



IMPLEMENTATION OF THE WORLD HEALTH ORGANIZATION'S TASK SHARING GUIDELINES FOR LONG-ACTING REVERSIBLE CONTRACEPTIVES AND PERMANENT METHODS ACROSS MOMENTUM SAFE SURGERY IN FAMILY PLANNING AND OBSTETRICS COUNTRIES

Desk Review

MOMENTUM Safe Surgery in Family Planning and Obstetrics



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ABBREVIATIONS

ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homeopathy
CHEW	Community Health Extension Worker
CHO	Community Health Officer
CHW	Community Health Worker
CORP	Community-Owned Resource Person
DHS	Demographic and Health Survey
DRC	Democratic Republic of Congo
FP	Family Planning
HRH2030	Human Resources for Health in 2030
IUD	Intrauterine Device
JCHEW	Junior Community Health Extension Worker
LARC	Long-Acting Reversible Contraceptive
LHV	Lady Health Visitor
LMIC	Low- and Middle-Income Country
MOH	Ministry of Health
NSV	No-Scalpel Vasectomy
OB/GYN	Obstetrician and Gynecologist
PM	Permanent Method
PPFP	Postpartum Family Planning
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
SOU	<i>Soins Obstétricaux d’Urgence</i> (generalist doctor competent in emergency obstetrics)
SOW	Scope of Work
SRH	Sexual and Reproductive Health
SSA	Sub-Saharan Africa
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Task sharing in the context of family planning (FP) is the systematic redistribution of FP counseling and methods to expand the range of health workers who can deliver these services. It is a high-impact practice for addressing the shortage of skilled health providers through a more rational distribution of tasks and responsibilities. The World Health Organization (WHO) has developed two guidance documents on task sharing and task shifting for evidence-based optimization of maternal and newborn health and FP and contraceptive use (WHO 2012, 2017). Several low- and middle-income countries, particularly in Sub-Saharan Africa, made commitments at various global and regional fora to increase access to a wide range of FP methods through task sharing. Pursuant to these commitments, prior reviews indicate that countries have adopted and implemented the WHO guidelines for task sharing and task shifting¹ to varying degrees, including allowing mid-level providers to deliver long-acting reversible contraceptives (LARCs). However, provision of permanent methods (PMs) by mid-level providers remains limited.

The MOMENTUM Safe Surgery in Family Planning and Obstetrics project (hereafter referred to as “the project”) is a five-year project funded by the United States Agency for International Development. The project supports priority countries to strengthen safe surgery within FP and maternal health programs by promoting evidence-based approaches and testing new innovations. The project seeks to support well-structured and supervised task sharing as a strategy for increasing access to LARCs and PMs as part of full, free, and informed method choice.

The project conducted this desk review between June and November 2021 to determine the extent to which the implementation countries had adopted and operationalized the WHO recommendations for task sharing to increase access to high-quality FP information and services. At the time of this desk review, project implementation countries included the Democratic Republic of Congo, India, Mali, Mozambique, Nigeria, Rwanda, and Senegal. The assessment also aimed to identify key challenges, barriers, and opportunities related to effective implementation of the WHO task sharing guidelines. The review included an assessment of national health systems documents and global evidence, including published and grey literature on task sharing. The project sourced national health systems documents from all implementation countries as well as documents and grey literature on task sharing for LARCs and PMs available online. The project sourced 41 documents, of which 32 were eligible for the review based on two criteria: the date of publication (within the last 10 years) and a focus on LARCs and PMs.

The assessment aimed to answer the following questions for each implementation country:

1. What is the status of task sharing in the provision of LARCs and PMs?
2. Which types and categories of health provider cadres are responsible for the provision of LARC and PM information and services² within the WHO recommendations?
3. Which cadres outside of those included in the WHO recommendations are allowed to provide LARC and PM information and services?
4. To what extent are the WHO task sharing guidelines adopted and/or codified in current national guidelines, scopes of work (SOWs), and training curricula and materials?

¹ According to the WHO, “task shifting” is the complete delegation of tasks to a lower cadre of providers whereas “task sharing” is the systematic redistribution of tasks to different cadres of health providers. The latter is the preferred approach, hence there is more reference to task sharing as opposed to task shifting in this document, although the terms are sometimes used interchangeably.

² “Services” in this context includes counseling and provision of the method or removal of the device or implant.

5. How are frontline health workers³ deployed for pre- and postsurgical tasks for PMs?
6. What are the roles of nurses and midwives in the delivery of antenatal, postabortion, and postnatal care, and how can we strengthen integration of LARC information and service provision within these services?

The project's desk review revealed that the cadres of health workers responsible for the provision of LARC and PM information and services were consistent with the 11 categories of healthcare workers listed in the WHO guidance documents, although their names, definitions, types of education and training, and roles and responsibilities varied significantly from country to country. Additionally, all implementation countries are implementing LARC and PM task sharing; however, the nature of the tasks shared varies.

There were some cadres outside of those recommended by the WHO providing LARC and PM services. For example, in Rwanda, a pharmacist can provide implant services per national FP guidelines and standards. However, this is contradicted by the Ministry of Health reference manual for continuous training in FP (currently under ministry review). In Nigeria, the national task sharing policy of the Federal Ministry of Health states that community health extension workers, who are categorized as lay workers, can perform intrauterine device and implant insertion and removal in healthcare facilities.

Nigeria is the only implementation country with a standalone policy on task shifting and task sharing, while the remaining six countries have integrated task sharing for LARCs and PMs into other national documents, such as national FP guidelines and standards and/or reference manuals for specific LARCs and PMs. In nearly all countries where the provision of LARCs is task shared with mid-level providers or a specific category of lay workers, the available LARC and PM training resources (including reference manuals) were consistent with national policy recommendations. In addition, the content was relevant and current, except for a few modules that need to be updated based on emerging evidence, notably around infection prevention. There were, however, some inconsistencies among national documents in select countries (e.g., Rwanda and Senegal) on the eligible cadres for training. Only one country (India) has indemnity cover for healthcare workers who provide FP services, including LARCs and PMs.

Key recommendations from the project's assessment include the following:

1. Conduct a follow-on in-depth review and analysis of select countries via key informant interviews with regulatory bodies and other stakeholders to gain more insight into the roles of each cadre and to secure additional supervision tools and SOWs for cadres involved in the provision of LARCs and PMs.
2. Advocate for implementation countries to update outdated policies, protocols, and other national guidelines to ensure that they reflect current evidence and to make these resources easily accessible to facilitate readiness for the provision of high-quality services.
3. Conduct further analysis of indemnity cover and other approaches for motivating healthcare workers, especially those with additional roles and responsibilities, to determine effectiveness and to inform replicability in other countries.
4. Support national programs to address inconsistencies across various national policy documents in relation to task sharing for improving access to LARC and PM services.
5. Analyze existing task sharing barriers and enablers, including other access barriers, to inform future program and policy actions.

³ Frontline health workers are healthcare workers who provide services directly in the communities. They are the first point of contact with community members and include lay workers (community health workers), nurses, midwives, associate clinicians, health assistants, clinical officers, health officers, and, in some settings, nonspecialist medical doctors.

BACKGROUND

In 2012, the World Health Organization (WHO) released a document entitled *Optimizing Health Worker Roles to Improve Access to Key Maternal and Newborn Health Interventions through Task Shifting*, which provides evidence-based recommendations to facilitate universal access to key effective interventions. This includes guidance on the use of various cadres of health worker to provide family planning (FP) methods. In 2017, the WHO released a second, complementary document, *Task Sharing to Improve Access to Family Planning/Contraception*, which includes a summary of recommendations for FP and contraception services specifically and provides further clarity on the similarities and differences between task sharing and task shifting. While the terms task shifting and task sharing are often used interchangeably, "task shifting" is the delegation or rational distribution of tasks among health workforce teams, with tasks completely delegated to lower-level cadre, while "task sharing" is the systematic redistribution of FP services, including counseling and provision of contraceptive methods, to expand the range of health workers who can deliver services (WHO 2017). Task sharing is a recognized strategy and a high-impact practice for addressing shortages of skilled FP health providers, particularly in low- and middle-income countries (LMICs), through more rational distributions of tasks and responsibilities (USAID 2019). Task sharing has shown to increase access to FP and reproductive health services as well as to support cost effectiveness (WHO 2017).

The WHO recommendations for task sharing provide guidance on what different cadres within the health system can or cannot do in relation to the provision of contraceptive information and services and the context in which different cadres are allowed to offer contraceptive services. Cadres of healthcare workers include: (1) those working at the community level, including those referred to as community health workers (CHWs), community health extension workers (CHEWs), and community health officers (CHOs); (2) mid-level healthcare providers such as nurses, midwives, and clinicians who work at community and facility levels; and (3) medical doctors and specialists who work primarily at the facility level.

TABLE 1: WHO GUIDELINE RECOMMENDATIONS FOR TASK SHARING OF CONTRACEPTION (2017)

FP Methods and Services Typically Offered by Cadre of Service Provider *										
National policies and service delivery guidelines dictate which cadres of providers can offer specific FP services. The chart below shows the FP methods that are typically offered by these cadres of providers based on recommendations from WHO.										
Contraceptive Service	Lay Health Workers (e.g., CHWs)	Pharmacy Workers	Pharmacist	Auxiliary Nurse	Auxiliary Nurse Midwife	Nurse	Midwives	Associate/Advanced Associate Clinicians	Non-specialist doctors	Specialist doctors
<ul style="list-style-type: none"> Informed choice counseling Combined oral contraceptives (COCs) Progesterone-only oral contraceptives (POPs) Emergency contraceptive pills (ECPs) Standard Days Method and TwoDay Method Lactational amenorrhea method (LAM) Condoms (male & female), barrier methods, spermicides 	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
<ul style="list-style-type: none"> Injectable contraceptives (DMPA, NET-EN or CICs) 	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
<ul style="list-style-type: none"> Implant insertion and removal 	R	✗	✗	✓	✓	✓	✓	✓	✓	✓
<ul style="list-style-type: none"> Intrauterine device (IUD) 	✗	✗	✗	R	✓	✓	✓	✓	✓	✓
<ul style="list-style-type: none"> Vasectomy (male sterilization) 	✗	✗	✗	R	R	R	R	✓	✓	✓
<ul style="list-style-type: none"> Tubal ligation (female sterilization) 	✗	✗	✗	✗	✗	R	R	✓	✓	✓
Considered outside of the typical scope of practice; evidence not assessed.	Recommended against	Recommended in the context of rigorous research		Recommended in specific circumstances	Recommended	Considered within typical scope of practice, evidence not assessed.				

All of the recommendations above assume that the assigned health workers will receive task specific training prior to implementation. The implementation of these recommendations also requires functioning mechanisms for monitoring, supervision, and referral.

The recommendations are applicable in both high- and low- resource settings. They provide a range of types of health workers who can perform the task safely and effectively. The options are intended to be inclusive, and do not imply either a preference for or an exclusion of any particular type of provider. The choice of specific health worker for a specific task will depend upon the needs and conditions of the local context.

Table 1 presents the WHO recommendations about FP tasks that can be performed by the different cadres of health workers effectively and safely. A summary description of specific WHO recommendations for the provision of long-acting reversible contraceptives (LARCs) and permanent methods (PMs) is presented below by method and by cadre of healthcare worker.

IMPLANTS

- **Lay health workers, including CHWs, CHEWs, and CHOs:** Lay health workers can only offer LARC and PM information and counseling, except in specific circumstances. The WHO recommends the provision of implant insertion and removal by lay workers only in the context of rigorous research and only by lay workers who have completed advanced training to offer high-quality and safe services to clients beyond the competencies required to offer short-acting methods of contraception.
- **Pharmacists and pharmacy workers:** Pharmacists and pharmacy workers can only offer information and services on short-acting methods of contraception. The WHO recommends against the provision of implant insertion and removal by pharmacists and pharmacy workers.
- **Auxiliary nurses and auxiliary nurse midwives:** Auxiliary nurses and auxiliary nurse midwives can provide implants in specific circumstances.
- **Midwives and nurses:** Trained midwives and nurses can provide implant insertion and removal.
- **Associate clinicians and advanced associate clinicians:** Trained associate clinicians and advanced associate clinicians can provide implant insertion and removal. As this is within their scopes of practice, the WHO did not assess evidence informing this recommendation.
- **Doctors of complementary medicine:**⁴ Doctors of complementary medicine can provide implant insertion and removal under specific circumstances.
- **Nonspecialist and specialist doctors:** Nonspecialist and specialist doctors can provide implant insertion and removal. This practice is within the typical scopes of practice of both cadres.

The WHO further recommends that for the provision of high-quality services, the removal of implants can require different and more advanced skills than those required for insertion and that any health worker trained to independently insert implants should also be trained to remove implants.

INTRAUTERINE DEVICES (IUDS)

- **Lay health workers, including CHWs, CHEWs, and CHOs:** The WHO recommends against the provision of IUD insertion and removal by lay workers.
- **Pharmacists and pharmacy workers:** The WHO recommends against the provision of IUD insertion and removal by pharmacists and pharmacy workers.
- **Auxiliary nurses and auxiliary nurse midwives:** Auxiliary nurses and auxiliary nurse midwives can provide IUD insertions and removals. Auxiliary nurses can only provide IUD insertions and removals in the context of rigorous research and additional training is required, as pelvic assessment competencies do not fall within the scope of the auxiliary nurse.
- **Midwives and nurses:** Trained midwives and nurses can provide IUD insertions and removals.

⁴ While doctors of complementary medicine are not featured in Table 1, the cadre is included in the 2017 WHO guidance.

- **Associate clinicians and advanced associate clinicians:** Trained associate clinicians and advanced associate clinicians can provide IUD insertions and removals. This is within their scopes of practice.
- **Doctors of complementary medicine:** Doctors of complementary medicine can provide IUD insertions and removals under specific circumstances.
- **Nonspecialist and specialist doctors:** Nonspecialist and specialist doctors can provide IUD insertions and removals. This is within the typical scopes of practice of both cadres.

STERILIZATION

- **Lay health workers, including CHWs, CHEWs, and CHOs:** The WHO recommends against the provision of sterilization services by lay workers. This is outside the typical scope of practice of this cadre.
- **Pharmacists and pharmacy workers:** Sterilization is outside the established competencies of pharmacists and pharmacy workers.
- **Auxiliary nurses and auxiliary nurse midwives:** Auxiliary nurses and auxiliary nurse midwives can provide vasectomy services only in the context of rigorous research. The WHO recommends against the provision of female sterilization by auxiliary nurses and auxiliary nurse midwives. As this is outside of their typical scopes of practice, the WHO did not assess the evidence informing this recommendation.
- **Midwives and nurses:** Midwives and nurses can only provide sterilization services in the context of rigorous research.
- **Associate clinicians and advanced associate clinicians:** Trained associate clinicians and advanced associate clinicians can provide sterilization services. As this is within their established competencies, the WHO did not review the evidence on this practice.
- **Doctors of complementary medicine:** The WHO recommends that female sterilization is outside the scope of practice for this cadre. Therefore, the WHO did not review the evidence on this practice. There is no recommendation on the provision of vasectomy services by this cadre.
- **Nonspecialist and specialist doctors:** Nonspecialist and specialist doctors can provide sterilization services as sterilization falls within established competencies of these cadres.

Many LMICs, particularly countries in Sub-Saharan Africa (SSA), made commitments at the FP2020 Summit in 2012 to adopt task sharing to increase access to FP services. Further advocacy through regional fora, such as the Ouagadougou Partnership, led to more countries adopting task sharing as a strategy for increasing access to a wide range of FP methods, including LARCs and PMs. In 2017, the Economic Community of West African States resolution for the promotion of task sharing and shifting in the implementation of FP and reproductive health programs was approved by member countries, marking an important commitment at the regional level in West Africa (WAHO 2017). Among other commitments, the resolution calls for mainstreaming task sharing into national plans for human resources, integrating CHWs into national health systems, and actively cooperating with all stakeholders involved in task sharing.

Prior reviews indicate that national guidelines in most LMICs, particularly those in SSA, allow mid-level health providers (in this context, nurses, midwives, and associate clinicians and clinical officers) to provide LARCs, and the provision of LARCs by mid-level health providers is generally accepted globally. Some LMICs (including Burkina Faso, Ethiopia, and Nigeria) have gone further, developing policies that allow trained lay workers (such as CHEWs) to provide implant and IUD information and services in health facilities and at the community level, based on the local context. Trained mid-level providers—such as clinical associates, clinical

officers, health technicians, health officers, advanced clinical associates, advanced clinical officers, and assistant medical officers—can offer PMs. Other cadres who can provide PMs include nonspecialist doctors and specialist doctors, such as obstetricians and gynecologists (OB/GYNs) and surgeons. Unlike LARCs, in practice, most countries in SSA limit the provision of PMs to doctors and specialists, even in settings where such services could potentially be performed by existing mid-level health providers.

According to the WHO, provision of high-quality, voluntary FP services can be safely and effectively offered by trained mid-level health providers as an integral part of postabortion and postpartum care. Development and implementation of national policies and guidelines; expanded scopes of work (SOWs) on task sharing that include ensuring the enabling environment to provide high-quality services (for example, availability of supplies and commodities, infrastructure, job aids, monitoring and supervision); mechanisms for motivating cadres with added responsibilities; and protections against liability are essential parts of the ecosystem needed to realize the full potential of task sharing to increase access to FP services.

DESK REVIEW

The MOMENTUM Safe Surgery in Family Planning and Obstetrics project (hereafter referred to as “the project”) is a five-year project funded by the United States Agency for International Development (USAID). The project supports priority countries to strengthen safe surgery within FP and maternal health programs by promoting evidence-based approaches and testing new innovations. Project implementation countries at the time of this desk review included the Democratic Republic of Congo (DRC), India, Mali, Mozambique, Nigeria, Rwanda, and Senegal. Among other priority interventions, the project supports well-structured and supervised task sharing in implementation countries to address unmet need for LARCs, PMs, and postpartum FP (PPFP). This includes immediate postpartum, post-cesarean delivery, postabortion, and predischarge voluntary FP as part of full, free, and informed method choice.

The project conducted the desk review to inform planning, including to determine the extent to which implementing countries had adopted and implemented the WHO recommendations for FP task sharing to increase access to high-quality information and services. The desk review included an assessment of existing policies and guidelines, regulatory frameworks, SOWs for the various cadres of health providers, training guidelines, and job aids.⁵ In addition to identifying the extent to which countries have codified the WHO recommendations within national guidance documents, this desk review also identified some of the key challenges, barriers, and opportunities for effective implementation of task sharing guidelines, where they exist. The project is using findings from this review to inform the design of country-specific technical assistance and capacity strengthening to support task sharing for provision of LARCs and PMs within a full range of FP methods.

METHODOLOGY

The project conducted this desk review from June to November 2021. The review consisted of two components: (1) a review of national health systems documents (national policy guidelines and protocols, scopes of practice documents, and related training resources); and (2) a review of global evidence, such as published reports, research studies, and select grey literature on task sharing in the project implementation countries, including sub-regions.

⁵ Throughout this desk review, the authors use the language that the respective policy in each country uses. For Francophone and Lusophone countries, we relied on translations.

In the first part of the review process, reviewers prepared a list of national reference documents to source from each country. The project identified a contact person in each country to assist with locating and sharing electronic versions of the most current national guidance documents. The project also reviewed locally generated evidence related to task sharing of LARC and PM service provision by cadres outside of the WHO recommended cadres but codified in national policies and other guidance documents for implementation.

The project received 42 national guidance documents and training resources from the seven implementation countries. Of these, the project retained 32 in the review based on two inclusion criteria: (1) that the documents were published within the previous 10 years and (2) that the publications focused on task sharing of LARC and PM counseling and service delivery. Table 2 presents a summary of the national guidance documents and training resources reviewed. A detailed list is included in Annex 1.

TABLE 2: SUMMARY OF REVIEWED NATIONAL GUIDANCE DOCUMENTS AND TRAINING RESOURCES

Type of Document	No. of Documents	Country
Task sharing policy	1	Nigeria
FP communication strategy and implementation plan	2	Mozambique
Sexual and reproductive health (SRH), including FP, policy, standard, norm, and protocol	8	DRC, India, Mali, Mozambique, Nigeria, Rwanda, Senegal
PM quality assurance and quality improvement guideline	1	India
LARC and PM curriculum (counseling and method provision)	11	India, Mali, Mozambique, Nigeria, Rwanda, Senegal
FP reference material (LARCs and PMs)	5	India, Rwanda
Code of practice for lay health workers (e.g., CHWs and CHEWs), nurses, midwives, clinicians, and advanced clinicians	1	Rwanda
SOW for nurses, associate clinicians, advanced clinicians, midwifery educators, nurse practitioner midwives, and midwives	2	India, Rwanda
Indemnity scheme for FP service providers	1	India
Total	32	

Materials published in French or Portuguese (from the DRC, Mali, Mozambique, Rwanda, and Senegal) required translation to English, for which the project used Microsoft Word translation.

The second component of the desk review involved an assessment of global evidence. This included a review of two USAID Human Resources for Health in 2030 (HRH2030) project reports, one on national FP policies in 10 countries (McGinn and Stratton 2020), and one in-depth analysis of task sharing policies in 2 countries, Burkina Faso and Kenya (Stratton, McGinn, and Ouedraogo 2021). The project also sourced additional online reference materials on global and regional commitments related to task sharing, as well as research publications on task sharing of LARC and PM services from specific implementation countries using Google and PubMed search engines. The project combined the search terms “task sharing,” “long-acting reversible

contraception,” and “permanent methods of contraception information and services” with each of the seven implementation countries and retrieved 15 articles from this exercise (see Annex 2).

REVIEW AIMS

The project systematically reviewed each document or publication to answer the following questions in project implementation countries:

1. What is the status of task sharing in the provision of LARCs and PMs?
2. Which types and categories of health provider cadres are responsible for provision of LARC and PM information and services⁶ within the WHO recommendations?
3. Which cadres outside of those included in the WHO task sharing recommendations are allowed to provide LARC and PM information and services (as articulated in national FP guidelines, task sharing policies, and other related national guidance documents)?
4. To what extent are the WHO task sharing guidelines adopted and/or codified by implementation countries in current national guidelines, SOWs, and training curricula and materials?
5. How are frontline health workers deployed for pre- and postsurgical tasks for PMs?
6. What are the roles of nurses and midwives in the delivery of antenatal, postabortion, and postnatal care, and how can we strengthen integration of LARC information and service provision within these services?

RESULTS

WHAT IS THE STATUS OF TASK SHARING IN THE PROVISION OF LARCS AND PMS?

Several reports and publications documented the progress made by LMICs in adopting and institutionalizing task sharing, especially for provision of LARC counseling and services (Konaté et al. 2015; Ouedraogo et al. 2021; LARC and PM Community of Practice 2016; McGinn and Stratton 2020). Although the reports do not include many project implementation countries, they indicate that most countries in SSA included task sharing in their FP2020 commitments and have made progress in implementing these commitments as part of their strategies for increasing access to and uptake of FP services. However, progress was uneven across the region. Most countries adopted strategies for implementation of task sharing that included initial testing of the approach or innovations in research settings before using findings to inform policy development, roll-out processes, or efforts to bring task sharing to scale.

Some of the challenges in implementing task sharing highlighted in the reports and publications at different phases of implementation research, as well as during roll out, included:

- A need for increased frequency of supportive supervision, particularly for programs that had introduced provision of LARCs by lay health workers
- A lack of incentives or motivation for cadres in consideration of added responsibilities

⁶ “Services” in this context includes counseling and provision of the method or removal of the device or implant.

- Difficulty ensuring a sustainable enabling environment (equipment, supplies, and commodities) to provide services

In May 2020, HRH2030 published a technical report describing how 10 LMICs (Burkina Faso, Cote d’Ivoire, Kenya, Madagascar, Malawi, Mali, Nigeria, Philippines, Uganda, and Zambia) adopted policies or service delivery guidelines aligned with or based upon the WHO guidelines on task sharing and self-care (McGinn and Stratton 2020). The report summarized findings from a desk review, identified gaps between existing national guidelines and current evidence, and noted opportunities for advocacy and policy change to increase access to FP services. The findings showed that half of the countries included in the assessment, including project implementation countries Mali and Nigeria, have policies and guidelines in place allowing mid-level providers and one cadre of trained lay worker (CHEWs) to provide implants and IUD services at health facilities. In addition, policies and guidelines in 4 of the 10 countries allowed for PM provision by trained nonphysician providers. Mali is the only project implementation country that reported allowing mid-level providers (medical assistants in particular) to offer sterilization services. However, the authors state that the nomenclature used for the cadres across the different countries made a full comparison difficult.

Overall, the report concluded that most countries included in the analysis were working toward reducing medical barriers to FP services within their written policies, in line with the most current evidence and WHO guidance on task sharing (see Table 1). The report also highlighted opportunities for increasing access to FP services and noted that some countries have more extensive task sharing policies than the WHO recommends, for example, allowing lay workers to provide implant insertions and removals. The report made several key recommendations pertinent to LARC and PM information and services, as summarized in Table 3.

TABLE 3: LIST OF KEY RECOMMENDATIONS ON TASK SHARING OF LARC AND PM INFORMATION AND SERVICES FROM THE HRH2030 TECHNICAL REPORT (2020)

No.	Recommendation
1.	Ensure effective dissemination and use of the most current national policies and guidelines by all cadres.
2.	Review job aids and other tools for cadres providing LARC and PM services.
3.	Review SOWs for CHEWs and other relevant cadres.
4.	Review curricula for strengthening capacity of CHEWs (and other relevant cadres) on LARC provision.
5.	Review the supervisory systems and the environments of CHEWs (and other relevant cadres) undertaking additional tasks (availability of required tools and supplies, work environment, recognition, certification, remuneration, etc.).
6.	Review consistency of task sharing policies and codes of practice from relevant regulatory authorities.
7.	Analyze policy and regulatory factors affecting task sharing through interviews with relevant stakeholders.
8.	Assess the levels of implementation of task sharing policies and identify barriers.
9.	Conduct an in-depth analysis of policies and regulatory factors affecting task sharing and self-care that would require information gathering at the local level.
10.	Conduct implementation research for a few countries implementing FP task sharing to supply information to the FP community on the degree to which such services are safe and programmatically feasible.
11.	Conduct user experience research to assess the availability and use of national FP guidelines by providers.
12.	Review drug regulation provisions for LARCs from relevant national authorities to determine if there are other barriers to task sharing.

HRH2030 conducted the recommended follow-on in-depth assessments in Burkina Faso and Kenya from 2019 to 2021, which included a desk review of key documents and key informant interviews in each country. HRH2030 published the first report on Burkina Faso (Stratton, McGinn, and Ouedraogo 2021), while the

second report on Kenya is pending. The report on Burkina Faso found that while the national policies and guidelines allow mid-level providers to offer sterilization, there are still barriers in the national documents that limit access, such as age and parity requirements. For example, the 2019 national reproductive health protocol states that female clients must be at least 35 years old with a minimum of three living children. Findings from a pilot intervention demonstrate that auxiliary nurses and nurse midwives successfully provided LARCs, expanding their SOW beyond the WHO recommendations for task sharing (Chin-Quee et al. 2020; Millogo et al. 2019). Task sharing for implant insertion and removal services to auxiliary nurses and midwives has not been implemented at scale and the cadres are closely supervised, which is consistent with WHO recommendations. Some of the challenges that limit operationalization of task sharing of LARC and PM services at scale include inadequate funding and inadequate availability of commodities, supplies, and instruments needed to offer a wide range of methods (Millogo et al. 2019).

The HRH2030 Phase II report made several recommendations for task sharing FP services. The two key recommendations related to task sharing LARC and PM services in Burkina Faso include:

- Consider revising national policies, norms, and protocols to remove language that may compromise rights-based principles and to remove medical barriers.
- Task sharing of implant and IUD insertion and removal by auxiliary nurses and auxiliary nurse midwives could be expanded widely.

While these recommendations are specific to Burkina Faso, they are widely applicable to most LMICs.

WHICH TYPES AND CATEGORIES OF HEALTH PROVIDER CADRES ARE RESPONSIBLE FOR PROVISION OF LARC AND PM INFORMATION AND SERVICES WITHIN THE WHO RECOMMENDATIONS?

The cadre names and types, definitions, levels of training, and roles and responsibilities vary significantly from country to country. The 2012 WHO task sharing document for maternal, newborn, and child health defines eight illustrative cadres of healthcare worker, including lay workers, auxiliary nurses, nurses, auxiliary nurse midwives, midwives, associate clinicians, advanced-level associate clinicians, and nonspecialist medical doctors. All cadres are involved in the provision of LARC and PM information and services in different settings across the globe. The 2017 WHO guidance document on task sharing for improving access to FP includes three additional categories: doctors of complementary medicine, specialist doctors, and individual method users. In the context of LARCs and PMs, method use requires the services of a provider to insert and/or remove the contraceptive device or to perform the required medical procedure(s). Although there have been small innovations in IUD self-removal, the practice is not widely available in any setting, partly due to lack of evidence generally, and particularly in LMICs. This review also did not identify clients or users as providers of LARCs or PMs in any of the national or global guidance documents or publications. Self-care for LARCs and PMs, as presented in the WHO's *Family Planning: A Global Handbook for Providers* (2018), is largely confined to: (1) actions that the client should perform in preparation for the procedure and/or after the procedure (e.g., care of the surgical site or wound, management of side effects, what to do if a client notices danger signs), (2) discontinuation of an implant or IUD, and (3) treatment for a complication arising from method use. The WHO self-care guidelines and framework, however, references self-management and care for short-acting contraceptives and fertility management but does not make reference to LARCs and PMs (2019).

Annex 3 lists the categories and various context-specific names of different cadres of providers involved in provision of LARC and PM information and services in the project's seven implementation countries, along with definitions of and training information for the different cadre types.

MAPPING CADRES OF PROVIDERS WITH MANDATES TO PROVIDE LARC AND PM INFORMATION AND SERVICES ACROSS PROJECT IMPLEMENTATION COUNTRIES

Generally, countries designate frontline healthcare workers as nurses, midwives, associate clinicians, health assistants, clinical officers, health officers, lay workers, and, in some instances, nonspecialist medical doctors. However, four of the seven review countries (DRC, India, Nigeria, and Senegal) either do not have clinical associates or such cadres in their health systems or do not assign reproductive, maternal, newborn, child, and adolescent health (RMNCAH) responsibilities, including the provision of LARC information and services, to such cadres. India is the only implementation country where doctors of complementary medicine form part of the formal health system and are allowed to provide FP services, including LARC services. The actual distribution of healthcare workers throughout a given country is influenced by several health systems-related and social factors; this includes the level of the facility, the geographical location of the facility (rural or urban), access to amenities (such as schools), security, and the country's maturity in creating economic and social platforms for improving health workforce recruitment, retention, productivity, and optimization. One of the WHO's recommendations for addressing such problems includes investing in rural and remote infrastructure and services to ensure decent living conditions for healthcare workers and their families (2021). In several countries, mid-level and lay workers are more prevalent in facilities located in remote and hard-to-reach areas; for example, in Nigeria most of the highly skilled providers are in urban facilities in the southern states, while CHEWs are mostly located in rural settings in the northern regions of the country (FMOH 2013, 2014). Table 4 maps different categories of health providers who are mandated to provide LARC and PM information and services, as well as other FP methods and integrated services, in the seven project implementation countries.

TABLE 4: MAPPING CADRES OF HEALTHCARE WORKERS RESPONSIBLE FOR PROVISION OF LARC AND PM INFORMATION AND SERVICES IN PROJECT IMPLEMENTATION COUNTRIES

Where boxes are blank and shaded gray, the cadre was not listed in the materials reviewed and/or the cadre does not exist within the formal health system in the country.

Cadre Category	Country						
	DRC	India	Mali	Mozambique	Nigeria	Rwanda	Senegal
Lay health workers	Relais communautaire	Accredited social health activist (ASHA), RMNCAH counselor	Agent de santé communautaire, relais, matrone	Agente polyvalente élémentaire	CHEW, junior CHEW (JCHEW), CHO, community volunteer (e.g., community-owned resource person [CORP] or village health worker)	CHW, agent de santé maternelle, binome, traditional birth attendant	Agent de santé communautaire, acteur communautaire, relais, relais communautaire, matrone
Auxiliary nurse midwives	Auxiliary nurse midwife	Lady health visitor (LHV), auxiliary nurse midwife			Nurse midwife		
Midwives	Midwife, auxiliary midwife	Midwifery educator	Midwife	Midwife	Midwife	Registered midwife	Midwife
Nurses	Nurse, auxiliary nurse	Staff nurse, senior nurse	Nurse, obstetric nurse, state certified nurse	Nurse	Nurse	Associate nurse, registered nurse	Assistant nurse, nurse, senior health technician
Associate clinicians			Medical assistant	Clinical officer		Clinical officer	
Advanced associate clinicians				Tecnico de cirurgia		Advanced clinical officer	

Cadre Category	Country						
	DRC	India	Mali	Mozambique	Nigeria	Rwanda	Senegal
Doctors of complementary medicine		Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homeopathy (AYUSH) practitioner					
Nonspecialist medical doctors	Medical officer	Medical officer	Doctor	Medical doctor	Medical officer	Medical officer	Médecin généraliste, médecin généraliste compétent en soins obstétricaux d'urgence (SOU)
Specialist medical doctors	OB/GYN, general surgeon, urologist	OB/GYN, general surgeon, urologist	OB/GYN, general surgeon, urologist	OB/GYN, general surgeon, urologist	OB/GYN, general surgeon, urologist	OB/GYN, general surgeon, urologist	OB/GYN, general surgeon, urologist

WHICH CADRES OUTSIDE OF THOSE INCLUDED IN THE WHO RECOMMENDATIONS ARE ALLOWED TO PROVIDE LARC AND PM INFORMATION AND SERVICES?

Use of auxiliary nurses, auxiliary nurse midwives, and lay workers (particularly CHEWs) to provide LARC information and services is the most widely adopted task sharing intervention across several countries in SSA to expand the method mix and increase access to FP. Several reports and publications from different SSA countries documented the use of CHEWs to provide implant and IUD information and services, which is outside the WHO recommendations (McGinn and Stratton 2020; Millogo et al. 2019). Nigeria's national policy on task shifting and task sharing cites locally generated evidence that informed policy decisions (FMOH 2013); see Annex 4 for a list of such local studies. One study demonstrated that CHEWs with appropriate training and supervision could safely and effectively provide implants in a research setting using a pre- and post-intervention design in two regions of northern Nigeria (Charyeva et al. 2015). Another study utilized a quasi-experimental non-inferiority design in two regions of Nigeria to compare moderate-to-severe adverse events resulting from the insertion of implants by CHEWs with those by nurses and midwives (Douthwaite et al. 2021). Due to the extremely low rates of moderate and severe adverse events, the study lacked adequate statistical power to demonstrate that CHEWs were equally competent as nurses and midwives. USAID's Evidence to Action project conducted an interventional study to assess the effects of CHEWs providing implants on contraceptive uptake at select health facilities in the local government areas of two Nigerian states (E2A 2017). The study found improved or highly competent counseling skills and strong implant insertion skills by trained CHEWs from baseline to endline, although these skills appeared to decline slightly at endline. This study also highlighted the importance of supportive supervision for program success in terms of service provision and quality assurance.

In Nigeria, CHEWs are frontline workers who spend 70% of their time working at the facility and the remaining 30% of their time working in the community (Egan, Devlin, and Pandit-Rajani 2017). Nigeria's national task sharing policy allows CHEWs to insert and remove implants in healthcare facilities. Further, the policy states that CHEWs and other health professionals (such as medical doctors, nurses, and midwives) are permitted to provide information about, insert, and remove implants at different times in relation to pregnancy (interval, postpartum, and postabortion). The task sharing policy document states that these directives are informed by locally generated evidence. To support CHEWs in provision of LARC information and services, Nigeria's Federal Ministry of Health published a competency-based training manual and participant reference book for CHEWs on implants and IUD insertion and removal in 2015 (additional information about the training is presented in the following section of this report). Further, CHEWs are allowed to perform selected emergency obstetric care procedures, including monitoring labor, conducting normal deliveries, manually removing placenta, and other primary healthcare interventions, as informed by locally generated evidence.

CHEWs are allowed to insert and remove IUDs in other countries as well, such as Burkina Faso and Ethiopia. In these settings, policies were similarly informed by evidence generated locally (Ouedrago et al. 2021; Pathfinder International 2011; Millogo et al. 2019; Chin-Quee et al. 2020).

Only Rwanda permits pharmacists to insert and remove implants, as per national FP guidelines and standards. However, this is contradicted by the 2021 national reference manual for continuous training in FP, which is currently under review by the Ministry of Health (MOH). Additionally, the project was unable to retrieve any locally generated evidence or publication to support this practice from Rwanda or other LMICs. The WHO guidelines do not recommend that pharmacists or pharmacy workers perform implant or IUD insertions and removals.

TO WHAT EXTENT ARE THE WHO TASK SHARING GUIDELINES ADOPTED AND/OR CODIFIED BY IMPLEMENTATION COUNTRIES IN CURRENT NATIONAL GUIDELINES, SOWS, AND TRAINING CURRICULA AND MATERIALS?

Nigeria is the only country with a standalone national task shifting and task sharing policy for essential healthcare services (FMOH 2014). The other six project implementation countries have embedded FP and reproductive health task sharing guidance in documents from their respective ministries, such as national guidelines, standards, norms and protocols, and reference manuals for different FP methods (MOHFW 2013, 2014a, 2014b, 2018; MSAS-DSME 2020; MSAS 2019a; RBC and MOH 2020). The national policies and guidance documents from five countries (DRC, Mali, Nigeria, Rwanda, and Senegal) recommend that information and counseling for implants should be provided by all cadres, including lay health workers. In the DRC and Mozambique, there is some reference to health cadres responsible for select LARC and PM services in national documents; however, these documents are outdated. The DRC guidelines are 10 years old (MSP 2012), and Mozambique's are 9 years old (MISAU 2013a). Further, the DRC MOH health zone standards describe the norms for provision of FP information at community and facility levels but does not specify the health worker cadres responsible for providing information and counseling at these levels. Guidance documents in five countries (Mali, Mozambique, Nigeria, Rwanda, and Senegal) include provisions for referrals to higher levels of care for management of complications, including deeply inserted, non-palpable implants.

The following sections describe how LARC and PM services are task shared among different cadres and how task sharing is codified in project implementation countries.

IMPLANT INFORMATION AND SERVICES

Implants are included in the range of FP methods offered in six of the seven review countries, India being the exception. This guidance is consistent with the WHO task sharing recommendations. In all project implementation countries where implants are offered, national documents state that implant insertion and removal services should be provided in healthcare facilities and not at the community level. The lowest level of facilities where such services are provided varied. However, outreach services are typically provided from higher- to lower-level health facilities in nearly all implementation countries. In Rwanda, implant insertion and removal services can be provided in community centers and other non-designated locations (such as schools) by the relevant cadre of health worker conducting the outreach event. Table 5 provides an overview of which cadres are allowed to provide implant information and services in the five project implementation countries where the method is available and where information is available. Implants are not included in the range of FP methods available in India and information was unavailable at the time of the assessment for Mozambique.

TABLE 5: CADRES ALLOWED TO PROVIDE IMPLANT INFORMATION AND SERVICES IN FIVE PROJECT IMPLEMENTATION COUNTRIES

Type of Information and Service, by Level	Cadre Allowed to Provide Implant Information and/or Services, by Country (% of implant users as recorded in the Demographic and Health Survey [DHS])				
	DRC (0.7%, DHS 2013-14)	Mali (6.7%, DHS 2018)	Nigeria (3.4%, DHS 2018)	Rwanda (26.6%, DHS 2019-20)	Senegal (9.7%, DHS 2019)
Implant insertion and removal information and services at facility level	Specialist, medical officer, nurse, midwife, auxiliary nurse, auxiliary midwife, relais communautaire	Specialist, medical doctor, midwife, nurse, obstetric nurse, matrone	Specialist, medical officer, nurse, midwife, nurse, midwife, CHEW, CHO	Specialist medical officer, clinical officer, nurse, midwife, associate nurse, pharmacist	Specialist doctor, generalist doctor, SOU, midwife, nurse, assistant nurse
Implant information at community level	<i>Information unavailable at time of assessment</i>	Relais, matrone, agent de santé communautaire	JCHEW, CHEW, CHO, CORP	CHW	Agent de santé communautaire, acteur communautaire, relais, matrone

Generally, across countries, training materials for implant and IUD insertion and removal are competency-based and focus on specific cadres of healthcare workers and/or on the different timings for insertion and removal (interval, postpartum, and postabortion). The PFP training is often a standalone training with separate training modules.

Nigeria has a standalone national LARC training curriculum for CHEWs and a separate standalone LARC training curriculum for doctors, nurses, and midwives. Each of these training resources includes the different timings of insertion and removal. The topics covered in the LARC training resources in Nigeria are generally relevant and current; however, they do not fully reflect the WHO's 2016 standards for infection prevention procedures related to decontamination of medical devices for healthcare facilities and the most recent guidance related to insertion site for implants. Supervision tools for Nigeria were not available for review.

The national PFP training curricula for providers in Mali and Senegal include implant and IUD materials. As in Nigeria, the content is generally current and relevant but does not reflect the 2016 WHO infection prevention guidance. Senegal's national PFP training curriculum goes beyond LARCs to also include hormonal vaginal rings (MSAS-DSME 2018a, 2018b). This curriculum is designed for OB/GYNs, *soins obstétricaux d'urgence* (SOU) (doctors competent in comprehensive emergency obstetric care), generalists trained in FP, senior health technicians, midwives, and nurses. However, despite being included in the curriculum, the trained senior health technician cadre does not appear in the national policy norms and protocols' list of providers who can deliver FP information and services.

The Rwanda MOH 2021 national reference manual for continuous training in FP includes implants within the method mix and includes the different timings for service delivery (interval, postabortion, and postpartum). However, this manual is still in draft and does not include content on newer implants registered in the country, such as Nexplanon. Some of the infection prevention protocols also contain outdated information on decontamination of medical instruments and equipment. Supportive supervision tools were not available for this desk review.

In Mozambique, national standards provide guidance for supervisors on what to assess, how to conduct assessments during a visit, how to analyze and share findings, and how to plan with facility staff to address performance gaps per the standards (MISAU 2013b). All FP methods are covered in the standards, as well as their initiation times (interval, postabortion, and postpartum). The manual also presents corresponding checklists for monitoring the standards. However, the document could benefit from updates and revisions. For example, the document refers to “trained provider” without defining the types of cadres that should provide implant insertion and removal services.

IUD INFORMATION AND SERVICES

All seven desk review countries include copper IUDs in their range of FP method offerings. Hormonal IUDs are included in national policy documents in select countries (DRC, Mali, Nigeria, Rwanda, and Senegal); however, content and guidance on the use of hormonal IUDs varies significantly. Table 6 provides an overview of the cadres that can provide copper IUD (interval, postpartum, and postabortion) information and services at the facility level for five of seven implementation countries; information across all types and levels was unavailable at the time of the assessment for the DRC and Mozambique. None of the country guidance documents authorize provision of copper IUD services (interval) at community level. Nigeria’s national task sharing policy states that CHEWs trained in insertion and removal of IUDs can perform these procedures at the health facility.

TABLE 6: CADRES ALLOWED TO PROVIDE IUD INFORMATION AND SERVICES IN FIVE PROJECT IMPLEMENTATION COUNTRIES

Type of Information and Service, by Level	Cadre Allowed to Provide Specified IUD Information and/or Services, by Country (% of IUD users as recorded in the DHS)				
	India (2.7%, DHS 2019-21)	Mali (1.0%, DHS 2018)	Nigeria (0.8%, DHS 2018)	Rwanda (2.1%, DHS 2019-20)	Senegal (1.9%, DHS 2019)
Interval IUD information and services at facility level	Specialist medical officer, AYUSH practitioner, nurse, auxiliary nurse midwife, LHV*	Specialist, medical officer, matrone, medical assistant, auxiliary nurse midwife, wise wife (midwife), obstetric nurse, state certified nurse	Specialist, medical officer, nurse, midwife, nurse midwife, CHEW, CHO	Specialist, medical officer, clinical officer, nurse, midwife	Specialist, generalist doctor, SOU, midwife, nurse, assistant nurse
Interval IUD information at community level	ASHA, auxiliary nurse midwife	Relais, matrone, agent de santé communautaire	CHO, CHEW, JCHEW, CORP	CHW	<i>Information unavailable at time of assessment</i>
Postpartum IUD services at facility level	Specialist medical officer, skilled birth attendant, LHV, trained AYUSH practitioner,	Specialist, medical officer, nurse, obstetric nurse, midwife	Specialist, medical officer, midwife, nurse, nurse midwife, CHEW, CHO	Specialist, medical officer, clinical officer, nurse, midwife	OB/GYN, SOU, doctor trained in FP, senior health technician, midwife, nurse

Type of Information and Service, by Level	Cadre Allowed to Provide Specified IUD Information and/or Services, by Country (% of IUD users as recorded in the DHS)				
	India (2.7%, DHS 2019-21)	Mali (1.0%, DHS 2018)	Nigeria (0.8%, DHS 2018)	Rwanda (2.1%, DHS 2019-20)	Senegal (1.9%, DHS 2019)
	nurse, auxiliary nurse midwife [†]				
Postpartum and postabortion IUD information at facility level	RMNCAH counselor, auxiliary nurse midwife, doctor, staff nurse	Specialist, medical officer, medical assistant, nurse, obstetric nurse, midwife	Specialist, medical officer, midwife, nurse, nurse midwife, CHEW, CHO	All FP providers [‡]	<i>Information unavailable at time of assessment</i>
Postabortion (first trimester) IUD services at facility level	Specialist, doctor, nurse, auxiliary nurse midwife	<i>Information unavailable at time of assessment</i>	Specialist, medical officer, nurse, nurse midwife, midwife, CHEW, CHO	<i>Information unavailable at time of assessment</i>	<i>Information unavailable at time of assessment</i>
Postabortion (second trimester) IUD services at facility level	Specialist, doctor	<i>Information unavailable at time of assessment</i>	Specialist, medical officer, nurse, nurse midwife, midwife, CHEW, CHO	<i>Information unavailable at time of assessment</i>	<i>Information unavailable at time of assessment</i>

* FP services (including IUD insertion and removal) can only be provided by providers who are empaneled by the relevant bodies at district and national levels.

[†] Provided by those empaneled or enrolled by state and/or district indemnity subcommittees.

[‡] This includes CHWs, nurses, midwives, clinical officers, nonspecialist medical doctors and general practitioners, specialists, and OB/GYNs.

Guidance documents from India, Mali, Nigeria, Rwanda, and Senegal state that the provision of information and counseling on IUDs can be performed by several cadres at the different levels of the healthcare system, as summarized in Table 6. Additionally, all seven project review countries provide guidance on the lowest level of facility permitted to provide IUD services, stating that IUD insertion and removal procedures should be performed in designated health facilities at a specified level and above within the healthcare system. The India reference manual for IUD services further specifies the kind of procedures (interval, postabortion, and postpartum insertion) that can be performed by various cadres (MOHFW 2018). Specialists, doctors, doctors of complementary medicine, nurses, midwives, and lady health visitors (LHVs) can offer postpartum IUD insertion; doctors (including specialists), nurses, and auxiliary nurse midwives can offer postabortion IUD insertion in the first trimester at health facilities. The only other country that specified cadres for postabortion IUD insertion at the facility level was Nigeria, where specialists, medical officers, nurses, nurse midwives, midwives, CHEWs, and CHOs are authorized. This information was not available in the other five countries at the time of the assessment.

All providers in India must complete a training in postpartum IUD services and register with the different indemnity health coverage systems at the national or district levels (see text box). Provision of postabortion contraception immediately after evacuation, particularly for second trimester abortions and for post-medical abortion contraception, can only be provided by medical officers. Though this guidance provides specificity, some of the requirements as stated in the national reference manual for IUD services, such as provision by only doctors and specialists, may hinder access, especially for the provision of postabortion contraception.

Indemnity Cover for Healthcare Workers Providing LARCs and PMs in India

India is the only country among those included in this review where the national reference documents explicitly state that indemnity coverage is available for all healthcare providers offering LARC and PM services (and other FP methods). Only trained health providers who are registered with the indemnity coverage can provide such services. This type of indemnity coverage protects the providers from litigation arising from contraceptive failure, medical error, or severe adverse events that may occur. Though not directly related to task sharing, the coverage ensures legal protection for new cadres assuming the task sharing roles, which can be a motivating factor.

Rwanda's national FP guidelines and standards specify that clinical officers, nurses, midwives, medical doctors, and specialists can insert and remove IUDs at health facilities in routine and outreach settings (RBC and MOH 2020). Rwanda, like most countries, has several cadres of nurses and midwives. The guidelines and standards, however, do not specify which cadre of nurse can provide such services. The SOW for associate nurses in the official ministerial orders states that associate nurses "can provide FP services, namely oral contraceptives, injectables, and implants with special attention to the needs of each individual and couple" (MOH 2012). The SOW is not specific for registered nurses, diploma-level and higher, including midwives at similar levels. Similarly, the summarized version of the scope of practice for clinical officers includes a broad statement that mandates clinical officers to "carry out preventive, promotive, and rehabilitative health services including management of maternal and child health and reproductive health services and screening of cases for referral" (RAHPC 2013). Additionally, clinical officers are permitted to carry out minor procedures and operations at the wards and in critical care units. The policy statement, however, does not specify the role of clinical officers in FP service provision, including LARCs. The national FP norms and standards guidelines, which are more operational, state that clinical officers can provide IUD and implant services.

Mali's national reproductive health norms and standards recommend that IUD insertion and removal procedures be performed by *matrones* (auxiliary midwives), auxiliary nurse midwives, midwives, obstetric nurses, state certified nurses, medical assistants, and medical doctors (MSAS 2019a). According to the national reference manual for training CHWs on integrated PFP and maternal, newborn, and child health and nutrition services, CHWs are expected to provide information and to counsel and refer clients who voluntarily choose a LARC or PM (MSAS 2020).

Skills training for IUD services is normally integrated with training on implant services, as an overall training on LARCs, except in India where implants are not offered. The content in India's copper IUD manual is current except for some of the infection prevention practices, which do not align with the WHO 2016 guidelines. The scope of practice for midwifery educators and nurse practitioner midwives in India states that nurse practitioner midwives are fully responsible and accountable for the provision of FP counseling and services during the prepregnancy, antenatal, and postpartum periods as well as for the provision of postabortion FP services (MOHFW 2021). The scope of practice further states that "the nurse practitioner midwife is a responsible and accountable professional who works with women to provide the necessary supportive

respectful care and advise to the women and their families during pregnancy, childbirth, and in the postpartum period.” The scope of practice mandates midwifery educators and nurse practitioner midwives to perform the following independently: FP counseling, insertion and removal of interval IUDs, insertion of postpartum and postabortion IUDs, and postabortion care (including postabortion FP). The scope of practice is consistent with the training resources and reference manuals for IUDs.

Rwanda’s draft national reference module for continuous training in FP includes content on provision of IUD information and services at different times in relation to pregnancy (MOH 2021). The content includes hormonal IUD provision and is current, except for some infection prevention practices. The cadres listed in the draft manual who can provide IUD services include doctors, nurses, and midwives. Clinical officers, however, are not included as IUD providers in the draft, although they are included in the national FP guidelines and standards. Nigeria’s national reference manuals and training curricula on LARCs for different cadres cover IUD insertion and removal, with current content, except for some of the infection prevention practices (FMOH 2015b, 2015c, 2015d). Mozambique’s technical reference manual for FP services also covers IUDs; however, only copper IUD content is included (MISAU 2013a). The manual includes various periods for IUD insertion (interval, postabortion, postpartum) but does not specify which cadre of health professional can provide IUD services. Senegal’s draft PFP training package specifies which cadres can participate in training on the provision of postpartum and postabortion IUD services, including gynecologists, medical doctors, midwives, senior health technicians, and nurses (MSAS-DSME 2021). However, the senior health technician cadre, as mentioned earlier, does not appear in Senegal’s national policies, norms, and protocols. Mali’s national manual for reproductive health procedures includes postpartum and interval IUD provision (copper and hormonal) but does not include postabortion IUD services (MSAS 2019b). The DRC LARC reference manuals and related training resources were not accessible for review.

FEMALE STERILIZATION INFORMATION AND SERVICES

The recommended surgical approaches for tubal occlusion and tubal ligation, include minilaparotomy, laparoscopic tubal occlusion, and trans cesarean and intra cesarean after delivery of the baby (and removal of the placenta) by cesarean section. India is the only country where laparoscopic tubal occlusion is the preferred approach for female sterilization as an interval procedure and where it can be provided by specialist OB/GYNs, doctors with postgraduate diplomas in obstetrics and gynecology, specialists in other surgical fields, and trained medical officers. All providers offering FP in India must be empaneled and registered at state and/or district levels. Information on laparoscopic tubal occlusion was not available at the time of the review in the documentation for the other six countries. In the remaining review countries, minilaparotomy is the preferred approach for female sterilization. Table 7 provides an overview of the cadres that can provide female sterilization information and services at the facility level for six of seven implementation countries; information across all types and levels was unavailable for the DRC at the time of the assessment. Only in Mali and Mozambique is minilaparotomy task-shared and permitted to be performed by mid-level providers with surgical skills, namely *tecnicos de cirurgia*⁷ and medical assistants, respectively. In the other review countries (India, Nigeria, Rwanda, and Senegal), national guidance documents state that minilaparotomy can only be performed by medical doctors or specialist doctors. As noted previously, Rwanda is the only review country with the associate clinician and clinical officer cadre of healthcare worker. Rwanda’s national FP guidelines and standards state that only medical doctors and specialists can provide female sterilization services; this is not consistent with the WHO’s 2012 guidance, which recommends that minilaparotomy be performed by advanced associate and associate clinicians, nonspecialist doctors, and

⁷*Técnicos de cirurgia* are surgically trained assistant medical officers and mid-level medical practitioners, a cadre introduced in Mozambique in 1984. As mid-level frontline healthcare workers, this cadre are trained to offer clinical and management services in rural areas.

specialist doctors. The two WHO task sharing guidance documents do not, however, provide recommendations on specific approaches, such as minilaparotomy, laparoscopic tubal occlusion, and other female sterilization approaches and techniques, that can be performed by a particular cadre.

TABLE 7: CADRES ALLOWED TO PROVIDE FEMALE STERILIZATION INFORMATION AND SERVICES IN SIX PROJECT IMPLEMENTATION COUNTRIES

Type of Information and Services	Cadre Allowed to Provide Female Sterilization Information and/or Services, by Country (% of female sterilization users as recorded in the DHS)					
	India (36.3%, DHS 2019- 21)	Mali (0.4%, DHS 2018)	Mozambique (0.2%, DHS 2011)	Nigeria (0.2%, DHS 2018)	Senegal (0.7%, DHS 2019)	Rwanda (2.0%, DHS 2019- 20)
Female sterilization information and pre-op counseling	ASHA, auxiliary nurse midwife, LHV, counselor,* nurse, midwife, medical doctor, specialist OB/GYN, other surgical specialist	Agent de santé communautaire, relais, auxiliary nurse midwife, obstetric nurse, matrone, nurse, medical assistant, doctor, specialist OB/GYN	<i>Information unavailable at time of assessment</i>	Village health worker, CORP, CHEW, nurse, nurse midwife, midwife, medical doctor, specialist	Acteur de santé communautaire, assistant nurse, nurse, midwife, generalist doctor, emergency obstetric care doctor, OB/GYN, surgeon	All cadres, including CHWs
Interval and postpartum mini-laparotomy	Specialist OB/GYN, other surgical specialist, doctor with OB/GYN post-graduate diploma, trained medical doctor with bachelor of medicine, bachelor of surgery	Specialist, medical doctor, medical assistant	Specialist, medical doctor, tecnico de cirurgia [†]	Specialist, medical officer	Specialist obstetrician and surgeon, SOU	Medical doctor, specialist
Post-caesarean tubal occlusion	Specialist OB/GYN, doctor with OB/GYN post-	Specialist, medical officer	Specialist medical officer, tecnico de cirurgia	<i>Information unavailable at time of assessment</i>	Specialist medical officer, SOU	Specialist, medical officer

Type of Information and Services	Cadre Allowed to Provide Female Sterilization Information and/or Services, by Country (% of female sterilization users as recorded in the DHS)					
	India (36.3%, DHS 2019- 21)	Mali (0.4%, DHS 2018)	Mozambique (0.2%, DHS 2011)	Nigeria (0.2%, DHS 2018)	Senegal (0.7%, DHS 2019)	Rwanda (2.0%, DHS 2019- 20)
graduate diploma, trained medical officer						

* India has an additional cadre who are professional counselors.

† Information sourced from publication on task sharing, not from the ministry policy documents.

India’s national reference manual for female sterilization states that minilaparotomy can be performed by specialists in OB/GYN, specialists in other surgical fields, doctors with OB/GYN postgraduate diplomas, and medical officers trained on the procedure (MOHFW 2014a). India’s quality standards and quality assurance in sterilization services are consistent with the reference manual for female sterilization in terms of which cadres are allowed to perform the procedure (MOHFW 2014b). However, according to the reference manual, there are restrictions on when a client can choose and receive female sterilization (MOHFW 2014a); these criteria include marital status, client age, spousal consent, and number of living children. Although these factors are not directly related to task sharing, they impose additional and unnecessary barriers to access. The scope of practice for midwifery educators and nurse practitioner midwives states that this cadre is responsible for preparing clients for sterilization and assisting surgeons performing the procedure; yet, this cadre does not appear in the national guidance reference manual for female sterilization.

According to the ministry’s reproductive health procedures, female sterilization in Mali can only be provided by medical doctors and medical assistants (MSAS 2019b). Per the national policy norms and protocols document, nurses, nurse midwives, and obstetric nurses are responsible for client counseling and evaluation (MSAS 2019a). These practices are consistent with the 2012 WHO recommendations.

In Rwanda, female sterilization can be performed by medical officers and OB/GYNs (RBC and MOH 2020). The national curriculum for female sterilization is consistent with the national guidelines and standards requirement in that the cadres identified for training include surgeons who are physicians, surgical assistants, nurses, and midwives (MOH 2015b). Clinical officers, who are mid-level providers, cannot perform female sterilization procedures but are allowed to provide all other FP methods (see text box). Further, according to the national reference manual for female sterilization, spousal consent is required before a married client can obtain a tubal occlusion (MOH 2015a). The informed consent form requires spousal signature and if the client does not have a husband, they must obtain a signature from the local authority. This requirement to obtain approval from a spouse or local authority infringes on clients’ rights, including the right to confidentiality, and is a barrier to access.

Clinical Officer SOW for Rwanda

The SOW for clinical officers in Rwanda allows for clinical officers with specialized training to conduct invasive surgical procedures in, for example, ophthalmology and otolaryngology. However, specialized surgical training on female sterilization for clinical officers is currently unavailable.

In Senegal, female sterilization can only be performed by the following cadres: trained non-specialist medical doctors, SOUs, specialist OB/GYNs, and specialist surgeons (MSAS-DSME 2020). Senegal does not have mid-

level cadres equivalent to associate clinicians and medical assistants as providers. Therefore, Senegal is unlikely to adopt the WHO recommendation on task sharing of female sterilization by such mid-level providers because they do not exist within the health system like they do in the DRC, India, and Nigeria. The national minilaparotomy training curriculum for female sterilization could not be accessed for review.

Mozambique's technical reference manual for FP services and its national standards for measuring performance of sexual and reproductive health (SRH) services provide guidance on procedures, standards, and benchmarks for measuring performance of female sterilization services and other FP methods (MISAU 2013b). These documents refer to health professionals and health workers and are not specific in terms of the cadres that are expected to perform the different tasks for minilaparotomy. These documents are outdated and would benefit from an update to specify this guidance.

The DRC's health zone standards for integrated maternal, newborn, and child health interventions provide general guidance for FP services and the human resource requirements by level of facility and department (MSP 2012). This includes guidance on some of the required instruments to perform surgical contraception and the importance of informed consent for sterilization (see text box). The guidance document does not provide specific information on the human resources and related requirements for female sterilization and other surgical contraceptive procedures; instead, it refers readers to the surgical contraception training resources for additional information. The female sterilization training resources could not be accessed for this review. The national health zone standards for integrated maternal, newborn, and child health also include some guidance on FP in postabortion care but do not include guidance on PFP services. As this guidance was developed in 2012, an update could address these gaps.

Surgical contraception (tubal ligation or vasectomy) should only be performed after the client has signed the informed consent form following counseling.

VASECTOMY INFORMATION AND SERVICES

The WHO recommends that vasectomies be provided by associate clinicians and doctors, including specialist doctors such as surgeons and urologists, as part of the established competencies. Mali and Mozambique are the only project implementation countries where trained mid-level providers (medical assistants and tecnico de cirurgia, respectively) are allowed to perform no-scalpel vasectomy (NSV) in line with the WHO recommendation for task sharing male sterilization (MSAS 2019a; Cumbi et al. 2007). In the other five countries, vasectomy can only be provided by trained nonspecialist doctors and specialists in other surgical fields, such as OB/GYNs. Table 8 provides an overview of the cadres that can provide vasectomy information and services at the facility level for six of seven implementation countries; information across all types and levels was unavailable at the time of the assessment for the DRC.

TABLE 8: CADRES ALLOWED TO PROVIDE VASECTOMY INFORMATION AND SERVICES IN SIX PROJECT IMPLEMENTATION COUNTRIES

Type of Information and Services	Cadre Allowed to Provide Male Sterilization Information and/or Services, by Country (% of male sterilization users as recorded in the DHS)					
	India (0.2%, DHS 2019-21)	Mali (Not reported, DHS 2018)	Mozambique (Not reported, DHS 2011)	Nigeria (Not reported, DHS 2018)	Rwanda (0.2%, DHS 2019-20)	Senegal (0.1%, DHS 2019)
NSV services at facility level	Specialist OB/GYN, doctor with OB/GYN post-graduate diploma, trained medical doctor*	Specialist, medical doctor, medical assistant	<i>Information unavailable at time of assessment</i>	Specialist, medical officer	Medical officer/ general practitioner, medical specialist OB/GYN	Specialist (obstetrician and surgeon), SOU
Vasectomy information and counseling	All trained providers, including ASHAs and auxiliary nurse midwives	Specialist, medical officer, medical assistant, nurse, obstetric nurse, midwife	All FP providers [†]	All FP providers [†]	All FP providers (e.g., clinical officers, nurses, midwives, matrones)	All FP providers (e.g., nurses, obstetric nurses, midwives, matrones)

* All providers trained to conduct NSV and must be empaneled.

†The specifics on types of cadres were not explicitly stated in the documents accessed for review.

In India, the national reference manual for male sterilization states that any trained and empaneled nonspecialist doctor can perform vasectomies in government facilities and accredited nongovernmental and private facilities and the state maintains an updated list of empaneled providers. India is the only country with guidance that includes conventional vasectomy in addition to NSV as an accepted technique (MOHFW 2013). The reference manual further identifies medical doctors or specialist surgeons, such as OB/GYNs, as eligible cadres to attend training on vasectomy, consistent with the national guidance in the standards and quality assurance in sterilization services (MOHFW 2014b). However, the document does not mention including assistant surgeons or surgical assistants as part of the trainee team. The scope of practice for midwifery educators and nurse practitioner midwives also includes counseling FP clients and assisting surgeons to perform vasectomies.

In Rwanda, vasectomy can be performed by medical doctors (general practitioners) and specialist OB/GYNs. Mid-level providers, like clinical officers, cannot perform vasectomy procedures. This practice is inconsistent with the WHO recommendations. In Senegal, according to the policies, norms, and protocols, only medical doctors trained in emergency obstetric care and specialist OB/GYNs and surgeons can perform vasectomies. General doctors cannot offer this method. This is also not consistent with the WHO recommendations. In Nigeria, only medical officers can provide vasectomies.

National guidance documents from India, Mali, Mozambique, Nigeria, Rwanda, and Senegal state that information and counseling on vasectomy should be provided by all cadres within the health system, ranging from lay workers at the community level to doctors and specialists at the facility level. Mozambique's technical reference manual for FP services (MISAU 2013a) and national standards for measuring performance

of SRH services, including FP (MISAU 2013b), provide technical information about vasectomy, performance benchmarks, and other information related to vasectomy, such as performance standards for counseling, client assessment, preparation for the procedure, and follow-up care. The national standards for measuring performance guidelines, however, do not provide details about the performance standards for NSV or about management of side effects and other problems associated with NSV. In addition, neither document provides information on which cadres can provide vasectomy services.

HOW ARE FRONTLINE HEALTH WORKERS DEPLOYED FOR PRE- AND POSTSURGICAL TASKS FOR PMS?

Both national guidance documents from India that focus on female sterilization (the reference manual for female sterilization and the standards and quality assurance for sterilization services document) refer to the surgical team requirements for provision of quality female sterilization services. However, in the section on training participants, particularly for training on minilaparotomy, the reference manual does not identify the members of the surgical team, which the standards and quality assurance in female sterilization manual indicates as ideally including a surgeon (medical doctor) and an assistant surgeon (normally a nurse or midwife). The reference manual further defines eligible trainees as specialists in medical fields other than OB/GYNs; doctors with bachelor of medicine, bachelor of surgery degrees; doctors with diplomas in gynecology and obstetrics; specialists in other surgical fields; and those trained in minilaparotomy. Surgical assistants, who are mostly nurses and midwives, are therefore not included in formal training on minilaparotomy in India, while surgeons, operating theatre assistants, and staff nurses are trained as teams on the laparoscopic tubal occlusion procedure.

The standards and quality assurance in sterilization services guidance defines the roles of the team members performing female sterilization procedures. According to this guidance, nurses and auxiliary nurse midwives are responsible for:

- Overseeing preparation and maintenance of the operating theater, including ensuring availability of all equipment, supplies, and instruments (including emergency equipment and supplies)
- Counseling and preparing the client
- Ensuring completion of pre-procedure documentation by the surgeon and anesthetist
- Assisting the surgeon in completing the pre-procedure client evaluation and ensuring written documentation of informed consent
- Assisting the surgeon and the anesthetist in performing the procedure and monitoring the client before, during, and after the procedure

Operation assistants work in coordination with nurses and auxiliary nurse midwives in:

- Ensuring the availability of all equipment, instruments, and supplies
- Preparing the operating theatre
- Assisting the surgeon and anesthetist during the procedure

The scope of practice for midwifery educators and nurse practitioner midwives does not cover how this cadre should be deployed, although it specifies that midwife educators and nurse practitioner midwives are responsible for assisting in tubectomy and vasectomy procedures (MOHFW 2021).

The role of nurses in provision of female sterilization in Rwanda is dependent on the nurse or midwife cadre SOW (MOH 2012). According to national guidelines, associate nurses can provide education about any FP method, including female sterilization, after specialized training and under supervision. Diploma- and degree-level nurse and midwifery cadres participate in the provision of FP services, as per the national standards.

Rwanda's tubal ligation by minilaparotomy under local anesthesia reference manual (MOH 2017) defines the role of physicians to include:

- Overall responsibility for the procedure
- Verification of informed consent
- Preoperative client evaluation
- Performance of the procedure
- Predischarge evaluation of client
- Postoperative follow-up review, as necessary

Paramedical staff are the frontline workers who are responsible for counseling and screening clients before the procedure and detecting anomalies, as well as maintaining infection prevention practices. Following the procedure, nurses and trained midwives are responsible for:

- Monitoring the client in the immediate postoperative period
- Discharging the client
- Ensuring client notes are completed
- Performing routine client follow-up care

In Rwanda, the national curriculum includes two additional staff: anesthetists and FP managers (MOH 2015a). These staff ideally act as circulating nurses and client monitors and ensure effective pain management. However, in practice, this role can be performed by the circulating nurse, who also doubles as the client monitor.

The SOW for nurses in relation to male sterilization, as described in the ministerial order, is not specific (MOH 2012). For example, it states that registered nurses and midwives at diploma and degree levels will:

- Participate in FP activities in conformity with the national health standards and protocols
- Provide FP services with particular attention to the needs of individuals and couples
- Conduct premarital counseling and provide FP services after special training in accordance with the needs of individuals and couples
- Implement and evaluate basic and extensive medical, surgical, and gynecological care of patients
- Perform normal deliveries and provide postpartum care to the mother and newborn (nurses) or provide care to the patient before, during, and after childbirth (midwives)
- Ensure infection prevention and control in the health facility

In Mali, medical assistants and medical officers, including specialist OB/GYNs, can provide vasectomy services in line with the national policy, norms, and protocols for reproductive health (MSAS 2019a). The tasks that can be performed by nurses and midwives for vasectomy services include:

- Education and counseling

- Eligibility screening of clients
- Aftercare following the procedure

In Senegal, the role of nurses and midwives in sterilization includes provision of information and counseling as well as evaluation of clients for eligibility.

Information on how frontline workers are deployed in pre- and post-procedure tasks from the remaining desk review countries (DRC, Mozambique, and Nigeria) was unavailable in the documents accessed for the review.

WHAT ARE THE ROLES OF NURSES AND MIDWIVES IN DELIVERY OF ANTENATAL, POSTABORTION, AND POSTNATAL CARE, AND HOW CAN WE STRENGTHEN INTEGRATION OF LARC INFORMATION AND SERVICE PROVISION WITHIN THESE SERVICES?

According to the SOWs for different cadres of nurses and midwives in Rwanda, the nurse is responsible for conducting normal deliveries and providing postnatal care while the midwife is responsible for providing care during the antenatal, intrapartum, and postpartum periods. The SOW for nurses and midwives does not specifically mention postabortion care but broadly references the roles and responsibilities of midwives in prevention and management of emergencies during pregnancy, childbirth, and the postpartum period. However, the SOW does not specify how the different cadres of nurses and midwives should be deployed at the facility level. Nurses and the midwives are expected to conduct their duties while respecting clients' and the clients' families' beliefs, cultures, customs, and values. According to the SOW for nurses and midwives, only diploma- and degree-level nurses are expressly accountable for their actions as they execute their professional responsibilities and managerial roles. No such accountability is stated in the SOW for associate nurses and midwives at diploma- and degree-levels (MOH 2012).

In Nigeria's task sharing policy, the roles and responsibilities of nurses and midwives in delivery of antenatal, intrapartum, and postnatal care include providing key services in the immediate postpartum period, such as provision of FP, promotion of breastfeeding and selfcare, and provision of information and counseling on nutrition and healthy lifestyles, including safer sex. This cadre is also expected to help with the initiation of breastfeeding as well as the provision of essential care to newborns and the detection, management, and referral of any newborn complications to appropriate care. Only midwives can perform male circumcision. Other tasks include caring for patients living with HIV, screening for gender-based violence and postpartum complications before discharge and during follow-up care, and managing these conditions and/or providing referrals for care at higher-level facilities. These contacts can all serve as entry points for integration of FP information and services. The task sharing policy, however, does not define specific tasks related to the provision of PPF by nurses and midwives during the immediate postpartum period. During the antenatal period, nurses and midwives are responsible for providing overall antenatal care; managing seropositive pregnant patients via provision of antiretroviral medication; providing preventive medication, counseling, and education to the pregnant person and their family; and detecting and managing pregnancy-related complications (only midwives). Nurses are also responsible for the detection and provision of first-line management of complications associated with miscarriages and abortions, including the provision of referrals, whereas midwives are responsible for management of complications of miscarriage and abortions, including evacuation of the uterus for incomplete abortion using manual vacuum aspiration. The training manual for doctors, nurses, and midwives on LARCs also includes the provision of LARCs during the

postpartum period. The SOWs for nurses and midwives that further articulates the roles of these cadres and how they should be deployed could not be accessed for the review.

The national guidance document for Mali broadly states that the roles of different cadres of nurses and midwives include the provision of care before and during labor and delivery and lists some of the activities that the different cadres are responsible for during the antenatal and postnatal periods, including postnatal care for adolescent mothers (MSAS 2019a). These specific tasks include: provision of antenatal care, evaluation of the pregnant patient, antenatal education and counseling (including FP counseling), and management of obstetric complications, including management of bleeding in early pregnancy. Obstetric nurses also treat abortion-related complications. Provision of care during the postnatal period includes reception and triaging of postnatal patients and completion of client evaluations, including screening the mother and newborn for complications and providing information, counseling, and maternal and child postnatal care comprising nutrition advice among other health education information. There is, however, no mention of the provision of FP information or services by any healthcare providers, including nurses and midwives.

National guidelines accessed for this desk review from the remaining three countries (DRC, Mozambique, and Senegal) lacked detailed information on the roles of nurses and midwives during the antenatal and postpartum periods. For example, there were PFP training resources from several countries; however, these documents focused on the transfer of skills to the eligible participants (including nurses and midwives) but did not provide specific information on the roles of nurses and midwives during the postnatal period. The national FP guidelines from Senegal defined the roles of nurses and midwives in general terms across the different facility levels to include the provision of client counseling and the provision of all FP methods except for permanent methods, for which they should refer clients, as needed. Postabortion care was only referenced under the description of “timing for provision of different types of contraceptive methods” and not in relation to which cadre is responsible for providing such services. Similarly, the national guidance document from the DRC refers to the roles of nurses in the provision of different methods of contraception at different times with relation to pregnancy (e.g., postpartum and postabortion periods) but does not cover their role in the provision of antenatal, postabortion, or postpartum care. The specific SOWs and scopes of practice for nurses and midwives from nearly all countries (except India and Rwanda) were unavailable for review. Furthermore, the other available national guidance documents that reference the SOWs for the relevant cadres contained limited information. As such, accessing additional documents from the countries during a separate in-depth assessment is needed before making recommendations for improving access to LARC information and services during the antenatal and postnatal periods, and as an integral component of postabortion care. Still, the limited inclusion of FP information and service provision by nurses and midwives in the peripartum period in the few documents available necessitates advocacy for elaboration and/or inclusion of the roles of nurses and midwives in FP (including LARCs and PMs provision in particular), given that FP is one of the key strategies for prevention of maternal, newborn, and child morbidities and mortalities.

DISCUSSION AND RECOMMENDATIONS

National policies, guidelines, and protocols for FP and other related thematic areas within the health sector should be readily accessible to all stakeholders. However, accessing the policy documents, SOWs for mid-level health cadres, and LARC and PM training resources from several implementation countries for this desk review was challenging at times. For example, SOWs for nurses, midwives, and clinical officers could only be retrieved from India and Rwanda. We therefore recommend that a subsequent in-depth assessment source the missing operational policies, guidelines, SOWs, and training resources in-country from relevant

institutions and entities. In addition, some of the documents that the project accessed were in draft form and under review by their respective ministries and a few were nearly a decade old and not necessarily in line with current evidence. **Of the seven countries included in the desk review, the project specifically recommends updating outdated documents in the DRC, India, and Mozambique.**

The definitions of different cadres of healthcare workers in the review countries were fairly consistent with the WHO definitions. CHEWs, who are lay workers, represent an exception. CHEWs are not usually regulated by a professional body, but in some countries, this cadre's education, registration, and practice are regulated, for example, by the Community Health Practitioners' Registration Board of Nigeria.

Five of the seven review countries (India, Mali, Nigeria, Rwanda, and Senegal) articulated task sharing for the provision of LARCs by mid-level healthcare providers in their national policies, norms, and protocols for SRH and FP. The official policy documents from the DRC and Mozambique did not explicitly state which cadres were allowed to provide which FP services or procedures, although these documents contained general statements on the "provision of FP by nurses and midwives" and the "provision of LARCs by providers who are not doctors," respectively. Additionally, the selected journal articles referencing the DRC and Mozambique included information on the various cadres with task-shared roles for the provision of LARCs and PMs (Cumbi et al. 2007).

The WHO recommendations state that implants can be provided by doctors, advanced associate and associate clinicians, nurses, and midwives. However, the national FP guidelines and standards in Rwanda state that pharmacists can provide implants, although this recommendation is not consistently reflected in other Rwandan national guidance documents, such as the draft national FP reference manual. **A subsequent in-depth review should explore the role of pharmacists in the provision of contraceptive implants to determine if there is any locally generated evidence supporting this practice in the Rwandan context,** and to answer the following questions:

- What is covered in the preservice and in-service training of pharmacists and their scopes of education and practice?
- How is this cadre of health worker supervised?
- Which tools are used for supervision and does such supervision include monitoring and supporting contraceptive implant services?
- Who is involved and what is the nature of support offered to pharmacists by supervisors?
- How do pharmacists report on such procedures and services and are there any modifications to the demand creation activities to ensure awareness among potential users?

It will also be important to solicit the views and recommendations of national pharmacist regulatory bodies in Rwanda.

One WHO task sharing recommendation focuses on the provision of implant services by auxiliary nurses and midwives, with oversight through monitoring and evaluation. Our desk review revealed that five project review countries have national guidance documents that allow auxiliary nurses, nurse midwives, and auxiliary midwives to insert and remove implants. However, it was difficult to determine whether such guidance is implemented under a different arrangement outside of routine supervision or monitoring and evaluation from internal and external supervisors. An in-depth assessment could provide further insights on the nature of supervision provided to auxiliary nurses, nurse midwives, and auxiliary midwives to ensure increased access to high-quality, safe services and a wide range of methods.

According to the WHO, allowing CHEWs to provide LARC and other SRH services (as is done in Nigeria) is a recommended practice in the context of rigorous research and should be implemented with lay workers with additional training and in settings where lay workers deliver services in health facilities with sterile conditions. From the desk review, the Nigerian CHEWs complete preservice training for three to three-and-a-half years, which is longer than the traditional apprentice and basic training for lay workers in most countries. They then complete an in-service competency-based training on LARCs. They also spend more than 70% of their time working in health facilities. Implant insertion and removal services are only available at health facilities in all review countries except for Rwanda, which allows for the provision of integrated FP services, including the provision of a wide range of methods in outreach settings outside of health facilities, including in public places, such as schools. From the literature review, several countries in SSA outside the project implementation countries (e.g., Burkina Faso and Ethiopia) have successfully adopted and implemented this task sharing practice with support from various partners, including the WHO (Ouedraogo et al. 2021; Pathfinder 2011).

Some of the national policy guidance documents and training materials included information on the different types of implants and timing of initiation (interval, postpartum, or postabortion). **Guidance should also include information on the facility or location where such services can be provided, and the cadre(s) allowed to provide such services.** From our desk review, the information on the cadres, different types of implants, and timing of initiation for provision of implant services was consistent across the different documents in all implementation countries, except for Senegal, where the PFP training manual includes senior health technicians as a cadre that can provide these services, but the national policy norms and protocols for FP and SRH services do not refer to their existence as a cadre within the health system. **It was also unclear from the review of documents why implants are not part of an expanded method mix in India. This may be an area for further inquiry.**

According to the WHO, auxiliary nurses and midwives are recommended under certain circumstances to provide postabortion contraception, including implants, while lay workers can provide postabortion implant services only in the context of rigorous research. However, in Nigeria, auxiliary nurses and midwives can provide postabortion contraception, including implants. The evidence supporting this practice in Nigeria is presented in the 2013 national task shifting and task sharing for maternal, newborn, child healthcare policy document and was generated from studies supported by several USAID-funded projects, including the Access to Clinical and Community Maternal, Neonatal, and Women's Health Services project; the Maternal and Child Health Integrated Program; and the Targeted States High Impact Project. **However, further research is necessary to determine how implant insertion and removal services for postabortion clients is covered in the SOWs for auxiliary nurses and midwives with relevant in-country institutions.**

One challenge that is normally not addressed fully when countries adopt task sharing is how the cadre assuming added responsibilities is compensated for the additional work or covered against liability as a way of motivating providers to assume these extra responsibilities. Issues of health worker protections and increased remuneration for those assuming additional responsibilities are two of the areas highlighted in the WHO task sharing guidance documents. From our desk review, India is the only country that has indemnity coverage in place for all trained providers involved in FP provision, including mid-level providers, and providers are also compensated for increased responsibilities. This information is explicitly provided in India's reference manuals for LARCs and PMs and a separate indemnity cover guidance document. **Further analysis of indemnity and its effectiveness could inform replicability in other countries.**

Nigeria is the only country where lay workers are allowed to provide IUD services and the national task sharing policy cites locally generated evidence supporting this policy recommendation. In all the countries where IUD insertion is performed by mid-level providers, relevant training materials (such as PFP and LARC

training curricula for mid-level and lay worker cadres) include copper IUDs, with a few also covering hormonal IUDs. Although no SOWs for mid-level providers from the implementation countries could be retrieved for review, the reference manual for IUD services from India, for example, provides an elaborate description of the roles and responsibilities of the different cadres involved in the provision of copper IUDs. The only national guidance documents with SOWs for mid-level providers were from India and Rwanda. However, the SOWs for nurses, midwives, and clinical officers in Rwanda were broad and did not provide detailed descriptions of what each cadre is responsible for in terms of IUD service provision. **Further review of the scopes of practice for nurses and midwives may be useful, as those guidance documents, developed by the relevant regulatory authorities, normally contain detailed descriptions of practices allowed for these cadres.** Additionally, in-depth interviews with relevant regulatory authorities during a follow-on in-depth assessment could also provide more information.

The scope of practice for midwifery educators and nurse practitioners in India and the SOW for nurses and midwives in Rwanda both include elements of provision of respectful care as part of client-centered quality of care. However, the aspects of professional accountability for the providers' actions are only included for the nursing cadre in Rwanda; midwives and associate nurses do not appear to be professionally accountable for their actions, although they are also involved in the provision of task-shared responsibilities, such as the provision of LARCs. Further, Rwanda's SOW for nurses and midwives is 10 years old and may benefit from an update to make it consistent with current practices. The scope of practice for midwifery educators and nurse practitioners in India is more recent and includes aspects of providing respectful care as part of client-centered quality of care as well as guidance that the providers are accountable for their professional actions. This includes responsibilities that are task-shared, such as the provision of LARC services. The WHO guidelines on task sharing state that it is important to specify which provider is ultimately accountable and responsible for care given, as such details are often not specified in the formal regulations or during day-to-day practices, which may undermine provider confidence levels.

According to India's reference manual for IUD services, the provision of postabortion FP in the second trimester is not task shared to mid-level providers, a policy recommendation that is inconsistent with the WHO recommendations on postabortion FP. **This is another area that can be explored further to determine the evidence supporting this policy recommendation.** Rwanda's policy and training documents are also inconsistent in the descriptions of different cadres eligible for LARC training, with clinical officers not included in the national reference module for continued training in FP. This may act as a barrier to task sharing of IUD insertion and removal procedures by clinical officers. **This should be explored further before engaging the Rwandan MOH to agree on the process for resolving this inconsistency.** Supervisory tools from six of the review countries, excluding Mozambique, were not available for review. **Future in-depth assessments could provide opportunities to access these tools to determine the extent to which they support enabling environments for task sharing.**

Five countries (DRC, India, Nigeria, Rwanda, and Senegal) have no policy recommendation on task sharing minilaparotomy for female sterilization to mid-level providers, such as associate clinicians or their equivalent. Four of these countries (DRC, India, Nigeria, and Senegal) either do not have or have phased out such cadres within their health system. Rwanda has this cadre but the relevant policy recommendations for task sharing of female sterilization to clinical officers are inconsistent with the WHO recommendations. **This provides an opportunity for the project to advocate for task sharing of female sterilization to clinical officers.** Senegal also has a senior health technician cadre; however, most of this cadre are nurses and midwives and the WHO recommendations state that nurses and midwives can only perform female sterilization in the context of rigorous research.

The reviewers identified additional barriers to accessing LARC and PM services, such as a mandatory spousal consent requirement in Rwanda before provision of female sterilization as a method of choice. There are similar barriers in India’s reference manual for female sterilization, including requirements related to marital status, minimum age of client, and number of living children. While the current method mix in India is highly skewed toward female sterilization, it is still important to ensure any medical barriers to access are removed (MOHFW 2014a).

Further, there are some inconsistencies in the composition of surgical teams eligible for training on female sterilization in India. Guidance on the ideal minilaparotomy teams to be trained includes surgeons but not surgical assistants (typically nurses or midwives). **This practice is inconsistent with other sections of the reference manual and with the training approach implemented globally. Additionally, India’s female sterilization reference manual and quality assurance guidelines were published in 2014; dialogues with the ministry about updating these resources may be useful.**

Five countries included in the desk review (DRC, India, Nigeria, Rwanda, and Senegal) lack policies for task sharing male sterilization to mid-level providers. Rwanda is the only country with a cadre of mid-level providers who could perform male sterilization procedures according to the WHO recommendations on task sharing, if appropriately trained, equipped, and supported. **For Mali and Mozambique, this provides an opportunity to document and share the successes, lessons, and factors that favor implementation of current policies on task sharing of female and male sterilization to mid-level providers.**

Summary of Key Recommendations*

- Conduct an in-depth review and analysis through key informant interviews with regulatory bodies and other stakeholders to gain further insights into the roles of each cadre and to secure additional supervision tools and SOWs or scopes of practice for cadres involved in the provision of LARCs and PMs.
- Advocate for implementation countries to update outdated policies, protocols, and other national guidelines to reflect current evidence and to make them easily accessible to facilitate readiness to provide high-quality services, specifically in the DRC, India, and Mozambique.
- In countries such as the DRC, India, and Nigeria, where there are established WHO collaborating centers, advocate for partnerships with the relevant centers and other stakeholders to engage and support the standardization of FP and SRH quality of care and associated policies, protocols, and guidelines.
- Conduct further analysis of indemnity coverage and other approaches for motivating healthcare workers, especially those with additional roles and responsibilities. Highlight the roles of norms and accountabilities as part of respectful care, quality of care, and human resources for health as opposed to solely focusing on practice hazards related to motivation to inform replicability in other countries.
- Support national programs in addressing inconsistencies across the various national policy documents in relation to task sharing to improve access to LARC and PM services (especially in India, Mali, Rwanda, and Senegal).
- Analyze existing task sharing barriers and enablers, including access barriers, particularly in India and Rwanda, to inform future program and policy actions.

*Please see Annex 5 for detailed recommendations by country.

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ANNEX 2: GLOBAL EVIDENCE REVIEWED

World Health Organization Publications
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12. Ouedraogo, Leopold et al. 2021. "Towards Achieving the Family Planning Targets in the African Region: A Rapid Review of Task Sharing Policies."
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ANNEX 3: DEFINITIONS OF HEALTHCARE WORKER CADRES

The following cadre definitions are drawn from the World Health Organization (WHO), specifically the 2012 *Optimizing Health Worker Roles to Improve Access to Key Maternal and Newborn Health Interventions Through Task Shifting* and the 2017 *Task Sharing to Improve Access to Family Planning/Contraception*. The 2017 summary brief recommends that different cadres of healthcare workers, under different circumstances, can provide long-acting reversible contraceptive and permanent method information and services. The healthcare workers who can provide family planning also include providers of complementary medicine such as Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homeopathy (AYUSH) practitioners.

Lay Health Workers. This is a broad category of healthcare workers, which the WHO's 2012 publication defines as "any healthcare worker who performs functions related to healthcare delivery and was trained in some way in the context of the intervention but has received no formal medical training or paraprofessional certificate or degree." This cadre works in different settings in project implementation countries and includes different types of community healthcare workers, such as community-based distributors, community health volunteers, junior community health extension workers, traditional birth attendants, community-owned resource persons, *agents de santé communautaires*, *relais*, *agents polyvalents élémentaires*, *agents de santé maternelles*, *bitomes*, and accredited social health activists. Community health extension workers and community health officers are also in this category, although these cadres receive a longer period of task and management training (three to three-and-a-half years). In some countries, these two cadres assume greater responsibilities and therefore spend more time in the health facility than at the community level.

Auxiliary Nurses. Auxiliary nurses, also referred to as associate or assistant nurses, possess basic nursing skills and complete formal apprenticeships or on-the-job training. This training varies from a few months up to two to three years. According to the WHO, this cadre also includes enrolled nurses who have basic nursing skills, receive training for three to four years, and perform simple and complex nursing procedures under the supervision of registered nurses and medical doctors.

Auxiliary Nurse Midwives. Auxiliary nurse midwives, also referred to as lady health visitors, have basic nursing skills and some midwifery skills but they are not full midwives. Auxiliary nurse midwives undergo formalized apprenticeships or on-the-job training. The period of training varies by country. This cadre provides maternal, newborn, and child health information and assists in the provision of care during the prenatal, intrapartum, and postpartum periods. Lady health visitors also work at the community level, visiting clients in their homes to provide care.

Nurses. This cadre is registered to practice nursing by a national regulatory authority that also determines the education requirements for nursing. Qualified nurses are skilled to provide a full range of nursing care. There are different grades of nurses, for example: registered nurse, staff nurse, diploma nurse, and nurse with a bachelor's degree. Nurses undergo professional training for three or four years to earn diplomas or degrees and can then pursue postgraduate degrees in nursing.

Midwives. Midwives are registered by national regulatory authorities to provide a full range of care during pregnancy, childbirth, and the postnatal period. They also offer care to the newborn and assist the mother during breastfeeding. Midwifery education is regulated by national regulatory authorities, with training requirements ranging from three to four years and resulting in either a diploma or a degree. There are several types or grades of midwives, for example: community midwives, registered midwives, and midwives with bachelor's degrees.

Associate Clinicians. Associate clinicians are a professional cadre registered by national regulatory authorities and skilled to diagnose and manage medical conditions and perform simple surgical procedures. National authorities dictate and regulate associate clinician education and practice. Basic training varies from three to four years, followed by an internship lasting six months to one year before certification and registration. The training duration and curriculum varies by country. There are different types of associate clinicians in the project implementation countries, including health officers, health technicians (with clinical backgrounds in nursing and training to diagnose and manage patients), medical assistants, and clinical officers.

Advanced Associate Clinicians. Advanced associate clinicians are a professional cadre registered by national regulatory authorities, which control the educational curriculum and practice of these clinicians. This cadre has advanced skills to manage medical conditions and perform general and obstetric surgical procedures. This cadre is certified after successful completion of a three- or four-year post-basic training followed by an internship (the duration of which varies significantly by country). Like other mid-level cadres, there are different types of advanced associate clinicians in the project implementation countries, including medical assistants in Mali, *tecnico de cirurgia* in Mozambique, advanced clinical officers in Rwanda, and senior health technicians in Senegal.

Doctors of Complementary Systems of Medicine. This is a professional cadre that is recognized, registered, and overseen by national regulatory bodies, which also dictate their education. Doctors of complementary medicine or alternative systems of medicine are allowed to practice complementary medicine after five to nine years of basic training. Doctors of complementary medicine are allowed to diagnose and manage medical and simple surgical cases. There are different types of doctors of complementary medicine, including Ayurvedic physicians and AYUSH doctors. Complementary medicine systems are more developed within health systems in Southeast Asia.

Doctors of Medicine, Medical Doctors, Medical Officers, Nonspecialist Medical Officers, Nonspecialist Doctors, and General Practitioners. This professional cadre is registered by regulatory bodies to practice medicine after successful completion of five to nine years of university training in medicine followed by a one-year internship program. All doctors are required to apply for renewable licenses to practice medicine at certain intervals, which vary depending on the national requirements of their country. National regulatory authorities regulate education requirements and practices of this cadre.

Specialist Doctors and Medical Specialists. This is a professional cadre with advanced competencies in a particular discipline of medicine. They are registered by the same national regulatory bodies as nonspecialist doctors. This cadre completes a post-basic degree training at a recognized training institution for at least three years. National regulatory authorities regulate education requirements and practices of this cadre. Additionally, specialists are expected to apply for renewable practicing licenses from the same regulatory bodies, the requirements of which vary according to local regulations. Examples of this cadre include obstetricians and gynecologists, urologists, and general surgeons.

ANNEX 4: STUDIES ON FEASIBILITY, SAFETY, AND ACCEPTABILITY OF COMMUNITY HEALTH EXTENSION WORKERS (CHEWS) TO PROVIDE IMPLANT SERVICES IN NIGERIA

Author(s)	Publication Title	Study Design	Study Dates and Locations	Findings	Recommendations
Charyeva et al.	<i>Task Shifting Provision of Contraceptive Implants to Community Health Extension Workers: Results of Operations Research in Northern Nigeria</i>	Pre-/post-intervention study	2013-2014 Bauchi and Sokoto states	<ul style="list-style-type: none"> CHEWs achieved competency after four to five insertions on actual clients. CHEWs performed implant insertion tasks correctly 90% of the time. Over 95% of clients served by CHEWs reported satisfaction with services. CHEWs were satisfied with the new task of providing contraceptive implants. CHEWs recommended frequent supportive supervision visits. CHEWs were unable to practice implant removal skills due to low service demand. 	<ul style="list-style-type: none"> Increase demand creation through community mobilization. Establish and monitor the minimum number of supportive supervision contacts for optimal functioning of task sharing. Improve availability of information, education, and communication materials and supplies for implant service provision. Include cost effectiveness studies in future research. Retrain CHEWs on implant removal as client load for removals increases.
Douthwaite et al.	<i>Safety, Quality, and Acceptability of Contraceptive Implant Provision by Community Health Extension Workers Versus Nurses and Midwives in Two States in Nigeria</i>	Quasi-experimental non-inferiority study	2015-2016 Kaduna and Ondo states	<ul style="list-style-type: none"> Adverse events for implant insertion procedures were similar among CHEWs, nurses, and midwives (non-inferiority could not be established). Implant expulsions were higher among clients of CHEWs compared with clients of nurses and midwives. <p><i>Note: This study focused only on implant insertion, not removal.</i></p>	<p>Overall results show feasibility of training CHEWs to deliver implants in remote settings, but to ensure safety and quality of service provision, attention must focus on:</p> <ul style="list-style-type: none"> Provider selection Training Supervision and follow up

Author(s)	Publication Title	Study Design	Study Dates and Locations	Findings	Recommendations
E2A	<i>Building Evidence to Support the Provision of Implants at Community Level through Task-Sharing. Operations Research, Kaduna and Cross River States, Nigeria</i>	Pre-/post-intervention study	2015-2016 Cross River and Kaduna states	<ul style="list-style-type: none"> • Implant counseling and insertion competency scores were high at the beginning of the intervention and, on average, showed a slight decline at endline* • Clients were satisfied with implant services provided by CHEWs at both intervention and comparison sites. • 96% of the CHEWs reported having provided implant removal services and related care for clients, including management of side effects. 	<ul style="list-style-type: none"> • Increase community outreach to create demand. • Strengthen mentoring and supportive supervision for certifying CHEWs and maintaining high-quality service provision. • Train and re-train CHEWs to provide implant services. • Provide supply chain and commodities logistic support to ensure availability.

* The slight decline of acquired skills in counseling and implant insertion procedures is likely due to the attrition of highly skilled providers and the need for refresher training for CHEWs.

ANNEX 5: SUMMARY OF KEY RECOMMENDATIONS, BY COUNTRY

Country	Recommendations
Democratic Republic of Congo	<ul style="list-style-type: none"> • Advocate for, and as appropriate, support review and updating of relevant national guidance documents, including relevant training resources.
India	<ul style="list-style-type: none"> • Support in-depth analyses of the indemnity cover for family planning (FP) providers to document its effectiveness in motivating providers and to determine its replicability in other countries. • Advocate for the elimination of medical barriers to accessing any FP method (e.g., barriers related to minimum age, number of children, and spousal consent). • Advocate for, and as appropriate, support review of reference manuals for intrauterine device service provision and sterilization to ensure they are current. • Advocate for relevant entities within the Ministry of Health and Family Welfare to address inconsistencies across different guidance documents and/or training resources on long-acting reversible contraceptives (LARCs) and permanent methods (PMs). • Conduct in-depth assessments to explore some of the factors influencing the availability of contraceptive implants as part of expanded method choice in the country.
Mali	<ul style="list-style-type: none"> • Advocate for and engage with relevant entities within the Ministère de la Santé et des Affaires Sociales to address inconsistencies across different guidance documents on LARC and PM services.
Mozambique	<ul style="list-style-type: none"> • Advocate for, and as appropriate, support review and updating of relevant national guidance documents, including relevant training resources. • Include performance standards for female and male sterilization in the national standards for measuring performance of sexual and reproductive health services.
Nigeria	<ul style="list-style-type: none"> • Advocate for updating the LARC training package for community health extension workers to incorporate current infection prevention and control evidence on decontamination of medical devices for reuse as well as recently revised insertion techniques for Nexplanon®.
Rwanda	<ul style="list-style-type: none"> • Advocate for policy change to allow trained clinical officers to offer sterilization services. • Conduct an in-depth assessment to determine the role of pharmacists in LARC provision. • Support relevant entities and institutions within the Ministry of Health to address inconsistencies across different national guidance documents on LARC and PM services. • Advocate for the elimination of medical barriers to accessing female sterilization (e.g., barriers related to consent from either a spouse or local administration). • Support the adoption of evidence-based infection prevention and control practices for decontamination of medical devices for reuse.
Senegal	<ul style="list-style-type: none"> • Advocate for relevant entities within the Ministère de la Santé et de l'Action Sociale to address inconsistencies across different guidance documents on LARC and PM services; this includes, for instance, ensuring that guidance on the role of the senior health technician cadre

	<p>in provision of LARCs at different timings (postpartum and postabortion) is consistent across different national policy documents.</p> <ul style="list-style-type: none"> • Advocate for the adoption of policies allowing trained non-specialist medical doctors to provide vasectomy services, as this falls within their scope of practice.
Crosscutting	<ul style="list-style-type: none"> • Advocate for and support countries to increase availability and access to national policies, protocols, and standards for FP and reproductive health as well as guidelines and scopes of practice for the different cadres involved in FP provision and other relevant stakeholders. • Conduct a follow-on in-depth review and further analysis through key informant interviews with regulatory bodies and other stakeholders to gain further insights into the roles of each cadre, and to secure additional supervision tools and scopes of work or practice for cadres involved in the provision of LARCs and PMs. • Conduct and support further analyses of existing barriers and enablers, including other access barriers, to inform future program and policy actions.



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