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Advocating for Global Guidelines on Family Planning Task-Sharing

CASE STUDY

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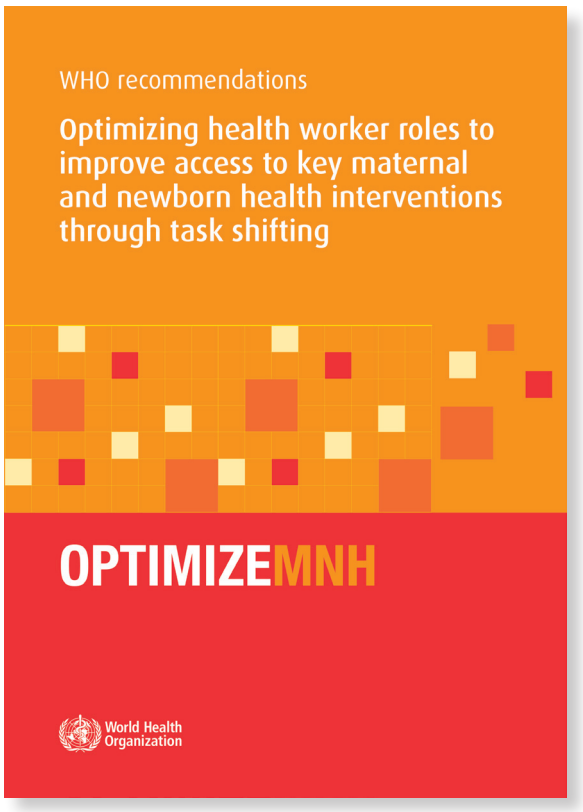
In December 2012 the World Health Organization (WHO) issued guidance on task-sharing for the provision of maternal and newborn health services, including family planning. It was the first comprehensive, global guidance on how to distribute tasks and responsibilities among cadres of health workers providing family planning services. In the guidance, WHO recommended that, with targeted monitoring and evaluation, lay health workers could provide contraceptive injections—a major strategy for reducing unmet need for family planning.

The guidance provides needed evidence to convince government health ministries to broaden task-sharing policies for family planning. It is a boon for advocates—but getting family planning into the guidance required a coordinated advocacy effort in itself.

Beginning in early-to-mid 2012, a working group of advocates within the Reproductive Health Supplies Coalition (RHSC), including Advance Family Planning (AFP) partners, led a highly consultative process and coordinated advocacy efforts to ensure that family planning was included in the guidance.[1,2]



Advocacy contributed to the World Health Organization recommendations in 2012.[3]

Task-sharing is essential to fulfilling the unmet need for family planning

Task-sharing is much more than a temporary, emergency response to health workforce shortages. A guiding principle of task-sharing is that no one health provider, or one cadre of providers, can do it all. Allowing a wider range of cadres to offer certain services, when this can be done safely and effectively, is essential to strengthening health systems. Task-shifting's benefits are three-fold: it improves health system efficiency, lowers costs, and expands access to basic health care services for hard-to-reach and rural populations.

An RHSC report notes that when more than 150 partners from 26 countries were asked to identify three main barriers to meeting the unmet need for family planning at the country level, lack of task-sharing practices was one of the most frequently mentioned.[4] Expanding health worker cadre roles to providing contraceptive methods "can significantly improve access to contraception for all individuals and couples."[5]

Barriers to task-sharing

Despite strong evidence indicating the safety, acceptability, and effectiveness of task-sharing for family planning, at the time that the guidance was developed the information had not been compiled in one place, covering all types of services and the full range of medical cadres. There was some resistance in countries. Many medical associations and resource-poor government agencies either directly opposed or did not prioritize task-shifting policies.

Comprehensive guidance and recommendations from WHO are seen as essential to helping build a case. "These changes at the global level help us get traction at the national level," a stakeholder in Uganda explains. "When one is able to quote WHO guidelines in our advocacy, it really helps."

Collaborating to create good guidance

Advocates connected through RHSC developed a more strategic advocacy plan in 2011, when they identified task-sharing for delivery of family planning as a key issue. Leo Bryant, a leader of the effort, was particularly interested from the service provider perspective of his institution, Marie Stopes International (MSI). In contacting WHO, he found that they were planning to develop guidance for task-sharing, looking broadly at maternal and newborn health (MNH) interventions within the OptimizeMNH project.[6]

The project originally planned to only include contraceptive injectables; however, through continued dialogue, advocates saw it as an opportunity to address task-sharing for family planning comprehensively. Rather than having recommendations for different methods scattered throughout different documents, there would be one definitive resource.

The RHSC's convening power and access to technical expertise played an important role in the WHO-led evidence review and consultation. Through RHSC's membership, connections, and mailing list, advocates quickly gathered together a working group of several agencies with expert experience and evidence from the field. This included representation from FHI360, Population Services International, Pathfinder International, Population Council, IntraHealth International, Jhpiego, and others. Importantly, the AFP initiative offered seed money to initiate development of the guidance within WHO.

Leo Bryant, who managed the process, explained, "We were speaking as a community with one strong voice. The ability to represent inter-agency consensus in the RHSC on this issue, rather than speaking as just one agency, carried a lot of weight."

Acting as a coordinated group also helped during the evidence review phase. The technical advisors and RHSC managed the submitted evidence. AFP and PAI provided necessary resources for a consultant, identified by WHO, to review the evidence and to provide modest travel funds related to the consultation.

Agreeing on what evidence to include was a significant challenge. Standard WHO procedure is to focus on randomized controlled trials. However, much of the evidence that exists is a result of less rigorous operations research and the fact that task-sharing has been

implemented for different cadres in many countries at scale for many years. In the end, consideration of large-scale national programs, as suggested by the advocates and others, was part of the evidence review.

A consultation followed the evidence review, and occurred in two separate meetings at WHO. The first covered maternal and newborn health interventions and took place in April 2012. WHO and partners decided to hold a separate meeting in June to develop the guidance for family planning. This allowed a smaller group with extensive expertise in family planning to develop detailed guidance. Significant debate over the details contributed to what the participants agreed was a good, comprehensive final product. As one person involved in the consultation explained, "the outcome of the meeting was everything we could have hoped for." After the meetings, advocates worked together to provide input on guideline wording so that task-sharing could be seen as a logical health system intervention, rather than an act of crisis management. Leo Bryant explained, "Submitting comments en masse lent much more credibility and weight to what we sent in."

An ongoing need to implement and update the guidance

The development of comprehensive, WHO-approved task-sharing guidance for family planning is a significant advocacy success that offers a powerful tool for decision makers, service providers, and advocates. Nevertheless, the overarching goal remains increased contraceptive access. To that end, the guidance must be promoted, adopted, and implemented. As one expert explained, "There has to be an accompanying plan to push [them] because there is so much resistance out there."

The Advocacy and Accountability Working Group within the RHSC was an appropriate forum to develop such a plan and channel both donor and country-level interest. The informal group of experts formed during the guidance development process was well placed to work together and, within their own agencies, to move this forward.

Since the guidance was published in 2012, the safety and effectiveness of task-sharing for family planning have been continuously monitored and documented. In July 2015, WHO incorporated task-sharing for family planning into new guidance relating to the provision of safe abortion care and post-abortion contraception.[7]

Ultimately, the value in having developed this guidance rests with the extent to which it can inform national programs and policies. Many partners—professional associations, service delivery and technical assistance organizations, UN agencies, and civil society groups—have key roles to play in bringing the guidance to the attention of policymakers. Equally critical is the engagement of professional organizations, such as those of the various health cadres, including nurses and midwives.

Lessons Learned

- **Collaboration and cohesion are key:** The credibility and weight of the recommendation to include family planning in the guidance was strengthened by a unified voice from a respected group of technical agencies and service providers. These agencies can continue to share their experience in operationalizing the guidance, citing results and challenges, and encouraging exchanges between national Ministries of Health to witness successfully implemented task-sharing efforts.

- **Convening power proves necessary:** AFP and RHSC networks and support enabled experts to come together and inform the WHO process.

- **Both evidence and experience are needed to inform guidance:** WHO's decision to include family planning in the guidance hinged on many factors. Evidence of safety, effectiveness and acceptability, though critical, was not sufficient.

- **View task-sharing in the larger health care context:** Task-sharing is important and useful, but its success ultimately rests with adequate investments in a functioning health system and appropriately-trained health workforce.

- **Adopting a task-sharing policy at the national level does not mean that it will be implemented at the subnational level:** AFP's focus countries with decentralized government systems—Kenya, Indonesia, and Nigeria—have yet to apply such national policies to the local level.

References

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