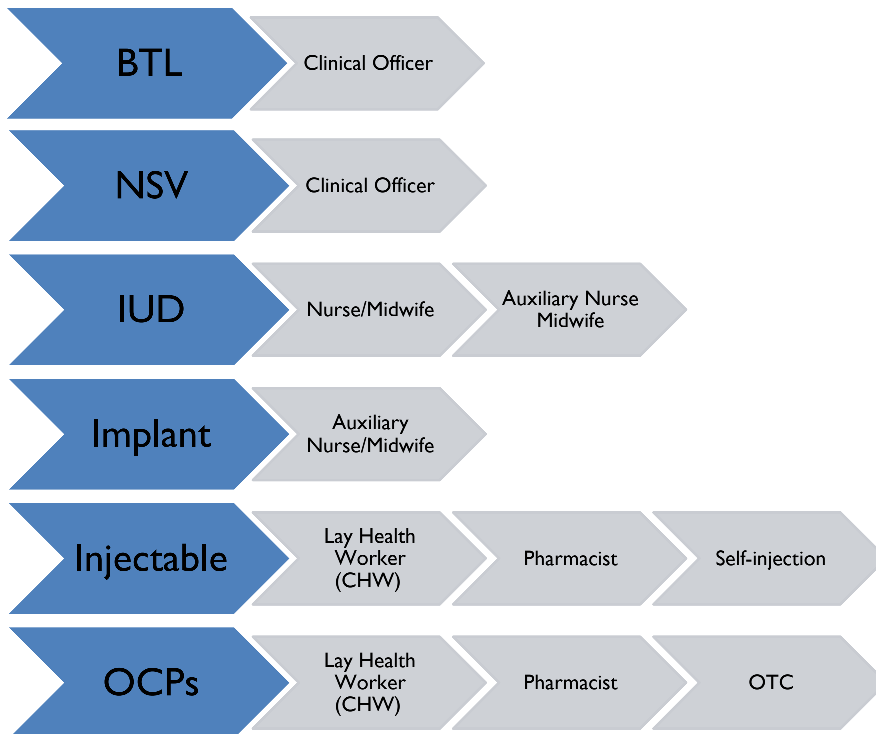
[12] WHO. 2019. *WHO Consolidated Guideline on Self-Care Interventions for Health*. Page 3.
[13] WHO, 2017.
[14] World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), Knowledge for Health Project. Family Planning: A Global Handbook for Providers (2018 update). Baltimore and Geneva: CCP and WHO, 2018.
[15] WHO. 2017.
[16] WHO. 2019.
[17] WHO. 2019.
[18] Grimes, David A. 2000. Emergency contraceptives over the counter: Allowing easy access is important. West J Med. 2000 Mar; 172(3):148-149. doi: 10.1136/ewjm.172.3.148.
[19] WHO. 2015. Medical Eligibility Criteria for Contraceptive Use. Fifth Edition. Geneva: WHO, 2015.

The qualifications of these cadres vary greatly, from little formal education, to secondary school graduates. Their FP training may be a couple of weeks to a month or longer, and these workers may or may not be part of the formal, paid, health system.

Mid-level health workers, usually secondary school graduates with specialized training thereafter (possibly holding a diploma), called auxiliary nurses or auxiliary nurse midwives by WHO, can provide all of the above, injectable contraceptives, and in specific circumstances, implant insertion and removal; WHO stipulates that auxiliary nurse midwives can also provide IUDs. In this analysis, the authors also included in this category a cadre called community health extension workers (CHEWs), as these generally seem to fit the education and training level of auxiliaries.

Voluntary sterilization services, also known as vasectomy (NSV) and bi-tubal ligation (BTL), have been traditionally delivered by specialists (e.g., ob-gyns or urologists) or general practitioners, who have been trained to provide surgical services. Research has shown clinical officers can safely provide NSV and BTL, and this is also included in WHO's guidance.

Figure 1. Benchmarks for lowest level of service delivery for select FP methods



Definition of Cadres

In both the WHO *Optimizing health worker roles to Improve access to key maternal and newborn health Interventions through task shifting* and *Task sharing to Improve access to Family Planning/Contraception*, WHO provides broad definitions of health worker cadres (Table 1). For example, a lay health worker is defined as someone who had received some training but holds no professional or paraprofessional certificate or tertiary education degree.[20] WHO notes these can be called community health worker, village health worker, promoter, traditional birth attendant, community health volunteer, etc. Likewise, a midwife is someone who has been assessed and registered by a state (midwifery) regulatory authority and their training has been for three, four, or more years in nursing school. These can be called registered midwives, nurse-midwives, midwives, community midwives. Challenges arise comparing across countries when cadres have different educational or training requirements. For example, midwives in Philippines are more like auxiliary cadres in East Africa. Likewise, at the community level, community health volunteers/lay workers usually have the least amount of education, but community health extension workers can be similar to auxiliary health workers in the level of education/training they receive. Where possible, this analysis tries to illuminate and differentiate cadre qualifications in the country summaries in Appendix B.

Table 1: Definition of cadres, adapted from WHO's *Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting (2012).*

Worker Type	Examples	Training
Lay Health Worker	Community health worker, village health worker, promoter, traditional birth attendant, community health volunteer, *relais*	Varies
	Community Health Extension Worker (CHEW), *Agent de santé communautaire* (ASC)	Secondary school + 1-3 years training
Pharmacy worker	Pharmacy assistant, pharmacy technician dispenser, pharmacist aide	Not defined
Pharmacist	Pharmacist, chemist, community pharmacist	Not defined
Auxiliary Nurse/midwife	Auxiliary nurse, nurse assistant, enrolled nurse, auxiliary midwife	Some secondary school; cadre training varies from a few months to 2-3 years
Nurse	Registered nurse, nurse practitioner, licensed nurse	3-4 years post-secondary education; registered
Midwife	Registered midwife, community midwife	3-4 years post-secondary education (2 in Philippines); registered
Associate Clinician	Clinical officer, medical assistant, health officer	3-4 years post-secondary education; registered
Doctor	Family doctor, general practitioner	5-9 years of post-secondary education; registered

[20] WHO. 2012. *Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting*.

Country selection

The authors selected 10 countries for this analysis (Table 2). Countries were chosen based on whether they received USAID funding for FP programs and would likely continue receiving USAID FP funding over the next 3-5 years, the availability of in-country contacts from which to obtain documents or supplementary information, and the likelihood of having national policies in either English or French. The authors also looked at the country's position on the "S-Curve" (see Appendix A) and selected a couple from each category.

Literature scan

This analysis was primarily a desk review. The authors collected national FP clinical guidelines (or similar documents, such as reproductive health or maternal and child health guidelines that included FP, but for clarity's sake, are all referred to as FP guidelines in this report),[21] task sharing policies or guidelines, and any other related material, such as training curricula, human resources for health (HRH) strategies, a national FP Costed Implementation Plan, introduction and scale-up plans for DMPA-SC, that could be obtained through an on-line search or through personal contacts/inquiries.

National FP clinical guidelines were considered "first order" of evidence as to the degree of task sharing and self-care that a country had adopted for family planning. The authors documented what the national FP guidelines said about how each method could be provided by which cadres in an Excel data collection tool, using a combination of yes/no designations (e.g., whether auxiliary nurses could provide implants), and commentary (e.g., if the document did not address that cadre or method, or if there were internal inconsistencies).

The authors then went to supporting documents, such as task sharing strategies, particularly if they were more recent, to confirm or supplement the information available in national FP guidelines. Inconsistencies were noted, both within a document and between documents. A summary of findings by country is presented in Table 3, while more details of each country is presented in Appendix B.

During this review of documents, the authors also sought to draw general conclusions about national FP guidelines writ-large that may assist others in development of future FP guidelines.

Table 2: Selected countries, their mCPR, and S-Curve placement

Country	Current mCPR (FP2020 data)	Place on "S-Curve"
Burkina Faso	27.1%	Medium
Côte d'Ivoire	20.1%	Medium
Kenya	62.2%	High
Madagascar	42.3%	Medium
Malawi	60.5%	High
Mali	14.6%	Low
Nigeria	14.2%	Low
Philippines	42.7%	Medium
Uganda	36.8%	Medium
Zambia	50.2%	Medium

[21] For uniformity's sake, the term "FP Guidelines" is used in this paper; the bibliography notes whether country document were FP guidelines, RH guidelines, or other health-related guidelines.

Summary of Findings

Below the authors outline findings based on the five questions posed under the Methodology section above. A visual summary of findings by country is presented in Table 3, while more details of each country are presented in Appendix B.

How close do national guidelines on family planning match WHO guidelines on which cadre can provide which method?

Publication dates: All countries had updated their national FP guidelines since WHO published their *Optimizing Health Worker Roles* document in 2012. At least five countries had published national FP guidelines since the 2017 WHO FP *Task Sharing* guidance. As such, all countries had the opportunity at least to have adopted task sharing guidance in-line with WHO recommendations. While the WHO self-care guidance is new, evidence on self-injection and over-the-counter provision of pills, particularly ECPs, has been around for a few years, and could have influenced the more recent country guidelines.

Task-Sharing Clinical Methods: Most countries had adopted some degree of task sharing for clinical methods (implants, IUDs, vasectomy, tubal ligation). Five of the 10 countries did not mention an auxiliary nurse or auxiliary midwife cadres. In the remaining five countries that mention these cadres, auxiliary nurses or CHEWS were allowed to provide implants in four of five countries (Burkina, Côte d'Ivoire, Mali, Nigeria). Uganda was the only country that has this cadre but disallows provision of implants. The same four countries (Burkina, Côte d'Ivoire, Mali, Nigeria) allowed an auxiliary cadre to provide IUDs (Nigeria listed the cadre as CHEW).

Three countries allow clinical officers to provide both tubal ligation and vasectomy (Kenya, Mali, Uganda). Zambia allows clinical officers to provide vasectomy only. Uganda's guidelines went further than WHO guidance and allows nurses and midwives to provide sterilization.

Pharmacies and Drug Shops: Pharmacies and drug shops are important points of access to FP[22] and the ability to easily obtain condoms, pills, or DMPA-SC from pharmacies and drug shops can substantially increase client access and convenience. WHO guidance explicitly mentions pharmacy workers and pharmacists as two cadres that can provide short-acting methods. Yet for the most part these cadres were absent or tangential in country FP guidelines. In many cases, they are included in lists of types of service delivery outlets in the country but then not really incorporated conceptually throughout the document. Kenya was the only country where pharmacies and drug shops were incorporated into a "who can provide" matrix for FP method provision. Côte d'Ivoire and Burkina Faso address them in the context of DMPA-SC and their recent task sharing policies while Zambia does state pharmacists can provide pills.

Stand-alone Task Sharing Policies: Despite the historical resistance to task sharing within the Ouagadougou Partnership countries, this now seems to be embraced as several countries in the Partnership have developed stand-alone task sharing (TS) policies. This is a positive trend for TS, but their content still leaves room for clarification. The policies assume the reader's familiarity with cadres and still include brief references to "provide FP methods" without further specification. Outside of the Partnership countries, Kenya and Nigeria also have stand-alone task sharing policies.

Range of FP Methods Addressed: In some references, COCs and POPs were grouped together and just referred to as "pills" (emergency contraceptive pills may have also been grouped in with COCs and POPs). In a few of the documents reviewed, FP methods were not uniformly or comprehensively covered. For instance, some methods were left out of a "who can provide" chart because they were a small portion of the method mix in that country. All countries mentioned ECPs; seven mentioned hormonal IUDs (LNG-IUS); four mentioned the vaginal ring; nine mentioned a variety of fertility-based methods (beyond Standard Days Method). Only Mali made explicit reference to upcoming introduction of a new method, vaginal rings.

Have national guidelines adopted self-care approaches to FP, such as OTC availability of hormonal pills and self-injection of DMPA-SC?

OTC availability of pills: Guidelines mention the availability of pills through pharmacies in about half the countries, though often they weren't explicit as to whether

[22] High-Impact Practices in Family Planning (HIP). 2013. "Drug Shops and Pharmacies: Sources For Family Planning Commodities And Information." Washington, DC: USAID; 2013 Jun.

they were available "over the counter." Kenya's and Zambia's guidelines do state that pharmacists can provide pills. Burkina Faso's guidelines state that pharmacies can sell pills but does not specify whether a client can purchase without a prescription; however according to in-country contacts, clients are able to purchase pills without a prescription. Likewise, in-country contacts in Malawi said this was also allowed (but could not point to a specific policy), and the Nigeria 2009 FP guidelines specified it was for resupply only.

Self-injection of DMPA-SC: Eight of the 10 countries – Burkina Faso, Côte d'Ivoire, Kenya, Madagascar, Mali, Malawi, Nigeria, and Uganda – either have a policy or guideline that allowed for self-injection of DMPA-SC, or a document that referenced it being introduced in phases, or in-country sources that confirmed it was being rolled-out.

Within a country, are there any inconsistencies between policy documents reviewed (e.g., guidelines, laws, SOPs, assuming available via desk review)?

In most cases, the authors noted inconsistencies either ***within*** the national FP guidelines (e.g., between different sections), or ***between*** the guidelines and other documents referenced. Some inconsistencies were problematic to resolve with informal inquiries to in-country contacts and would require looking into cadre scopes of work and training materials that were not obtainable through an HQ desk review methodology.

Is there a relationship between degree of task sharing in the national guidelines and the current use of FP (modern contraceptive prevalence rate or mCPR)? I.e. do countries ranking high on the "S-Curve" also have extensive task sharing policies?

Within this sample of 10 countries, there seems to be no current link between the extent of task sharing for FP and a country's mCPR (see Appendix A). While countries like Malawi and Kenya have high levels of mCPR, and equally extensive task sharing policies, Mali and Nigeria also both have embraced task sharing to a certain degree yet have very low mCPR. A more thorough analysis of the extent of implementation of task sharing, along with a longer time horizon and more country samples, would be needed to draw any conclusions as to whether task sharing policies correlated with a country's mCPR growth.

Through the review of multiple country national FP guidelines, are there any overarching impressions on content, format, or approach to provide additional conclusions regarding the current state of national FP guidelines, or recommendations for future development of FP guidelines?

Document collection: It was challenging to obtain the documents required for this analysis through a desk review. Some key documents were only obtained in draft format or didn't include publication dates. It was even more difficult to find supporting documents such as provider training curricula or scopes of work. Country efforts in eGovernment to post documents online should be accelerated.

Document format: National RH/FP clinical guidelines differ widely in length, content, and style. The newer documents provided convenient tables listing "who can provide." Some countries did not list a date of publication of its guidelines, making it difficult to assess which international guidance might have influenced them. For example, a document might reference the WHO 2015 MEC, but it was unknown whether it was published in 2016 or 2018.

Classification of Cadres: The variability in terminology and training of various cadres hinders cross-country comparisons. Most countries seem to have a variety of cadres that align to WHO's definition of a lay health worker and were labeled with such diverse terms as community health volunteer, social worker, or environmental health officer. In some cases, these lowest cadres were only generically referred as being able to "provide FP methods" (i.e., guidelines didn't specify which methods). The local requirement for a cadre (qualifications, training duration, etc.) often differed or was not transparent. For example, a midwife in Philippines has less training than a nurse and would be closer to an auxiliary cadre in East Africa. Whereas in East Africa, a midwife is usually a nurse with additional training (i.e., higher level than a nurse). However, it was difficult to find this information across all cadres and all countries to generate a full comparison for this analysis. Lack of details on cadre designations and qualifications might be because local stakeholders developing national guidelines possess implicit knowledge of the health system, and don't think it is necessary to provide these details. But to outsiders without this intimate knowledge of the health system context, information can be missing or confusing.

Table 3: The status of task sharing and self-care in 10 countries in national FP guidelines and related sources

		Burkina Faso	Cote d'Ivoire	Kenya	Madagascar	Malawi[¥]	Mali	Nigeria	Philippines	Uganda	Zambia
	Year of doc(s) reviewed	2018, **2019**	2012, **2019**	2017, **2018**	2017	2014	2012, 2015, 2019	2009, 2014, 2018	2012, **2014**, 2015, 2018	2015, 2016, **2017**	n.d., post 2015
	Current mCPR	27.1%	20.1%	62.2%	42.3%	60.5%	14.6%	14.2%	42.7%	36.8%	50.2%
Self Care	DMPA-SC self-injection		P				P			P	
	ECPs OTC										
Pharma - cies	OCPs by pharmacists							2009 resupply only			
	Injectables by pharmacists			*							
CHWs	OCPs by CHWs							2009 resupply only			
	Injectables by CHWs			*		HSAs not CBDAs				*	
	Implants by CHEWs/ASC		CNM		CNM	CNM	Inconsistent				
Auxiliary cadres	Implants by Auxiliary Nurses			CNM	CNM			CNM	CNM		CNM
	IUDs by Auxiliary Nurse Midwives			CNM	CNM			Listed as CHEW	CNM		CNM
Clinical Officers	Sterilization by Clinical Officers	CNM	CNM	*	CNM			CNM	CNM	& Nurses midwives	NSV only
Specific TS Policy		2019	2019	2017	No	No	No	2014	No	No	No

*only if specifically trained to do so

P=Being introduced in phases as outlined in separate DMPA-SC scale up plan or other document CNM=Cadre not mentioned

¥ Results for Malawi were largely determined through informal inquiries, since national FP guidelines were silent on task sharing

FP Policy (or other doc) says yes	FP Policy (or other doc) says no	Not specified/addressed	Secondary or informal sources say yes

Discussion and Recommendations

In most, if not all cases, getting a clear picture of the policy landscape on FP task sharing and self-care in the 10 countries selected was extremely challenging. The authors had to source and review multiple types of documents (FP/RH clinical guidelines, task sharing guidelines, training manuals, scale-up strategies, etc.), and found inconsistencies both internally and between documents. Likewise, without an in-depth knowledge of governance hierarchies in a country, it is impossible to know if documents supersede each other based on publication date or other factors. As one might expect, documents with more recent publication dates were much more aligned to current evidence and WHO guidance than older ones, even though the vast majority of the documents were produced after the first WHO guidance on task shifting for FP was published (2012). Given these limitations, we conclude that overall, most of the countries analyzed were working towards reducing medical barriers for family planning in-line with most current evidence and WHO guidance within their written national FP guidelines, but some opportunities to further increase access remain. The countries reviewed seem to be doing fairly well in establishing policies for task sharing clinical methods where appropriate cadres exist, and for promoting community-based provision of short-acting methods, including injectables. Self-injection is also working its way into recent government FP publications and as countries update their guidelines, this trend will likely continue.

However, while task sharing and self-care advocates may be claiming victory with updated FP guidelines, other regulatory barriers, such the classification of hormonal contraceptives by the national drug authorities, or changes to provider scopes of practices or licensing, may block any advances achieved through updated FP guidelines. Informal discussions on the preliminary results of this analysis with other task sharing experts suggested this. For example, specifically for Uganda, where the FP guidelines state nurses and midwives could perform sterilization, in-country contacts didn't think that was actually allowed. A full analysis of all policy and regulatory factors affecting task sharing and self-care would require on-the-ground information-gathering. This could be complemented with assessing the degree of *implementation* of existing policies/guidelines and any barriers that countries might be encountering, through such in-country assessments.

For the task sharing areas where WHO guidance remains cautious – implant insertion and removal by CHWs; IUD and vasectomy by auxiliaries; and vasectomy and sterilization services by nurses and midwives – a few countries seem to be moving in this direction, so more implementation research is needed to fully inform the FP community to what degree task sharing these services is safe and programmatically feasible.

There are some specific topics that could be strengthened in national FP guidelines. First and foremost is the integration of pharmacies and drug shops within guidelines. This cannot just start and end with mentioning their role as FP service delivery points but should include explicit mention throughout where appropriate, and more conceptual integration on how to leverage their role to increase access within a national family planning program. The current focus on introducing DMPA-SC provides an opportunity for greater engagement of pharmacies and drug shops (e.g., policy change for patent and proprietary medical vendors [PPMVs] is a specific objective of Nigeria's DMPA-SC scale up plan), but the FP community should work holistically to ensure policy advocacy on pharmacies and drug shops include engagement on other relevant methods like pills, ECPs, SDM, diaphragms, and vaginal rings. Related to this, now that WHO self-care guidelines promote OTC provision of hormonal contraceptive pills, this should be a major area of advocacy for policy change for advocates trying to advance self-care policies and regulations. Advocates will also need to consider how incorporating pharmacies and drug shops into task sharing and self-care service delivery models will fit with any country efforts to advance universal health coverage or health insurance schemes to ensure that this mode of increasing service delivery access to FP doesn't increase out of pocket payment for contraceptives.

Since these policy and clinical documents aren't updated very often, countries may also want to ensure they cover contraceptive methods that may be very new for that country, or not yet available in the public sector, since the FP market and method mix can change over the five plus years between national clinical guideline updates. Many countries use WHO's *Family Planning – A Global Handbook for Providers*[23] as a reference tool when developing their national FP

[23] WHO Department of Reproductive Health Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), Knowledge for Health Project. 2018. *Family Planning: A Global Handbook for Providers.* Baltimore and Geneva: CCP and WHO.

guidelines. Since this handbook includes all safe and effective globally available FP methods, countries can reliably address newer methods in national guidelines, even if they are only currently minimally available in-country.

Finally, national FP guidelines are often large documents (200-300 pages), requiring a significant effort to produce and disseminate, and may suggest challenges for ease-of-use by clinics and front-line providers. The format and topics covered in these guidelines varied from country to country. For instance, some had handy "who can provide" tables. Some countries relayed information about method availability by service point level (e.g., primary, secondary, tertiary levels of health facilities), which didn't clearly convey if all cadres listed at that facility level could provide the method available at that facility level. Some countries focused specifically on clinical/medical information, while other countries included broader FP programming information, such as chapters on monitoring and evaluation or commodity management. The global FP community may want to consider providing more specific guidance for countries on how to develop national FP guidelines, particularly as it relates to format and content. Additionally, more "user experience" research may be beneficial to inform how best to ensure FP service delivery guidance is readily available to, and used by, providers in low-resource settings. If newer FP guidelines are embracing task sharing and self-care, it is essential that they are effectively disseminated and used by all the cadres if these policy changes are going to positively impact contraceptive access. While not extensively researched, existing literature does recognize that barriers to using clinical guidelines include poor dissemination to all facilities and provider cadres (including for cost reasons), content not aligning with what providers really feel they need, and the fact that the size and comprehensiveness of the documents do not make them easily portable as a quick reference tool.24,25,26 With more focus on mobile health tools, improving the format, content, accessibility, and use of national FP guidelines is achievable.

Next Steps

In the process of developing this analysis, it became evident that knowing what national FP guidelines state may not provide a fully accurate picture of the policies supporting or hindering the adoption of task sharing or self-care for family planning. A full analysis of all policy and regulatory factors affecting task sharing and self-care is greatly needed, such as reviewing drug regulations, provider scopes of work, and other guidelines produced by other ministry units that may supersede or infringe on full implementation of FP clinical guidelines. This requires on-the-ground information-gathering and could be complemented with assessing whether the government has embarked on implementation plans for existing policies/guidelines (such as training programs, changes in commodity distribution, etc.) and any barriers that countries might be encountering to fully realize their desired task sharing or self-care objectives.

[24] Fischer, F., K. Lange, K. Klose, W. Greiner, and A. Kroemer. 2016. *Barriers and Strategies in Guideline Implementation—A Scoping Review*. Healthcare (Basel). 2016 Sep; 4(3): 36. doi: 10.3390/healthcare4030036

[25] Tessema. G.A., J. S. Gomersal, C.O. Laurence, and M.A. Mahmood. 2019. *Healthcare Providers' Perspectives On Use Of The National Guideline For Family Planning Services In Amhara Region, Ethiopia: A Qualitative Study*. BMJ. Vol 9, Issue 2.

[26] Kraft. J.M, T. Oduyebo, T.C, Jatlaoui. K.M, Curtis. M.K, Whiteman et al. 2018. *Dissemination and Use of WHO Family Planning Guidance and Tools: A Qualitative Assessment*. Health Res Policy Sys. 2018; 16:42.

Appendix A. Country Stages of mCPR Growth

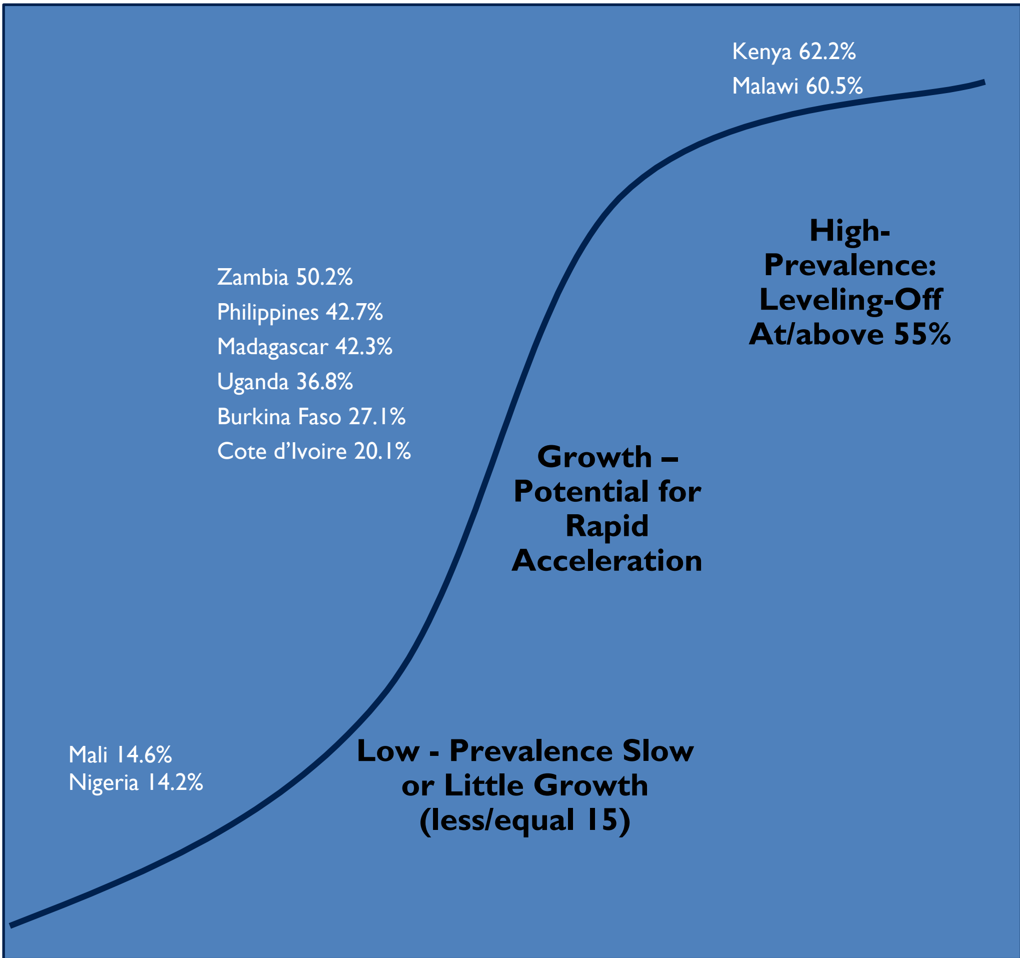
The "S-Curve"

Historically, the increase of modern contraceptive use in a country goes through an "S-Curve" trend of growth. In early stages, a country's mCPR is low – there may be low demand for contraceptives, substantial socio-cultural barriers to use, and poor health system infrastructure to delivery family planning choices. In the growth phase, socio-cultural norms have shifted so that there is more demand for family planning, and the country is investing more in FP service delivery, making it more accessible (geographically, financially), and improving quality of care and perhaps introducing more method options. For countries with a higher mCPR, most clients wanting family planning have ready access, and contraception is socially acceptable. Programs at this stage are usually focusing on improving quality, addressing equity issues among sub populations (youth, indigenous, the poor), expanding method choice, and improving sustainability of the program. For more information see Track20.org.

Figure 2 outlines the countries covered in this analysis, with their national prevalence of modern contraception for married women.

The mCPR data was obtained from the FP2020 website.

Figure 2. S-Curve of mCPR for 10 countries



Appendix B. Country Results

Burkina Faso

mCPR 27.1%; most recent FP guidelines: 2019

Burkina Faso		
Year of doc(s) reviewed		2018, 2019
Current mCPR		27.1%
Self-care	DMPA-SC self-injection	
	ECPs OTC	
Pharmacies	OCPs by pharmacists	
	Injectables by pharmacists	
CHWs	OCPs by CHWs	
	Injectables by CHWs	
	Implants by CHEWs/ASC	
Auxiliary cadres	Implants by Auxiliary Nurses	
	IUDs by Auxiliary Nurse Midwives	
Clinical Officers	Sterilization by Clinical Officers	Cadre not mentioned
Specific TS Policy		2019

Yes	No	Informal sources say yes

Burkina Faso updated their national policies, norms and protocols (PNP), *Politique et Normes en Matière de Santé de la Reproduction,* in 2019 and as such are very much in line with WHO guidelines. Specific details on provision of family planning is addressed as part of community health protocols, *Composantes Communes.* There is a useful overview table in the PNP section on norms (Table XI, p. 68) indicating which cadre can provide which method and at what level of facility. The table does not include, however, reference to ECPs, natural methods or LAM and does not include pharmacists as a cadre. ECPs are described in more detail in the norms in their own section (and under each type of pill), as are natural methods and LAM. Thus, a provider needs to consult the Norms to understand what exactly is allowed, and Table XI in the main Policy document can be used as a quick reference only. The PNPs also do not include diaphragms as a method.

Pharmacists and pharmacies are mentioned in the national PNPs. Often, they are paired with doctors (e.g., as "*medecins/pharmaciens")* as the cadre authorized to offer certain methods (pills, injectables) and for some methods (barrier) there is no mention of them. As a source of contraceptives, pharmacies are listed as a location where certain methods are offered. To further task sharing and self-care, this is an important cadre that has the potential to facilitate greater access to family planning services and methods for many women, however clear directives about which methods pharmacists can provide with or without prescription are not included in documents.

Adolescents are addressed as a population group in the PNPs and the norms outline in table format which cadre can provide which type of services. For FP, however, all contraceptives are grouped together (including ECP), therefore this table (Table VIII, p. 63) defers to Table XI referenced above.

In 2019, Burkina Faso also validated a specific task sharing policy – *Document national d'orientation sur la délégation des tâches en SR/PF/VIH/nutrition* – that addresses family planning along with other health services. The policy includes detailed tables by service area describing which cadre is sharing tasks with whom (by cadre) and which tasks are to be shared. The TS policy acknowledges the importance of task sharing and allows for additional cadres to offer FP. For example, the policy authorizes the CHEW-level cadre (*agents itinérant de santé* [AIS]) to offer long-acting reversible methods (implants and IUDs, insertion and removal) and CHWs to initiate and resupply pills, and offer DMPA-SC. The importance of task sharing is also briefly addressed in the updated PNPs (p. 44). Between the two policy documents there are some small inconsistencies, with the PNP document providing the greatest level of detail.

Cadres and Qualifications

Burkina has a long list of cadres authorized to offer FP services and methods including, community health workers (CHW), community health extension workers (CHEW), auxiliary midwife and nurse, nurse, midwife, physician-non specialist and OB/GYN.

The task sharing policy references phasing out several cadres (*infirmiers brevets* and *accoucheuses auxiliaires*) but this isn't

referenced in the PNPs. CHWs require primary school and receive a two-week training which includes FP.

According to in-country contacts, for the CHEW level, secondary school is required, and training can last up to two years. Training for nurses and midwives is three years and the FP module lasts 1.5 and 4 weeks, respectively.

Côte d'Ivoire

mCPR 20.1%; most recent FP guidelines: n.d., circa 2012

Côte d'Ivoire		
Year of doc(s) reviewed		2012, 2019
Current mCPR		20.1%
Self-care	DMPA-SC self-injection	Piloting
	ECPs OTC	Not mentioned
Pharmacies	OCPs by pharmacists	Not mentioned
	Injectables by pharmacists	
CHWs	OCPs by CHWs	
	Injectables by CHWs	
	Implants by CHEWs/ASC	Cadre not mentioned
Auxiliary cadres	Implants by Auxiliary Nurses	
	IUDs by Auxiliary Nurse Midwives	
Clinical Officers	Sterilization by Clinical Officers	Cadre not mentioned
Specific TS Policy		2019

Yes	No	Informal sources say yes

The guidelines reviewed for Côte d'Ivoire, *Protocole des services de santé de la reproduction* do not list a publishing date, but according to an in-country contact it was issued around 2012. This document is organized in tabular form by service delivery level (community, primary care health facilities and referral hospitals), facilitating reference to which method is provided by which cadre at the three levels of care. Overall, these guidelines are not well aligned with the latest WHO guidelines. In contrast to other countries, the only cadres listed providing FP services are doctors, nurses, midwives, *agents de santé communautaire* (ASC or in English, CHWs), and traditional birth attendants (although this cadre is not discussed in detail). Thus, there is no mention of pharmacists throughout the guidelines. In addition, pharmacies are not included as a location for FP services. At the highest level of facility, sterilizations are permitted; however, since doctors, nurses and midwives are classified as providers at this level, per the tables, it's not clear from the table if the individual cadres are authorized to perform this service or not. Another deviation from the latest WHO guidelines is that there is no mention of IUD/implant removal by any cadre in the guidelines. There is inclusion of ECPs by all facility levels (whether this includes both traditional birth attendants [TBAs] and CHW is not clear) and the IUD for emergency contraception is at primary and reference hospital levels, both which are in line with WHO.

Côte d'Ivoire, similar to Burkina Faso, finalized a specific task sharing policy in 2019, "*Politique nationale de délégation des taches en Santé de la reproduction/planning familiale"*. The policy addresses task sharing beyond FP, covering RH, MNCH, HIV, and malaria, and includes a section on adolescents. This policy, being very recent, is more in line with WHO recommendations than the protocol guidelines. The policy includes detailed tables by service area describing which cadre is sharing tasks with whom (by cadre) and which tasks are to be shared. In addition, it includes a version of the WHO table in Table 3 (p. 34) providing a quick reference for providers, which conforms with our analysis benchmarks. The task sharing policy takes great strides in describing task sharing for FP compared to the older national FP protocols. For instance, CHWs (along with social workers) can both initiate and resupply pills, and provide DMPA-IM and SC; auxiliary cadres (*aide-soignant/auxiliaires de santé* or AS) can insert and remove IUDs and implants, and private pharmacies can also distribute and administer DMPA-SC. Peer educators and traditional healers are also allowed, per Table 3 to initial pills and DMPA-SC; however, these cadres are not specifically mentioned in the DMPA-SC scale up plan (October 2019). In terms of sterilization, the task sharing policy allows general medical doctors to perform BTL and NSV, tasks shared from OB-GYNs and specialist surgeons.

While the task sharing policy includes tables (pp. 22, 27) indicating what task is delegated from whom to whom, the reader needs to know the cadres and services when reading the policy as there are many cadres listed on page 34 that are not defined (and aren't included in the protocols either). This is a similar finding to Burkina Faso. There is a specific section

on adolescents, but it only indicates "Offer modern FP methods" without further details. In references to LARCs (implants, IUDs) the policy refers only to insertion in the tables within the document but includes removal in the WHO-version table (Table 3, pg. 34). This difference reflects that insertions are the only task shared whereas removal requires higher level skills and qualifications; this demands careful review of Table 3 and other sections of the policy. Private pharmacies are well included in the policy and referenced as a location with personnel able to offer pills, ECPs, DMPA-SC and condoms, reflecting current emphasis on including pharmacists as providers of DMPA-SC.

Self-care is addressed through the upcoming introduction of self-injection of DMPA-SC (2020) as described in the DMPA-SC scale-up plan (October 2019). Pharmacist will also be allowed to sell or administer DMPA-SC.

Cadres and Qualifications

In the guidelines, there are fewer cadres of providers, including only TBA, CHW, nurse, midwife and doctor. In the Task Sharing policy, however, there are a larger number encompassing different levels of physicians (OB/GYNs, surgeons, generalists) and community level-focused cadres such as CHW, "*aide-soignant*" (a cadre to be phased out and converted to "health auxiliary"; the first class will be in 2020), social workers, matrons, peer educators and traditional healers, and pharmacist (private sellers). The CHW cadre is further divided into the CHW-basic and CHW-coach, the primary differences being years of experience as a CHW and the capacity to supervise (coach). According to materials prepared for a regional workshop on CHWs in September 2019, these workers have primary education and receive a month of training. The AS follow a 7-month training after completing the 3rd class of college, while nurses and midwives receive 3 years of training after their baccalaureate. Nurses, midwives and physicians receive 4 weeks of training on RH (beyond FP it includes PAC, STI/HIV and infertility) according to the 2011 Health Providers Curriculum on Contraceptive Technology.

Kenya

mCPR 62.2%; most recent FP guidelines: 2018

Kenya		
Year of doc(s) reviewed		2017, 2018
Current mCPR		62.2%
Self-care	DMPA-SC self-injection	
	ECPs OTC	
Pharmacies	OCPs by pharmacists	
	Injectables by pharmacists	*only if trained
CHWs	OCPs by CHWs	
	Injectables by CHWs	*only if trained
	Implants by CHEWs/ASC	
Auxiliary cadres	Implants by Auxiliary Nurses	Cadre not mentioned
	IUDs by Auxiliary Nurse Midwives	Cadre not mentioned
Clinical Officers	Sterilization by Clinical Officers	*only if trained
Specific TS Policy		2017

Yes	No	Informal sources say yes

Kenya's *National Family Planning Guidelines for Service Providers* (6th edition) were updated in 2018, and as such are very in-line with WHO recommendations, though there are some inconsistencies in where the information can be found within the document. The guidelines offer a quick reference table on what cadre can provide which method (pg. 27), covering most information at a glance. However, this table neglects to specify what CHEWs can provide, and leaves out several less-common methods (e.g., spermicides, diaphragm). It also does not explicitly categorize ECPs in the chart but addresses their dispensing in other sections. Of note is that Kenya's 2018 guidelines state injectables are approved for self-injection, and that pharmacists can provide to clients both injectables and contraceptive pills. It also specifically states ECPs are available OTC from pharmacies. Kenya also allows appropriately

trained registered clinical officers to provide female and male sterilization.

Kenya also has a *Task Sharing Policy Guidelines 2017-2030* document that pre-dates the new FP guidelines. The Task Sharing guidelines is a relatively strong document, however there were notable inconsistencies between this and the FP clinical guidelines, despite them being produced only about one year apart. This may be attributable to an evolution of thinking, or simply reflect the challenge of ensuring consistency in national guidelines development, when often the government units, working group compositions, and development partners drafting guidelines can differ. For instance, the *Task Sharing* guidelines specify that clinical officers and nurses/midwives working at Level 1 and Level 2 health facilities should only refer for long-acting or permanent methods (pg. 56), but they may provide long-acting methods at Levels 3-5 health facilities (pg. 67). It does not mention clinical officers being able to provide sterilization services (unlike the mention of RHCOs in the 2018 FP clinical guidelines). The *Task Sharing* guidelines also specify that Community Health Volunteers (CHVs) should not initiate injectables or pills, only re-supply, and it specifies pharmacists should only dispense pills, and does not say they can provide injectables. There are also internal inconsistencies within the Task Sharing guidelines. For instance, the list of cadres at Levels 3-5 health facilities that can provide oral contraceptive pills under Youth and Adolescent Care (pg. 75) is much more comprehensive than who can provide oral contraceptive pills under Family Planning & Reproductive Tract Infections (pg. 68).

Cadres and Qualifications

The main cadres listed include community health workers (CHWs), community health extension workers (CHEWs), clinical officers, nurse-midwives, and physicians. CHEWs supervise CHWs. A 2007 training manual for CHEWs states they receive a two-week training. Nurse training varies from two-year certificates for enrolled nurses, to three-year diplomas for community health nursing, and BSc (and above) for nurse-midwives. Clinical officers, at a minimum, undertake a three-year diploma program with a 1-1.5-year practicum thereafter. They are licensed by the Clinical Officers Council. There are higher diplomas and a BSc in Clinical Medicine also available.

Madagascar

mCPR 42.3%; most recent FP guidelines 2017

Madagascar		
Year of doc(s) reviewed		2017
Current mCPR		42.3%
Self-care	DMPA-SC self-injection	
	ECPs OTC	
Pharmacies	OCPs by pharmacists	
	Injectables by pharmacists	
CHWs	OCPs by CHWs	
	Injectables by CHWs	
	Implants by CHEWs/ASC	Cadre not mentioned
Auxiliary cadres	Implants by Auxiliary Nurses	Cadre not mentioned
	IUDs by Auxiliary Nurse Midwives	Cadre not mentioned
Clinical Officers	Sterilization by Clinical Officers	Cadre not mentioned
Specific TS Policy		No

Yes	No	Informal sources say yes

Madagascar has over ten years' experience allowing CHWs to offer injectables at the community level. This cadre was first referenced in national guidelines developed in 2006,27 and Madagascar is considered a pioneer in task shifting to CHWs. The current national guidelines, Norms et procedures en Santé de la reproduction, 3rd edition, were issued in 2017 and are somewhat aligned with WHO guidelines. Their long history of CHW provision of FP is reflected in the guidelines,

[27] Hoke. T, Wheeler. S, Lynd. K, Green. MS, Razafindravony. BH. et al. 2012. *Community-based provision of injectable contraceptives in Madagascar: "task shifting' to expand access to injectable contraceptives,* Health Policy and Planning 2102:27:52-59

with the exception of mentioning CHWs offering ECPs. With respect to CHWs and injectables, in-country contacts report that recent concerns centered on misuse of injectables has raised questions about the absence of legal texts authorizing CHWs to offer medical services. Thus, outcomes of these discussions may prompt revisions in the next version of guidelines. Aspects of the national guidelines that are not consistent with WHO include no mention of pharmacists as a cadre offering FP and nurses/midwives are included as providers of sterilizations at hospitals. WHO guidelines permit sterilizations by this cadre within the context of rigorous research; however, the guidelines are not clear as to whether or not these cadres are limited to only performing this procedure in the presence of a physician.

Madagascar does not have a specific policy on task sharing. However, they do have a recently approved scale-up plan for DMPA-SC, *Plan national de mise à l'échelle (1028-2020) DMPA-SC (June 2018)* and an accompanying annex, *Guide opérationnel de l'introduction de l'auto-injection du DMPA-SC à Madagascar (October 2019)* outlines how self-injection will be rolled out and addresses the important role of task sharing for increasing access to contraception. The operational guide makes references to WHO recommendations on task sharing and self-care and how for Madagascar this approach contributes to expanding access and cost efficiency. The guide authorizes distribution via pharmacies and administration by pharmacists, a cadre not referenced in the 2017 national guidelines. The national plan provides additional information on task sharing regarding provision of short-term methods through pharmacies, noting that they all require a prescription (not in alignment with WHO recommendations) and that there is the intention for the MOH to approve pharmacies to offer all short-term methods, however in-country contacts confirm that this approval has not yet been granted in policy or guidelines.

Cadres and Qualifications

Agents communautaires (ACs) are the local community health workers. Similar to *relais* in West Africa, there are no formal educational requirements, though ACs are literate and are selected by communities. Their training varies. Other cadres providing FP include nurse, midwife, and physician. Nurses and midwives receive 3 years of training following their baccalaureate.

Malawi

mCPR: 60.5%; most recent FP guidelines 2014

Malawi		
Year of doc(s) reviewed		2014
Current mCPR		60.5%
Self-care	DMPA-SC self-injection	
	ECPs OTC	
Pharmacies	OCPs by pharmacists	
	Injectables by pharmacists	
CHWs	OCPs by CHWs	
	Injectables by CHWs	HSAs not CBDAs
	Implants by CHEWs/ASC	Cadre not mentioned
Auxiliary cadres	Implants by Auxiliary Nurses	
	IUDs by Auxiliary Nurse Midwives	
Clinical Officers	Sterilization by Clinical Officers	
Specific TS Policy		No

Yes	No	Informal sources say yes

Malawi was a relatively early adopter of task sharing in FP when the government initiated the provision of DMPA-IM by health surveillance assistants (HSAs) in 2008.[28] In 2013, Malawi started allowing community midwife assistants (CMAs) to provide implants.[29] Malawi has continued to recognize the value of task sharing and self-care in family planning. Their 2015 *Family Planning Costed Implementation Plan* (CIP) sets as objectives the task sharing of injectables to community-based distribution agents (CBDAs), of implants

[28] Richardson. F, M. Chirwa, M. Fahnestock, M. Bishop, P. Emmart, and B. McHenry. a. 2009. *Community-Based Distribution of Injectable Contraceptives in Malawi*. Washington, DC: Futures Group International, Health Policy Initiatives, Task Order I.

[29] Davis, D., C. Lemani, and J. Tang. 2018. "Task Shifting Levenogestrel implant insertion to community midwife assistants in Malawi: results from a non-inferiority evaluation." *Cotracept. Reprod. Med.*; 3:24.

to health surveillance assistants (HSAs), and changing community midwives' (CMAs) scopes of work so they can provide implants and postpartum IUD insertion. Malawi is also one of the first countries to conduct research in self-injection of Sayana Press; impressed with its high client acceptability and impact on reducing discontinuation, Malawi has started to roll out self-injection of Sayana Press in select areas (currently in 7 districts).

Nonetheless, written policy documentation of task sharing in Malawi is balkanized. Malawi's current *National Reproductive Health Service Delivery Guidelines (2014-2019)* is silent on who can provide which contraceptive methods and does not address the role of pharmacies or drug shops in FP provision. Malawi's *National Community Health Strategy (2017-2022)* highlights Malawi's desire to have most of Malawi's Essential Health Services provided by community health volunteers (CHVs) or HSAs. Annex C (pg. 83) provides a list of community interventions that can be provided by community health workers which encompasses volunteers and HSAs; it includes injectable, pill, male condom. However, aggregating these methods as such gives the erroneous impression that CHVs can provide injectables, when in fact, only HSAs are allowed, according to in-country contacts. Malawi's *Guidelines for Family Planning Communication (2011)* mentions that FP services are available at facilities and through CBDAs and HSAs, but does not specify which methods at which level, nor does it address pharmacies or drug shops. A report on *Costing of Integrated Case Management in Malawi* (2013) highlights HSAs are able to provide injectables and CBDAs can provide pills and condoms.

Informal inquiries found that pharmacies can sell injectables (DMPA branded as Safe Plan), branded contraceptive pills including ECPs, without a prescription, alongside the diaphragm, and male and female condoms, however the authors were not able to obtain written documentation on this.

In summary, it seems that Malawi is making great strides in increasing access to family planning. Malawi seems to be on the cutting edge of self-care in FP, with clients' ability to obtain pills and ECPs from pharmacists and drug shops, and self-injection of DMPA-SC being rolled out. Furthermore, implants have been task shared with auxiliary cadres (CMAs), and clinical officers are allowed to provide sterilization services. However, these levels of task sharing are not documented in the government documents we reviewed, and in-country contacts were unable to obtain written confirmation. As such, official policies on task sharing and self-care, and the extent they are being implemented, cannot be confirmed without further in-country inquiries.

Cadres and Qualifications

Malawi has several cadres of community health workers. HSAs provide health services in the community and at health facilities, and make up about half of the health workforce.[30] They are paid members of the Malawi health system, usually have 4 years of secondary school and then receive 12 weeks of training (8 classroom, 4 practical).[31] CHVs are unpaid and include community based distribution agents (CBDAs). CBDAs trainings may be variable but 4 weeks of training and/or on the job training is likely.[32] CHVs are supervised by HSAs. Malawi also has community midwife assistants (CMAs), who are licensed to practice by the Nurses and Midwives Council of Malawi but are supervised by nurse midwife technicians (NMTs). CMAs are part of community health teams and receive 18 months of training post-secondary school.[33] NMTs have three years of post-secondary education and receive a diploma.

---

[30] Government of the Republic of Malawi, Ministry of Health. 2017. *National Community Health Strategy 2017-2022*.

[31] Devlin, K. Farnjuam Egan. And T. Pandit-Rajani. 2016. *Community Health Systems Catalog Country Profile: Malawi.* Arlington VA: Advancing Partners & Communities.

[32] Devlin, K. Farnjuam Egan. And T. Pandit-Rajani. 2016. *Community Health Systems Catalog Country Profile: Malawi.* Arlington VA: Advancing Partners & Communities.

[33] Davis, D. N., C. Lemani, N. Kamtuwanje, B. Phiri. 2018. Task Shifting levonorgestrel implant insertion to community midwife assistants in Malawi: results from a non-inferiority evaluation. Contracept Reprod Med. 2018; 3:24.

Mali

mCPR: 14.6%; most recent FP guidelines 2019

Mali		
Year of doc(s) reviewed		2012, 2015, 2019
Current mCPR		14.6%
Self-care	DMPA-SC self-injection	Piloting
	ECPs OTC	
Pharmacies	OCPs by pharmacists	
	Injectables by pharmacists	
CHWs	OCPs by CHWs	
	Injectables by CHWs	
	Implants by CHEWs/ASC	Inconsistent
Auxiliary cadres	Implants by Auxiliary Nurses	
	IUDs by Auxiliary Nurse Midwives	
Clinical Officers	Sterilization by Clinical Officers	
Specific TS Policy		No

Yes	No	Inconsistent

In 2019, Mali updated their national guidelines – *Politique, Normes et Procedures en Santé de la Reproduction* – which are well in line with WHO recommendations on task sharing concepts. Similar to Kenya, these guidelines offer a quick reference table (pg. 60) on what cadre can provide which method, covering most information at a glance. Task sharing reflected in these updated guidelines include the provision of female and male sterilization by clinical officers (*assistant medical)*, IUD provision by nurses, and implant provision by auxiliary midwives (*matrones*). The PNPs do include reference to upcoming introduction of the patch and vaginal rings (p. 14), and yet there is only reference to the Copper IUD as offered in the public sector with no mention of hormonal IUDs.

There are two levels of CHWs in Mali – volunteers called *relais*, and a formal/paid cadre called *agents de santé communautaires* (ASCs) – and both are recognized as a vital link in the health system. They both provide FP counseling and offer non-prescription methods (pills, condom, cycle beads, LAM). The ASCs can provide injectables. Emergency contraception is only provided by *matrones* and higher – this is not in line with international guidance and likely reduces access. Pills are offered OTC in Mali so it is possible to buy combinations usable for ECP but may not be in legal or pharmaceutically-appropriate formulations. There is an inconsistency with the Essential Care in Community (SEC) Implementation Guide, 2015 (pg. 21) which permits CHWs to provide Implanon NXT. This does not appear to be general practice.[34]

Development of the PNPs and a DMPA-SC introduction and scale-up plan occurred over a couple of years. Both document sets were validated in 2019 and yet include several inconsistencies, reflecting perhaps, as noted for Kenya, that there is an important challenge of ensuring consistency in development of different national guidelines particularly when the government units, working group compositions, and implementing partners can differ. One concerns pharmacists who are hardly mentioned in the PNPs, however, they are authorized to offer modern methods including injectables. In the Policy and Norms (p. 15), there is a note indicating that pharmacists are to distribute modern methods, but details of which are not provided. In the DMPA-SC plan, pharmacists are listed as an important provider for the use and scale-up of DMPA-SC and are authorized to offer (sell, inject) DMPA-SC. The second is reference to self-injection which is described in the DMPA-SC scale-up plan (2019-2021) but isn't mentioned in the PNPs.

During the course of this analysis, one of our research questions was whether the degree of task sharing had any correlation to mCPR. Mali has a long history of task sharing one of the most popular reversible methods – injectables. Dating back to the early 2000s, community health workers were authorized to offer injectables as part of the community health program. In 2012, Mali began to allow auxiliary

[34] Dr. Oumar Bagayogo, "Questions historiques sur la délégation des taches au Mali." Received by Sara Stratton, 16 October 2019.

midwives (*matrones*) to provide injectables and implants.[35] Yet Mali's overall mCPR remains low. As such, this indicates that improving access to contraceptives through task sharing has not been a panacea to improving contraceptive use in Mali.

Cadres and Qualifications

Mali has differing levels of community health workers. *Relais communautaires (relais)* are volunteer health promoters/ educators, often with no formal educational requirements (though usually are literate). They receive 1-2 weeks of training and may receive additional trainings on specific topics. Mali's *agents de santé communautaires* (ASCs) receive stipends largely through donor projects. ASCs are required to have a grade 9 education and a certificate as a nurse's aide or auxiliary midwife; they receive three weeks of training and may receive additional training as needed (e.g., donor-funded trainings on specific topics).[36] Matrones are the local term for auxiliary midwives. Other cadres offering FP include nurses, midwives, medical assistants (nurse or midwife with additional training, equivalent to a clinical officer), and physicians.

Nigeria

mCPR: 14.2%; most recent FP guidelines: 2009

Nigeria		
Year of doc(s) reviewed		2009,2014, 2018
Current mCPR		14.2%
Self-care	DMPA-SC self-injection	
	ECPs OTC	
Pharmacies	OCPs by pharmacists	2009 resupply only
	Injectables by pharmacists	
CHWs	OCPs by CHWs	2009 resupply only
	Injectables by CHWs	
	Implants by CHEWs/ASC	
Auxiliary cadres	Implants by Auxiliary Nurses	Cadre not mentioned
	IUDs by Auxiliary Nurse Midwives	Listed as CHEW
Clinical Officers	Sterilization by Clinical Officers	Cadre not mentioned
Specific TS Policy		2014

Yes	No	Yes, with caveat

Nigeria last issued a *National Service Protocols for Family Planning* in 2009. Page *xix* lists which cadres can provide which methods. It states surgical and implant methods are the purview of medical doctors; IUDs can be provided by nurses, nurse-midwives, registered midwives, community health officers, public health nurses, and community midwives health visitors. Senior community health extension workers and rural superintendents can provide all short-acting methods. Pharmacists, pharmacy assistants/technicians, proprietary and

[35] Mbow FB, Ningue EAB, Diop N, Mané B, Ngouana R. 2015. "La délégation des tâches dans le domaine de la planification familiale au niveau communautaire dans les pays du Partenariat de Ouagadougou: Expériences et leçons apprises pour une mise en œuvre effective – Présentation par pays". Dakar: Population Council.

[36] Advancing Partners and Communities. 2016. Community Health Systems Catalogue Country Profile: Mali. Available at: https://www.advancingpartners.org/sites/default/files/catalog/profiles/mali_chs_catalog_profile_0.pdf

patent medicine vendors (PPMVs), junior community health extension workers, volunteers, CBD agents, village health workers, TBAs, etc., can resupply pills and provide condoms and foaming tablets.

In 2014, Nigeria issued a *Task Sharing and Task Shifting Policy for Essential Health Care Services in Nigeria*. This document lists CHEWs, nurses, and midwives as providing injectables, implants, and IUDs, but only medical officers providing sterilization services. There is no mention of condoms, pills, or natural FP methods such as Standard Days. ECPs were mentioned under post miscarriage care, and all cadres were allowed to provide, including village health workers.

In 2018, Nigeria developed a DMPA-SC scale-up plan. It specifies that current policy does not allow community pharmacies and PPMVs (drug shops) to stock or administer injectables but recognizes that in practice they do. As such it does set out objectives to change policy and formalize pharmacy and PPMV roles in provision of DMPA-SC. According to informal inquiries during this assessment, while DMPA-SC is on the Essential Medicine List and the Patent Medicine List, full policy changes required to allow PPMVs to provide DMPA-SC have not yet been put into effect. A key next step is getting PPMVs accredited by the Pharmacist Council of Nigeria.

Cadres and Qualifications

Village health workers (VHWs) are volunteers, often expert clients or mentor mothers. Community health extension workers (CHEWs) are paid staff posted at primary health care centers. CHEWs undergo 36 months of post-secondary school training and receive a diploma. Junior CHEWs are trained for 2.5 years and entry to the JCHEW program does not require as high marks as the CHEW program. A JCHEW requires two additional years of training to be certified as a CHEW.[37] General (registered) nurses in Nigeria have three years post-secondary training. One can then take additional courses for 12-18 months to become a registered midwife. A Bachelor of Nursing is a five-year program with one-year practicum.

Philippines

mCPR: 42.7%; most recent FP guidelines: 2014

Philippines		
Year of doc(s) reviewed		2012, 2014, 2015, 2018
Current mCPR		42.7%
Self-care	DMPA-SC self-injection	
	ECPs OTC	
Pharmacies	OCPs by pharmacists	Not specified/ addressed
	Injectables by pharmacists	
CHWs	OCPs by CHWs	Not specified/ addressed
	Injectables by CHWs	
	Implants by CHEWs/ASC	
Auxiliary cadres	Implants by Auxiliary Nurses	Cadre not mentioned
	IUDs by Auxiliary Nurse Midwives	Cadre not mentioned
Clinical Officers	Sterilization by Clinical Officers	Cadre not mentioned
Specific TS Policy		No

Yes	No	Informal sources say yes	Not specified/ addressed

The most recent FP guidelines in Philippines is the *Philippine Clinical Standards Manual on Family Planning*, 2014 edition. The clinical standards stipulate that FP counseling can be done by a nurse, midwife, doctor, or health educator who has received training in the Basic Comprehensive FP Course or the Competency-Based Training (CBT) Level 1/Level 2.

The clinical standards outline what methods can be provided at which level of facility (rather that what type of provider). For instance, it outlines that pills, injectables, IUDs, implants,

[37] PO, N. L, Lo. U, Ac. O, Va. O, Hna. and C, Jm. 2015. “Availability of Skilled Birth Attendants in Nigeria: A Case Study of Enugu State Primary Health Care System.” *Ann Med Health Sci Res.* (1): 20–25. doi: 10.4103/2141-9248.149778

and NSV are available from primary care facilities, and these facilities are staffed by midwives and nurses (pg. 265). As such, one would infer that midwives and nurses can provide implants and NSV. However, when the authors went to other relevant documents, conflicting information emerged. The authors reviewed information from the national health insurance scheme – PhilHealth. A 2018 PhilHealth Circular (2018-0005) lays out guidelines for accreditation of free-standing FP clinics. On pg. 4 it itemizes what certificate of trainings are needed by provider, and lists NSV only alongside the physician, inferring that nurses and midwives would not be conducting NSV. Likewise, a 2015 PhilHealth Circular (2015-0038) only accredits physicians and midwives to provide implants (8b). Local HRH2030 staff in the Philippines provided additional clarification on these contradictions by stating that NSV can only be performed by doctors in Philippines, and that while nurses and midwives could provide implants with relevant training, at the moment PhilHealth will only reimburse doctors and midwives for implant insertion/removal. Philippines is a good example of how national FP guidance on task sharing (and self-care) needs to be complemented by other health policy and regulatory changes in order to be fully implemented.

Philippines's *Clinical Standards Manual* does not cover the role of pharmacies or community health workers in FP provision in any detail. It states "Some FP methods can also be obtained through pharmacies or drug stores and through the network of community-based volunteer health workers. However, this manual does not provide standards for these set-ups" (pg. 283). When the authors inquired with local HRH2030 staff, they stated that currently there is no document to provide these standards. Philippines has "barangay" (village) health workers that largely act as public health educators and referral mechanisms to midwives stationed at a health post. A 2016 country profile stated that BHWs could provide fertility awareness methods, LAM, condoms and resupply pills.[38] It is also unclear what pharmacies are allowed to provide in Philippines. A 2013 Deliver Project document states that the Pharmacy Law prohibits dispensing ethical/regulated drugs (of which OCPs are included) without a prescription.[39] However, the most recent Demographic and Health Survey (2017) does state that about 11% of pill users obtain it from non-medical sources (shop) and 53% from a pharmacy (though this is likely with a prescription).

Emergency Contraception is restricted in Philippines. The reproductive health law of 2012 states that ECPs shall not be procured, and the ICEC database says there is no dedicated ECP product in the Philippines. Nonetheless, the national FP Clinical Standards Manual does have a section on levenogesteral (LNG) and Yuzpe regime of oral contraceptive pills for women who are victims of assault.

The CBT Level 1 manual (n.d., but post 2006 Clinical Standards) mentioned above states learners are health service providers (Introduction, pg. x). The 2012 RH Law infers these cadres do play a role in FP provision. In Section 4(n) public health care service provider refers to licensed and accredited public health care institutions, health care professionals (doctor, nurse, or midwife), public health workers, or barangay health workers who have undergone an accredited government or NGO training program, and are accredited by the local health board.

A quick review of Philippine's FP2020 commitments indicates that advancing task sharing was not one of their objectives/commitments. Other health strategies echo this. For instance, mention of HRH in "FOURmula One," Philippines' implementing framework for health reforms, focus on equitable distribution of HRH. As such, while there is ample room for advocacy and policy change in Philippines to advance task sharing and self-care, since these are not goals of the national FP program, and given historical political challenges with family planning, significant advocacy groundwork would be needed to further align Philippines with current WHO recommendations.

Cadres and Qualifications

Midwives, nurses, and physicians are the main providers of FP in Philippines. While nurses and physicians have generally similar training to other countries reviewed, midwives in Philippines are a cadre lower than nurses and typically have only two years of post-secondary training, as opposed to four years for nurses. As such, midwives in Philippines may be considered similar to auxiliary cadres in East Africa.

---

[38] Devlin, K. Farnjuam Egan. And T. Pandit-Rajani. 2016. *Community Health Systems Catalog Country Profile: Malawi.* Arlington VA: Advancing Partners & Communities.

[39] USAID | DELIVER PROJECT, Task Order 4. 2013. Contraceptive Security Indicators Data 2013. Arlington, Va.: USAID | DELIVER PROJECT, Task Order 4.

Uganda

mCPR: 36.8%; most recent FP guidelines 2017

Uganda		
Year of doc(s) reviewed		2015, 2016, 2017
Current mCPR		36.8%
Self-care	DMPA-SC self-injection	Piloting
	ECPs OTC	Not specified
Pharmacies	OCPs by pharmacists	Not specified
	Injectables by pharmacists	
CHWs	OCPs by CHWs	
	Injectables by CHWs	*only if trained
	Implants by CHEWs/ASC	
Auxiliary cadres	Implants by Auxiliary Nurses	
	IUDs by Auxiliary Nurse Midwives	
Clinical Officers	Sterilization by Clinical Officers	nurses and midwives
Specific TS Policy		No

Yes	No	Informal sources say yes	Not specified/ addressed

Uganda's FP-CIP (2015) highlights task sharing as a major priority (strategic priority #3) and specifically commits to expanding task sharing for injectables, implants, and tubal ligations (pg. 29). Uganda's 2017 *National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights*, published in 2017, strongly adheres to the WHO guidance for task sharing, and states "task sharing to VHTs, nurses and midwives will be encouraged..." (p. 26).

Uganda's sexual and reproductive health (SRH) policy guidelines generally align with international guidance. Table 2 (p. 29) clearly lists family planning service provision by cadre of staff. The cadres include CHEWs and Village Health Teams (VHTs), nursing assistants, nurses, midwives, clinical officers, and doctors. Pills (including ECPs), condoms, fertility awareness methods, and LAM are all provided by VHTs/CHEWs. Injectables are also provided by these cadres with a caveat that they will require special training and close supervision (aligned with WHO guidance).

For implant insertion/removal, Uganda only allows nurses to perform these tasks, whereas WHO recommends auxiliary nurses or auxiliary nurse midwives could provide in specific circumstances. Uganda is actually "ahead" of WHO recommendations on vasectomies and tubal ligations in that its national SRH policy guidelines allows nurses and midwives to perform sterilizations but notes that special training and supervision will be required. WHO categorizes these methods for these cadres as recommended "in the context of rigorous research." Uganda does unequivocally allow clinical officers to provide sterilizations.

Where Uganda's task sharing could be improved is perhaps in engagement of pharmacies and drug shops. These SRH guidelines acknowledge pharmacies and drug retail shops as a recognized outlet of FP service provision (section 3.2.7.2, pg. 25). However, the guidelines do not directly address which FP methods can be provided by these outlets. In Table 2 mentioned above, Uganda equates social marketing agents with health promoters and only allows them to undertake IEC or provide condoms. One could infer that pharmacies/ drug shops might be social marketing outlets but limiting their role to provision of condoms misses an opportunity to allow them to initiate or sell COCs/POPs without a provider prescription, provide ECPs, or dispense injectables. The authors went to secondary sources of information to further explore the role of pharmacies in contraceptive provision in Uganda. Stanback, et al. (2011) documented drug shops providing pills and in some cases injectables.[40] In 2017, the Uganda National Drug Authority Board authorized private drug shops in 20 districts to offer injectables.[41] In a 2018 article *Exploring the Regulation of Task Sharing for Access to Family Planning Services in Uganda*, Mulumba et al. warn that task sharing in Uganda is happening in an unregulated

[40] Stanback J, Otterness C, Bekiita M, Nakayiza O, Mbonye AK. 2011. "Injected with controversy: Sales and administration of injectable contraceptives in Uganda. International Perspectives on Sexual and Reproductive Health," *PubMed*. 37(1): 24-29.

[41] Advance Family Planning. 2017. "Uganda National Drug Authority Approves Drug Shops in 20 Districts to Provide Injectable Contraception."

environment and suggest several approaches to legal reforms that could support task sharing.

Uganda was the first African country to pilot CHW provision of DMPA-IM and is now one of the first African countries to research and roll out self-injection of Sayana Press.[42] In 2017, Uganda's National Drug Authority issued regulatory approval of self-injection of Sayana Press. By mid-2018, women were self-injecting in four districts outside of a research study.[43]

Several dedicated emergency contraceptive pills products are registered in Uganda, per the NDA database.[44] The 2017 *National Policy Guidelines and Service Delivery Standards* for SRH (mentioned above) allows for CHEWs and village health teams (lay volunteers with some health training) to provide ECPs, but do not specify whether pharmacies or drug shops can legally provide ECPs.

Cadres and Qualifications
Village health teams are community volunteers tasked with promoting health and facilitating timely health service delivery in the community; this may include commodity distribution, disease surveillance, and community health information management. [45] Village health teams (VHTs) volunteers are required to be literate and receive varied training; 5-7 days for an initial training, plus specialized training thereafter (e.g., for injectables provision).[46] In 2016, Uganda introduced community health extension workers (CHEWs). Per Uganda's 2016 CHEW strategy, CHEWs are to be 18-35 years of age and hold a Uganda Certificate of Education (equivalent to "O level" in UK system, or about grade 10 in USA); they receive 1 year of training (6 months classroom, 6 months on the job), are based at a Health Center II, and spend 60% of their time working in communities (40% time at the Health Center).

Zambia

mCPR: 50.2%; most recent FP guidelines: n.d.

Zambia		
Year of doc(s) reviewed		n.d., post 2015
Current mCPR		50.2%
Self-care	DMPA-SC self-injection	[red]
	ECPs OTC	[red]
Pharmacies	OCPs by pharmacists	[green]
	Injectables by pharmacists	[red]
CHWs	OCPs by CHWs	[green]
	Injectables by CHWs	[green]
	Implants by CHEWs/ASC	[red]
Auxiliary cadres	Implants by Auxiliary Nurses	Cadre not mentioned
	IUDs by Auxiliary Nurse Midwives	Cadre not mentioned
Clinical Officers	Sterilization by Clinical Officers	NSV only
Specific TS Policy		No

Yes	No	Informal sources say yes

[42] Cover, J., A. Namagembe, J. Tumusiime, et al. 2017. A prospective cohort study of the feasibility and acceptability of depot medroxyprogesterone acetate administered subcutaneously through self-injection. Contraception. 95;3: 306-311. March 1, 2017.
[43] PATH. 2018. "The Power to Prevent Pregnancy in Women's Hands: DMPA-SC Injectable Contraception."
[44] National Drug Authority. 2020. "Drug Register".
[45] Ministry of Health: Republic of Uganda. 2010. VHT Village Health Team Strategy and Operational Guidelines.
[46] Advancing Partners and Communities. 2017. "Community Health Systems Catalogue Country Profile: Uganda".

Zambia's current national *Family Planning Protocols and Guidelines* (3rd edition) does not specify a date, but references WHO's 2015 update to its *Medical Eligibility Criteria for Contraceptive Use*, and therefore the authors can assume the WHO 2012 guidance on task shifting (at the very least) could have been taken into account during drafting. Zambia's national FP protocols are similar to the Philippines in that they start first with a description of what level of facility provides which methods, and which providers might staff that service delivery point (Table 1, p. 9). Interestingly, in method-specific chapters that describe each contraceptive method, its efficacy, side effects, etc., there is a section "who can provide" where more detail is available. This is a unique approach not seen in the other guidelines reviewed.

Zambia is generally in-line with international guidance for most methods. Zambia allows oral contraceptive pills to be provided by trained community health assistants, community health workers, traditional birth attendants, pharmacists, and social marketing retailers. Zambia also allows community health assistants and community-based distributors to provide injectables. Zambia's guidelines don't mention an auxiliary cadre that can provide implants or IUDs, limiting these to only nurses, midwives, clinical officers, and physicians. Zambia has task shared vasectomy with clinical officers, but tubal ligation remains the purview of physicians. Pharmacists are mentioned in the male and female condom sections, but also included as potential social marketing outlets, and therefore the authors inferred where the guidelines mention social marketing it includes pharmacists. As such, pharmacies acting as social marketing outlets, can provide oral contraceptives, including ECPs, but they are not explicitly allowed to provide injectables.

Potential areas for further efforts to increase task sharing and self-care in Zambia include task sharing tubal ligation to clinical officers and strengthening policies and regulations to ensure ECPs and pills are available over the counter and self-injection and advance provision of hormonal methods are addressed.

One small area of technical concern is section 21.6, where the guidelines say return to fertility for ECPs has not been studied. There's no concern on return to fertility after ECP use in global evidence/guidance, and so Zambia may want to consider reframing this point on its next iteration.

Cadres and Qualifications

Zambia's community cadres include community-based workers (formal) or community-based volunteers (informal). Community health assistants (CHAs) are the primary community health cadre and these are formally trained, incorporated into the health system, and usually have secondary school education and receive a year of training (classroom and practical). [47] Community health volunteers (CHVs) are informal cadres, supported by a variety of small public or private programs; they usually have a grade 9 education and pre- and in-service training varies. [48]

The community-based cadres mentioned in the national FP protocols include community health assistants (CHAs), community health workers (CHWs), community-based distributors (CBDs), and social marketing retailers. The other cadres mentioned included clinical officers, environmental health officers, nurses, midwives, and physicians. Clinical officers have three years of post- secondary education with a conferred diploma.[49] Environmental health officers may be another term for Environmental health technologists, which hold diplomas in Environmental Health Technology and report to public health officers. Nurses, midwives, and physician qualifications are similar to other East African countries.

The protocols include a section on social marketing, where it describes contraceptive social marketing (CSM) outlets as including trained health providers, pharmacists, and non-medical personnel like those working in community services. Trained CSM personnel can provide oral contraceptives with a checklist.

[47] Advancing Partners and Communities. 2016. "Community Health Systems Catalogue Country Profile: Zambia".
[48] Advancing Partners and Communities. 2016. "Community Health Systems Catalogue Country Profile: Zambia".
[49] Kafue Institute. N.d. "Clinical Officer General."

Appendix C. References

Burkina Faso

Ministère de la santé. 2018. *Strategie Nationale de Santé Communautaire du Burkina Faso 2019-*

2023. Ministère de la santé. 2019. *Protocoles de la santé de la reproduction composantes communes.*

Ministère de la santé. 2019. *Document national d'orientation sur la delegation des taches en SR/PR/VIH/Nutrition*.

Ministère de la santé. 2019. *Politiques et Normes en matière de santé de la reproduction*.

Ministère de la santé. July 2016. *Curriculum de formation des sages-femmes et maïeuticiens d'état*,

Ministère de la santé. October 2015. *Programme de formation des infirmières et infirmières d'état*.

Côte d'Ivoire

Republique de Côte d'Ivoire. *Protocole des services de sante de la reproduction*. N.d.

Republique de Côte d'Ivoire. N.d. Plan *Strategique de la santé communautaire* 2017-2021

Republique de Côte d'Ivoire. 2019. *Politique Nationale de Delegation des Taches en Sante de la Reproduction/Planification Familiale*. Ministère de la Santé et de l'Hygiène Publique

Ministère de la Santé et de l'Hygiène Publique. 2019. *Plan de passage à l'échelle du DMPA-SC en Côte d'Ivoire*

Ministère de la Santé. 2011. *Formation des agents de santé en technologie contraceptive. Manuel de Référence.*

Ministère de la Santé. N.d. *Formation des agents de santé en technologie contraceptive. Guide du Facilitateur.*

Kenya

Ministry of Health, Division of Family Health, Family Planning Program. 2018. *National Family Planning Guidelines for Service Providers 6th edition. Nairobi, Kenya: RMHSU,*

Ministry of Health. 2017. *Task Sharing Policy Guidelines 2017-2030.*

Ministry of Health. 2007. *Linking Communities within the Health System: The Kenya Essential Package for Health at Level 1*. A Manual for Training Community Health Extension Workers. March 2007. Available at: https://waterfund.go.ke/toolkit/Downloads/3.%20Manual%20for%20Training%20CHEWS(MoH).pdf.

Malawi

Government of Malawi, Ministry of Health. 2014. *National Reproductive Health Service Delivery Guidelines, 2014-2019*. Lilongwe: Government of Malawi.

Government of Malawi, Ministry of Health. 2017. *National Community Health Strategy, 2017-2022*. Lilongwe: Government of Malawi.

Government of Malawi. 2015. *Malawi Costed Implementation Plan for Family Planning, 2016-2020.* Lilongwe: Government of Malawi.

Mali

Advancing Partners and Communities. 2016. *Community Health Systems Catalogue Country Profile: Mali*. Available at: https://www.advancingpartners.org/sites/default/files/catalog/profiles/mali_chs_catalog_profile_0.pdf.

Ministère de la Santé et l'Hygiène Publique. December 2015. *Soins Essentiels dans la Communauté : Guide national pour la mise en œuvre*

Ministère de la Santé et des Affaires Sociales. June 2019. *Politique et Normes des Services de Sante de la Reproduction.*

Ministère de la Santé et des Affaires Sociales. 2019. *Procédures en Sante de la Reproduction. Composantes Communes : Planification Familiale, IST/VIH et SIDA/PTME, Gendre & Sante, Pathologies Génitales et Dysfonctionnements Sexuels chez la Femme.* Volume 2

Ministère de la Santé et des Affaires Sociales. 2019. *Plan de mise à échelle du DMPA-SC (Sayana Press) au Mali, 2019-2021*

Nigeria

Federal Ministry of Health, Nigeria. 2009. *National Family Planning/Reproductive Health: Service Protocols revised version.*

Federal Government of Nigeria. 2014. *Task Sharing and Task Shifting Policy for Essential Health Care Services in Nigeria*

Federal Government of Nigeria. 2018. *National DMPA-SC Accelerated Introduction and Scale Up Plan 2018-2022*. Ministry of Health.

Philippines

Department of Health. 2014. *The Philippine Clinical Standards Manual on Family Planning*, 2014 edition. Manila, Philippines: DOH, 2014

Philippine Health Insurance Corporation. 2015. "Philhealth Subdermal Contraceptive Implant Package". PhilHealth Circular (2015-0038)

Philippine Health Insurance Corporation. 2015. "Guidelines for Accreditation of Free-Standing Family Planning (FP) Clinics". PhilHealth Circular (2018-0005)

Congress of Philippines. 2012. "Responsible Parenthood and Reproductive Health Act of 2012."

Department of Health. N.d. *Family Planning Competency-Based Training: Facilitator's Guide*.

Philippines FP2020 Commitments. 2012. www.familyplanning2020.org/philippines.

Uganda

Akol, A. 2014. "Getting Closer to People: Family Planning Provision by Drug Shops in Uganda." Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4307862/.

Cover, J. 2018. "Continuation of injectable contraception when self-injected vs. administered by a facility-based health worker: a nonrandomized, prospective cohort study in Uganda". Available at: https://www.contraceptionjournal.org/article/S0010-7824(18)30133-1/pdf

Mulumba, M., Nassimbwa, J., Sekimpi, C., and Kyateeka, F. 2018. "Exploring the Regulation of Task Sharing for Access to Family Planning Services in Uganda". *LOJ Nur Heal Car*. DOI: 10.32474/LOJNHC.2018.01.000112.

Uganda Ministry of Health. 2015. *Family Planning Costed Implementation Plan 2015-2020*. Available at: https://health.go.ug/content/uganda-family-planning-costed-implementation-plan-2015-2016.

Uganda Ministry of Health. 2016. *Community Health Extension Workers Strategy in Uganda 2015/16 – 2019/20.*

Uganda Ministry of Health. 2017. *National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights. Fourth Edition (Draft)*.

Global

WHO. 2012. *Optimizing Health Worker Roles To Improve Access To Key Maternal And Newborn Health Interventions Through Task Shifting*. Available at: https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/978924504843/en/

WHO. 2017. *Task Sharing to Improve Access to Family Planning/Contraception.* Available at: https://www.who.int/reproductivehealth/publications/task-sharing-access-fp-contraception/en/

WHO. 2019. *WHO Consolidated Guideline on Self-Care Interventions for Health*. Available at: https://www.who.int/reproductivehealth/publications/self-care-interventions/en/

World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), 2018. *Knowledge for Health Project. Family Planning: A Global Handbook for Providers (2018 update)*. Baltimore and Geneva: CCP and WHO.

A midwife provides prenatal care to one of her patients. Photo Credit: Ibrahima Kamaté, HRH2030 (2019).

Program Partners

- Chemonics International
- American International Health Alliance (AIHA)
- Amref Health Africa
- Open Development
- Palladium
- ThinkWell
- University Research Company (URC)

About HRH2030

HRH2030 strives to build the accessible, available, acceptable, and high-quality health workforce needed to improve health outcomes.

Global Program Objectives

1. **Improve performance and productivity of the health workforce.** Improve service delivery models, strengthen in-service training capacity and continuing professional development programs, and increase the capacity of managers to manage HRH resources more efficiently.
2. **Increase the number, skill mix, and competency of the health workforce.** Ensure that educational institutions meet students' needs and use curriculum relevant to students' future patients. This objective also addresses management capability of pre-service institutions.
3. **Strengthen HRH/HSS leadership and governance capacity.** Promote transparency in HRH decisions, strengthen the regulatory environment, improve management capacity, reduce gender disparities, and improve multi-sectoral collaboration for advancing the HRH agenda.
4. **Increase sustainability of investment in HRH.** Increase the utilization of HRH data for accurate decision-making with the aim of increasing investment in educating, training, and managing a fit-for-purpose and fit-for-practice health workforce.

www.hrh2030program.org

This material is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of cooperative agreement no. AID-OAA-A-15-00046 (2015-2020). The contents are the responsibility of Chemonics International and do not necessarily reflect the views of USAID or the United States Government.

© Chemonics 2019. All rights reserved.

251 18th Street, S Arlington, VA 22202 | Phone: (202) 955-3300 | Fax: (202) 955-3400 | Email: info@HRH2030Program.org