WEBINAR SERIES



Promoting
health throughout
the life-course
during the
COVID-19
pandemic





WEBINAR-5: TASK-SHARING TO MAINTAIN SEXUAL AND REPRODUCTIVE HEALTH SERVICES

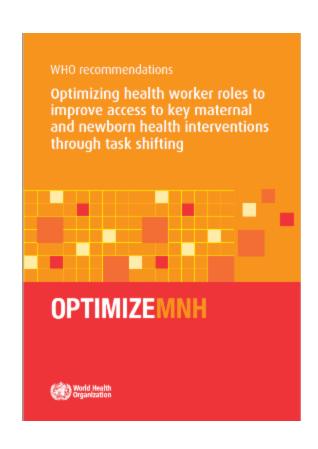
WHO guideline on Task-sharing in SRH

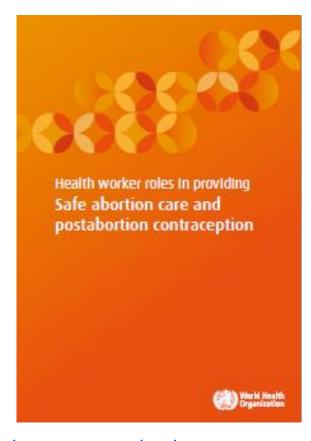
DURING COVID-19



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Guidelines on task sharing in safe abortion and family planning





SUMMARY BRIEF



Task sharing to improve access to Family Planning/Contraception

Summary information

Proble

Poor access to family planning services due to inadequate

Option

Enabling additional cadres of health workers to provide family planning services through competency-based training

Comparison

Method delivered by other 'higher' clinical cadres or no method delivered

Setting:

Lower level and community/primary health care setting

Benefits of task sharing of contraceptive services:

- Offering contraception through a wide range of providers enables access and availability
 Evidence and experience support that various type:
- Evidence and experience support that various typof providers can safety and effectively provide contraception
- Sharing routine tasks with lower level cadres allows higher cadre clinicians more time to use their specialized skills.
- Access to contraception is part of a comprehensive sexual and reproductive health and rights package t women and men
- Policies are enforced to allow effective use of defined skills and competencies of the health workforce.

RECOM ON FAM

ON FAMILY PLANNING RELATED TO CADRES OF PROVIDERS

- The WHO recommends that family planning services and methods can be safely and effectively provided by different health worker cadies, under specified circumstances.
- Community health workers can safely and effectively provide the following contraceptive services: education and counselfing, information on SDM, 2Day Nethod, and LAMC end contraceptives and condens; and hormonal injectables, under targeted monitoring and evaluation.
- Auolilary nurses and auolilary nuse midshive can safety and effectively provide education and counselling, information on 50M, 20ay Method, and LAM, oral consuceptives, condoms, hormonal injectables, and contraceptive implancy, and (for auxiliary nurse midshives) IUDs.
- Nurses and midwives can safely and effectively provide education and counseiling information on SDM, 2Day Method, and LAM, oral contraceptives, condorns, hormonal injectables, contraceptive implants, and IUDs.
- WHO recommends further research on the safety and effectiveness of nurses and midwives delivering tubal ligation and vesser turns.
- Operators of retail outlets such as drugs shops and pharmacies and can safely and effectively provide contraceptive services commercurate work their clinical qualifications according to the caches listed in this document.

https://www.who.int/reproductivehealth/publications/en/
https://srhr.org/safeabortion/

Context and caveats

- Linked with WHO clinical recommendations
- Planned, regulated expansion of roles within a health systems context monitoring, mentoring, referral.
- Training
- Options are about being 'inclusive' and not about excluding more specialist providers.
- High and low resource settings
- □ Applicable across a range of legal contexts



Based on large body of evidence

E.g. Evidence base for task sharing in safe abortion care

Safety, effectiveness, satisfaction

Qualitative data on acceptability

Qualitative data on feasibility

36 studies from 18 countries

- Africa 4
- Eastern Mediterranean – 3
- Europe 12
- Latin America 2
- North America 7
- South-East Asia 13
- Western Pacific 0

83 studies from 24 countries

- Africa 15
- Eastern Mediterranean – 0
- Europe 10
- Latin America 32
- North America 12
- South-East Asia 16
- Western Pacific 2

121 papers from 5 selected countries + in-depth interviews with in-country experts

- Bangladesh
- Ethiopia
- Nepal
- South Africa
- Uruguay

Recommendations considered safety, effectiveness, feasibility, access, applicability, resource use considerations



Health worker

"All people engaged in actions whose primary intent is to enhance health. This includes physicians, nurses and midwives, but also laboratory technicians, public health professionals, community health workers, pharmacists, and all other support workers whose main function relates to delivering preventive, promotive or curative health services" WHO 2006, 2013



Management of abortion and post-abortion care in the first trimester

		Lay hea wo		Phan work		Pharn cists	na-	Doctors comple- mentary systems medicin	y of	Auxiliary nurses/ ANMs	Nurses	Midwives	Associate/ advanced associate clinicians	Non- specialist doctors	Specialist doctors
Vacuum															
rovision of inf															
	Lay health workers	Pharmacy workers	Pharma- cists	Doctors of comple- mentary systems of medicine	Auxiliary nurses/ ANMs	Nurses	Midwiw	advanced associate clinicians	Non- specialis doctors			S	S	❤.	❤.
nformation on afe providers/ aws	②	⊘	②	⊘ .	② .	᠍.	0	. 📀.	•). ② .					
Assessing eligibility for medical abortion						,	(R) (R) (R)								
Administering the medications and managing the process and common side-effects independently			ocess		$\widetilde{}$.	.			
Assessing further cli				lure and t	he need	l for		R		R					
		for s	ndation subtasks below)	E	3	menda for sub (see be	otasks	\checkmark)	♡		②		⊘ .	❷.
Manager uncomple incomple abortion miscarria with misopros	licated ete n/ age	١,	R	6	3	3	3	€)	②	•	Ø	•	❷.	❷.

^{*} considered within typical scope of practice; evidence not assessed.





^{**} considered outside of typical scope of practice; evidence not assessed.

Management of abortion and post-abortion care beyond 12 weeks

	Lay health workers	Pharmacy workers	Pharma- cists	Doctors of comple- mentary systems of medicine	Auxiliary nurses/ ANMs	Nurses	Midwives	Associate/ advanced associate clinicians	Non- specialist doctors	Specialist doctors
Dilatation and evacuation	€3	€3	₿	8	€3	€3	€3	R	②	❷.
Cervical priming (osmotic dilators)	₿	₿	₿	8	8	\bigcirc	\bigcirc	\bigcirc	② .	❷.
Cervical priming (medications)	8	8	8	\bigcirc	\bigcirc	\bigcirc	\bigcirc	\bigcirc	② .	② .
Medical abortion > 12 weeks	₩	⊗	&	8	8	\bigcirc	\bigcirc	\bigcirc	②	② .



Health worker roles in the provision of Family Planning

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
Informed choice counselling 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	⊘ .	⊘ .	② .	⊘ .	⊘ .	⊘ .	❷.	⊘ .	⊘ .	③ .
Injectable contraceptives (DMPA, NET-EN or CICs)	⊘	⊘	②	②	O	② .	⊘ .	⊘ .	⊘ .	❷.
Implant insertion and removal	R	3	3	\bigcirc	\bigcirc	②	②	⊘ .	⊘ .	⊘ .
Intrauterine device (IUD)	3	3	3	R	©	②	②	⊘ .	⊘ .	❷.
Vasectomy (male sterilization)	€3.	€3.	€3.	R	R	R	R	❷.	❷.	❷.
Tubal ligation (female sterilization)	8	€3.	8	€3.	8	R	R	② .	⊘ .	② .





Role of self-management approaches

Where women have access to information and to back up health provider should they need or want it

	Self
Medical abortion in the first trimester	No recommendation for overall task – recommendations for specific components as below
Self-assessing eligibility	R
Managing the mifepristone and misoprostol medication without direct supervision of a health-care provider	
Self-assessing completeness of the abortion process	

Self administration of injectable contraception





From Recommendations to Reality

- The support and mentoring of professional bodies and of the OBGYN community
- Moving towards primary care level
- Power imbalances, gender dynamics, health worker workloads, conscientious objection
- Small scale efforts vs. going to scale
- Regulatory barriers
- Supplies and commodities

