MARIE STOPES UGANDA
Children by choice, not chance

Task Sharing Surgical Methods of Contraception in Uganda: Making the Case for Clinical Officers

Recommendations from the research findings:

- The legal barriers that prevent clinical officers (COs) from performing surgical contraception should be removed. This could be achieved by the Ministry of Health harmonising the current policy documents on task sharing surgical contraception. Documents to harmonise include the 2010 Policy Guidelines and Service Delivery Standards for Community Based Provision of Injectable Contraception in Uganda and Addendum to the 2006 Uganda National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights.

- All Clinical Officers (COs) who perform surgical contraception should first be trained and certified prior to performing surgical contraception. The current Marie Stopes Uganda task sharing training model (which is based on the Ministry of Health training of health cadres in long acting and permanent methods of family planning) should be replicated as a training model.

- Revise medical training curricula so CO students are trained to perform surgical contraception.

- Health Centre IVs and Health Centre IIIs (HCs) should be sufficiently equipped with a functional theatre, equipment and necessary medicine

- Fill the staffing gaps at all levels to ensure that additional responsibility of task sharing surgical contraception doesn't overwhelm and overshadow routine clinical responsibilities. For example, a facility with one clinical officer shouldn't be allowed to task share surgical contraception.

- Strengthen support, supervision and mentorship of trained and practicing COs to build confidence of practitioners and ensure safety of clients.

- Strengthen the referral system to track and ensure that any complication arising out of the task sharing strategy is attended to in a timely manner.

- Strengthen monitoring and evaluation and ensure that service data is captured, analysed to inform programme progression during scale up.

Research Background and objectives

Access to family planning (FP) services still remains a big challenge in Uganda. The Ministry of Health Family Planning Costed Implementation Plan, 2015–2020, highlights task sharing as a priority intervention towards improving Uganda's FP indicators and increasing access to FP.

The specific objectives of this investigation were: (1) To describe the experiences and challenges of clinical officers involved in provision of surgical methods of family planning; (2) To identify recommendations and perspectives on task sharing from other stakeholders in the health sector; (3) To assess the resource and capacity requirements for scaling up task sharing in health facilities in Uganda; (4) To develop an implementation strategy necessary for effective scale-up of task sharing into the national health systems; (5)To recommend necessary updates to the current MoH Policy Guidelines and Service Standards for SRHR.

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Research Methods

The study employed mixed methods of data collection including data extraction and desk reviews, observations, key informants and in-depth interviews. The data were collected by a team of six researchers (two investigators and four trained research assistants) in the months of September and October 2015. The team visited 4 regional referral hospitals (Arua, Fort Portal, Lira and Mbale), 7 Health centre IVs, 8 Health centre IIIs, 7MSU clinics, 4 Reproductive Health Uganda facilities, and 1 Uganda Health Marketing Group (UHMG) facility.

Research Results

Experiences of COs in conducting bilateral tubal ligation and vasectomies

On average, COs had two-to-three years' experience of conducting bilateral tubal ligation (BTL). Three of the COs had each conducted over 150 BTL operations. COs in the northern region reported the lowest number of BTL operations whereas those in the western and central reported the highest number of procedures performed. Overall, very few had performed vasectomies. All (except two) felt confident in performing BTLs and rated themselves very highly on a scale of 1-5. COs reported that counselling men for vasectomy was very hard with those in the north and west Nile sub-regions facing more difficulties compared to those in the central, western and Soroti sub-region.

Perspectives and recommendations on task sharing surgical contraception to Clinical Officers

The concept of task sharing was unanimously supported by a cross section of stakeholders in in the health sector save for two who were strongly opposed to the idea of using clinical officers to conduct vasectomies and BTLs. Reasons for and against task sharing surgical contraception and recommendations for scale up are highlighted in the illustrative force field-analytical diagram (Figure 1).

Resource and capacity requirements for implementing task sharing in health facilities in Uganda

Of the 24 health facilities surveyed, all (except two HCIIIs) had at least one functioning sterilizer. One hospital and one HCIII did not have an examination table. Three Hospitals and all HCIIIs & IVs lacked mini laparotomy kits for performing BTLs; unlike MSU and RHU facilities. Overall, the private health providers (MSU & RHU) were better equipped for surgical contraception. A range of family planning methods were provided at the various healthcare delivery facilities. Pills were provided in all health facilities apart from one hospital, three HCIVs and 2 HCIIIs. Reasons for lack of these services at these facilities were attributed to mainly stock outs. All facilities had condoms except two MSU facilities.

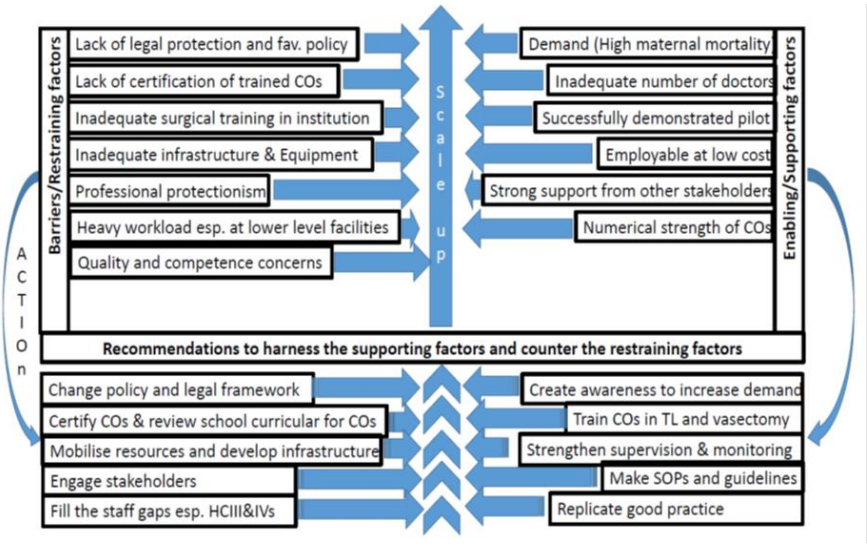

Figure 1: Force field analysis - Restraining, supporting factors and recommendation for scale up strategy

More than half (59.3%) of the facilities had at least one operational theatre. None of the HCIIIs had an operational theatre. Hospitals and MSU facilities had adequate facilities for family planning commodities (Figure 2, below). Basic medicines and supplies required for performing BTLs and Vasectomy were reported to be available in many facilities. As expected, most doctors were at the regional referral hospitals compared to the lower facilities. Understaffing was commonly reported. Of the 27 health facilities, only five reportedly had clinical officers performing BTLs.

Necessary updates to the current MoH Policy Guidelines and Service Standards for SRHR

The desired change to allow COs to provide surgical contraceptive services is already provided for in the 2006 draft policy guidelines and services standards for SRHR. The required change is also visible in the 2010 Policy Guidelines and Service Delivery Standards for Community Based Provision of Injectable Contraception in Uganda, an Addendum to the 2006 Uganda National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights. The amendment is highlighted in chapter 3 (family planning and contraceptive service delivery), Table 1 which illustrates family planning provision by cadre of staff. The amendment recognises clinical officers among the cadres designated to conduct bilateral tubal ligation and vasectomy. The drawback is that the amended 2006 MoH policy guidelines and service standards for SRHR remains in a draft form and is un-published. The 2006 policy document should formally be passed and published for public consumption.

Implementation processes necessary for effective scale-up of task sharing into the national health systems

The implementation process necessary for effective scale up are as highlighted in figure 3. The broader steps include creating a favourable environment, health system strengthening, advocacy and monitoring and evaluation.

Figure 2: Adequacy of storage facilities for family planning