National Family Planning Guidelines in 10 Countries:

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

The World Health Organization (WHO) has issued guidelines on which cadres can provide which family planning methods and recommendations on self-care models for contraceptive access. This brief summarizes the extent to which 10 countries have adopted policies, service delivery guidelines, or other government documents in line with the current evidence on task sharing and self-care for family planning.

USAID and its implementing partners have been working to reduce unnecessary medical barriers to family planning (FP) for decades, including efforts to expand the health worker cadres authorized and trained to provide family planning services through task sharing and to promote client self-care. A new report from HRH2030, *National Family Planning Guidelines in 10 Countries: How well do they align with current evidence and WHO recommendations on task sharing and self-care?* examines how 10 countries[1] (see table below) have adopted policies or service delivery guidelines in line with WHO guidelines on task sharing and self-care. It also identifies areas where national guidelines remain behind current evidence, and highlights opportunities for country-level advocacy and policy change to increase access to family planning.

Country	2019 mCPR (FP2020 data)	Place on "S-Curve"[2]
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

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 over-the-counter 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?
5. 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?

This analysis was primarily a desk review. The authors collected national FP clinical guidelines (or similar documents), task sharing policies or guidelines, and any other related material, such as training curricula, human resources for health (HRH) strategies, introduction and scale-up plans for DMPA-SC, that could be obtained through an online 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.

[1] Countries were chosen based on several factors, including whether they received USAID funding for FP programs and would likely continue to do so in next few years.

[2] Historical data shows that modern contraceptive prevalence grows in an S-shaped pattern. Learn more at track20.org.

Select Findings

The full findings with a country by country analysis are available at this link to the full report here.

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

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 (2019), evidence on self-injection and over-the-counter provision of pills, particularly emergency contraceptive pills, has been around for a few years, and could have influenced the more recent country guidelines.

Most countries had adopted some degree of task sharing for clinical methods (implants, IUDs, vasectomy, tubal ligation). In four countries (Burkina, Côte d'Ivoire, Mali, Nigeria), auxiliary nurses or community health extension workers were allowed to provide implants. The same four countries allowed an auxiliary cadre to provide IUDs. Kenya, Mali, and Uganda allow clinical officers to provide both tubal ligation and vasectomy. Zambia allows clinical officers to provide vasectomy only. Uganda's is "ahead" of WHO guidance, allowing nurses and midwives to provide tubal ligations and vasectomies and with training and supervision. It is important to note these are within policy documents and may not reflect the status of implementation.

Since pharmacies and drug shops are routinely used as important points of access to family planning in many countries, the ability to easily obtain condoms, pills, or DMPA-SC from pharmacies and drug shops can substantially increase contraceptive 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 but then not really incorporated conceptually throughout the guidelines. Kenya was the only country where pharmacies and drug shops were included in a "who can provide" matrix for FP method provision.

Despite the historical resistance to task sharing within Francophone West Africa, several countries within the Ouagadougou Partnership have developed stand-alone task sharing policies. This is a positive trend, but their content still leaves room for clarification. Outside of the Partnership countries, Kenya and Nigeria also have stand-alone task sharing policies.

Conclusions and Next Steps

While most of the countries analyzed were working towards reducing medical barriers for FP in line with current evidence and WHO guidance within their national FP guidelines, some opportunities exist to further increase access. 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 as 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. 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. Informal discussions on the preliminary results of this analysis with other task sharing experts suggested this.

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.

In the next phase of this work, HRH2030 plans to do a deeper dive with in-country assessments in two countries.

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