policy

November 2015

REPOSITIONING FAMILY PLANNING IN WEST AFRICA

Task Sharing Synthesis Report

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HEALTH POLICY PROJECT

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Suggested citation: Konaté, M. K, M. Maiga, E. McGinn, and A. Chen. 2015. *Repositioning Family Planning in West Africa: Task Sharing Synthesis Report.* Washington, DC: Futures Group, Health Policy Project.

The Health Policy Project is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-10-00067, beginning September 30, 2010. It is implemented by Futures Group, in collaboration with CEDPA (CEDPA is now a part of Plan International USA), Avenir Health (formerly Futures Institute), Partners in Population and Development, Africa Regional Office (PPD ARO), Population Reference Bureau (PRB), RTI International, and the White Ribbon Alliance for Safe Motherhood (WRA).

Repositioning Family Planning in West Africa: Task Sharing Synthesis Report

CONTENTS

Acknowledgments

The Health Policy Project would like to thank the Ministries of Health of Burkina Faso, Mauritania, Niger, and Togo for supporting this study and giving political support necessary for its realization. The team would like to especially thank the technical and financial partners, international agencies, and national and international nongovernmental organizations working in and for family planning.

Our thanks also go to consultants and transcribers for their diligence and hard work. The authors would like to particularly thank the interviewees in Burkina Faso, Mauritania, Niger, and Togo, who contributed to this study and provided useful information that we hope will be used to improve family planning in West Africa.

Executive Summary

The francophone West African countries are experiencing a critical shortage of health service providers, which affects access to and the provision of essential family planning services and contraceptives. Task sharing, or task shifting, a strategy endorsed by the World Health Organization, aims to shift family planning tasks from higher-level service providers to lower-level health staff to (1) share the burden of family planning services within a health facility and (2) increase access by providing family planning services through different service delivery points. As part of the action planning and budgeting process of the Ouagadougou Partnership/Call to Action (February 2011) to advance family planning in West Africa, Burkina Faso, Mauritania, Niger, and Togo committed to implementing one or more forms of task sharing.

In 2014, the USAID-funded Health Policy Project conducted desk reviews and qualitative interviews in Burkina Faso, Mauritania, Niger, and Togo **to assess the implementation of task sharing for family planning services and develop comprehensive recommendations to improve task sharing policies for family planning** to contribute to the availability and sustainability of family planning services in West Africa.

The Health Policy Project found that three years after the Ouagadougou conference the provision of family planning services at the community level had expanded. As seen in the results of this study, some community health workers, regionally referred to as *Agents de Santé Communautaires*, in Niger, and increasingly in Togo, initiate contraceptive pills and provide injectables. However, results from this study show that overall, national policies still lag behind WHO guidance, and implementation of task sharing needs further emphasis and action. Generally speaking, *Agents de Santé Communautaires*, pharmacists, and auxiliary cadres are still underutilized in their potential to provide a range of family planning methods.

The Health Policy Project also found that while support for task sharing exists in each country, notable resistance remains among some key stakeholders. A more concerted and tactical effort is needed to map key pathways to change and design and execute concrete strategies to immediately advance task sharing at both the policy and programmatic levels.

In particular, training and supervision of *Agents de Santé Communautaires* needs to be standardized and formalized in Burkina Faso, Mauritania, and Togo. Niger provides a regional example of how *Agents de Santé Communautaires* can be incorporated into the formal health system. West Africa can also look to other countries in East Africa and Asia for successful models of task sharing to expand access to oral contraceptive pills, injectables, and emergency contraception (EC). Countries should also focus on how long acting methods (intrauterine devices, implants) can be more readily provided by mid-level cadres. Finally, governments need to enhance their stewardship of and coordination with the private sector to ensure greater consistency in policy implementation, quality of training, and range of services provided through a total market approach.

This report is an English-language summary if findings from four separate French-language reports:

- *Repositionnement de la Planification Familiale au Togo: La Délégation des Tâches*, available at http://www.healthpolicy-project.com/index.cfm?ID=publications&get=pubID&pubID=655
- *Repositionnement de la Planification Familiale en Mauritanie: La Délégation des Tâches*, available at http://www.health-policyproject.com/index.cfm?ID=publications&get=pubID&pubID=647
- *Repositionnement de la Planification Familiale au Niger: La Délégation des Tâches*, available at http://www.healthpolicy-project.com/index.cfm?ID=publications&get=pubID&pubID=644
- *Repositionnement de la planification familiale au Burkina Faso: étude qualitative sur la délégation des taches*, available at http://www.healthpolicyproject.com/index.cfm?ID=publications&get=pubID&pubID=653

Abbreviations

AIS	Agents Itinerants de Santé
ASC	Agents de Santé Communautaires
ATBEF	Togolese Association for Family Welfare
BAC	senior secondary school
BEPC	junior secondary school
CBD	community based distribution
CHW	community health worker
COC	combined oral contraceptives
CSPS	Centre de Santé et de Promotion Sociale
EC	emergency contraception
FP	family planning
HPP	Health Policy Project
IUD	intrauterine device
MOH	Ministry of Health
NGO	nongovernmental organization
POP	progestin-only pills
WHO	World Health Organization
USAID	United States Agency for International Development

1. Introduction

Francophone West African countries are among 57 countries identified as having a critical shortage of health service providers by the World Health Organization (WHO) (WHO, 2006). This shortage of health service providers affects overall public health and impacts access to family planning (FP) services. Regrettably, research shows that this shortage is projected to deepen in West Africa (Green, 2010; WHO, 2006). Additionally, there are important regional inequities in access to physicians, nurses, and midwives, particularly among rural populations. (McDavid and Kodjo, 2012; Maiga and Lo, 2012; McDavid and Attama, 2012).

> *"Almost 40 years of evidence and expert opinion support the safety, feasibility, and effectiveness of task sharing in the provision of family planning services."*
>
> *-Janowitz et al., 2012, p.60*

WHO endorses task sharing (also referred to as task shifting) to help address the shortage and uneven distribution of healthcare workers by sharing tasks within a health facility and across different types of health worker cadres and service delivery points (WHO, 2012b). By reorganizing existing workforces, task sharing allows for a more effective use of existing human resources and improves access to care and services. Task sharing is seen as an effective strategy to improve the use of health system human resources (WHO, 2012b). Particularly in the field of family planning, "almost 40 years of evidence and expert opinion support the safety, feasibility, and effectiveness of task sharing" (Janowitz et al., 2012, p.60).

Figure 1. WHO's Guidelines for Optimizing the Delivery of Key Interventions for Maternal and Newborn Interventions through Task Shifting/ Sharing: Summary on Family Planning

- Community health workers can effectively provide specific contraceptive services such as oral contraceptives, condoms, and hormonal injectables. For hormonal injectables close monitoring is advised.
- Auxiliary nurses and auxiliary nurse midwives can effectively provide a wide range of contraceptives such as oral contraceptives, condoms, hormonal injectables, contraceptive implants and (for auxiliary nurse midwives) IUDs.
- Nurses and midwives can effectively undertake a range of contraceptive services such as oral contraceptives, condoms, hormonal injectables, contraceptive implants, and IUDs.
- While nurses and midwives could potentially deliver a full range of family planning options that includes tubal ligation and vasectomy as well, WHO recommends further research of these cadres delivering those surgical services before they can be recommended for practice.

Source: WHO, 2012a

Most critically, community health workers (CHWs)— usually frontline paraprofessionals with only basic health skills—can be trained to safely and effectively provide FP services and information about reproductive health in rural and other underserved communities. WHO states that, "community health workers can effectively provide specific contraceptive services such as oral contraceptives, condoms, and hormonal injectables. For hormonal injectables close monitoring is advised" (see Figure 1) (WHO, 2012a, p. 2). By bringing information, services, and supplies to the communities where women and men live and work, CHWs address barriers to access (WHO, USAID, and FHI, 2010; WHO, 2012a; WHO, 2012b).

Task sharing to CHWs has had tangible results. For instance, in Madagascar, individuals who had access to a CHW were 10 times more likely to use modern contraceptives than individuals who did not. Further, in countries, such as Bangladesh and Indonesia, where CHWs deliver an important share of modern contraceptive methods to their communities, unmet need for FP in rural areas is low (HIP, 2015). Given the shortage of essential human resources for health, task sharing for FP services is an essential element of countries' successful family planning programs, and their ability to meet international commitments for family planning.

Task sharing for family planning has been on the West Afri-

ca FP agenda for several years. The USAID/WA AWARE II project (2009-2012) worked to advance task sharing in the region. For instance, Togo signed a memorandum of understanding with AWARE II to permit CHWs to initiate pills and provide injectables in two project-supported districts. Furthermore, as part of the action planning and budgeting process of the Ouagadougou Partnership/Call to Action to advance family planning in West Africa (February 2011), Burkina Faso, Mauritania, Niger, and Togo all committed to implementing one or more forms of task sharing (see Table 1).

Table 1. Ouagadougou Commitments to Task Sharing, by Country

Burkina Faso	Prioritized task sharing and committed to permit CHWs to provide initial cycle of pills and injectables, and to permit assistant birth attendants (in French, accoucheuses auxiliaires) to provide injectables, implants, and intrauterine devices (IUDs).
Niger and Togo	Prioritized task sharing to permit lower-level and non-clinical staff—most notably CHWs—to offer women their first cycle of pills and provide injectables.
Mauritania	Prioritized task sharing and committed to permit nurses to provide long-acting, FP methods at health centers and during outreach visits, and to permit lower-level staff to offer women their first cycle of pills.

Source: Unpublished proceedings from the "Population, Development, and Family Planning in West Africa: An Urgency for Action" conference, Ouagadougou, Burkina Faso, February 2011.

2. Objective And Methodology Of The Study

In order to support the commitment that the governments of Burkina Faso, Mauritania, Niger, and Togo made to effectively reposition FP services and implement task sharing for family planning services, the USAID-funded Health Policy Project (HPP) conducted desk reviews and qualitative interviews in each of the four countries. The study aimed to **assess the implementation of task sharing for FP services and develop comprehensive recommendations to improve task sharing policies for family planning** to contribute to the availability and sustainability of FP services in West Africa. Specifically, the study sought to:

1. Better understand existing service delivery sources for contraceptives in each country
2. Analyze existing government policies and guidelines regarding the provision and distribution of contraceptives
3. Understand the role of different health provider cadres, in particular, community health workers—referred to in the region most commonly as *Agents de Santé Communautaires* (ASCs)—in the provision of contraceptive commodities and FP services
4. Summarize suggestions received from key stakeholders on how to improve task sharing for family planning and community-based distribution (CBD) of FP products and services

2.1. Literature Review

Beginning in June 2013, HPP conducted a literature review on task sharing policies and the implementation of task sharing in Burkina Faso, Mauritania, Niger, and Togo, including community-based provision CBD (also known as CBD) of pills and injectables, and the provision of long-acting contraceptive methods by lower-level health providers. The documents and data reviewed included national policy documents (including any addressing task sharing policies, norms, and procedures), grey literature, journal articles, and program evaluations. The results informed key informant interview and focus group discussion guides.

2.2. Key Informant Interviews

Between August 2013 and March 2014, HPP collected qualitative data in the four USAID/West Africa focus countries: Burkina Faso, Mauritania, Niger, and Togo. Information was obtained through in-depth interviews[1] with key informants on the implementation and enforcement of task sharing policies in their respective countries. HPP used a semi-structured interview guide, which was informed by a country literature review (section 2.1) and the WHO guidelines outlined in *Optimizing the Roles of Health Workers to Improve Access to Interventions for Maternal and Newborn Health through Key Task Shifting* (OMS, 2012). An in-country consultant made appointments with participants. Before each interview, the researcher obtained verbal consent from the participant. All interviews were conducted in French. The duration of each interview varied between 30-45 minutes. Each interview was recorded, transcribed, and analyzed by two researchers. HPP analyzed the implementation of task sharing for FP services by mapping 16 FP services across a matrix of 11 cadres of providers.[2]

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[1] Most interviews were one-on-one, though in some cases more than one individual was interviewed at once. In Togo, seven ASCs were interviewed through a focus group discussion.

[2] The 16 FP services include FP counseling, home visits, presentations on health education, combination oral contraceptives, progestin-only pills, male condoms, female condoms, Depo-Provera, Noristerat, IUDs, bilateral tubal litigation, vasectomy, implants (Jadelle), emergency contraception, periodic abstinence methods, and lactational amenorrhea method..

2.2.1. Sample Size

This study interviewed 120 participants (see Table 2). Key informants included Ministry of Health (MOH) central officials; MOH regional officials; staff in the public health sector in health districts; donors; representatives of local and international nongovernmental organizations (NGOs); private for-profit pharmacists; and community health workers (including ASCs).

2.3. Limitations

Several conclusions of this study are based on qualitative research findings from key informant interviews. The study is limited to self-reported opinions and input from government, district, and community participants who provide FP services in the public and private sectors. Despite this limitation, the number of people interviewed (see Table 2) allowed HPP to get a reasonably representative sample of participants from each country.

Table 2: Sample Size of Key Informants, by Country

Country	Sample Size
Burkina Faso	39
Mauritania	30
Niger	24
Togo	27

Source: Unpublished proceedings from the "Population, Development, and Family Planning in West Africa: An Urgency for Action" conference, Ouagadougou, Burkina Faso, February 2011.

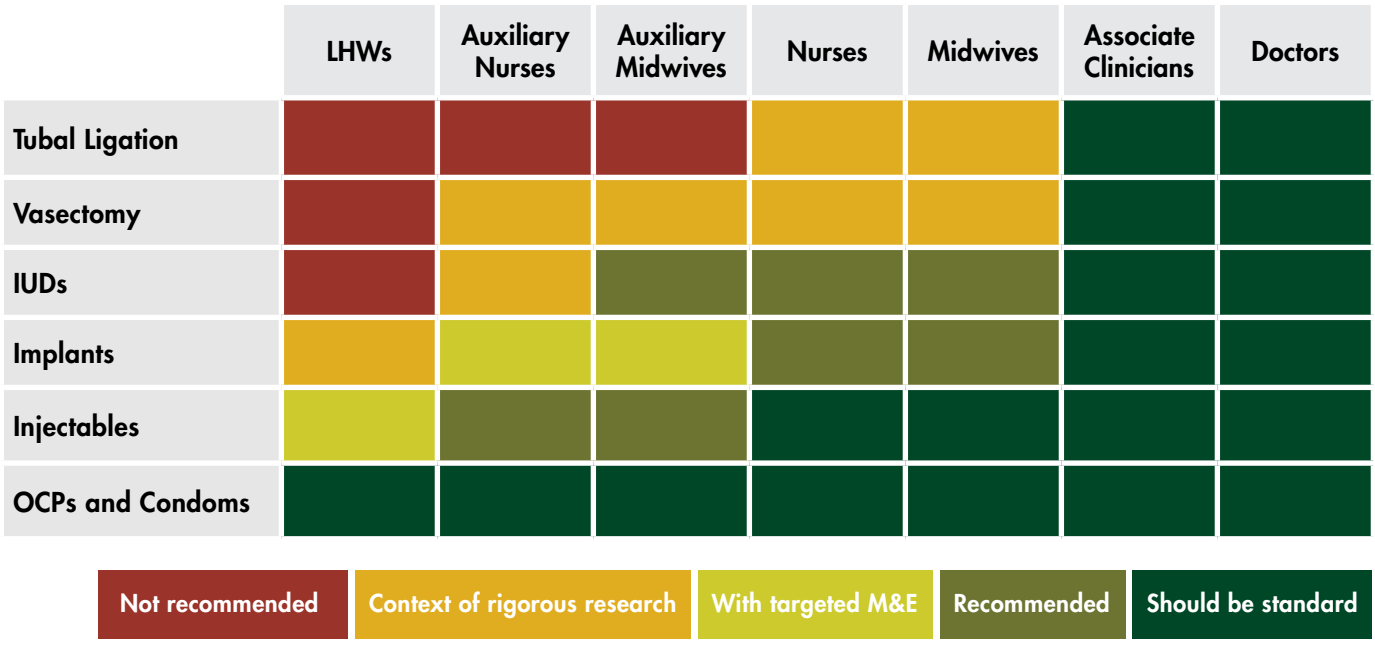
3. Who Guidance

WHO has providing evidence-based guidance on reducing medical barriers to family planning for years, including publishing medical eligibility criteria for contraceptive use, and selected practice recommendations, including information on the low-medical risk of using contraceptives in most circumstances.

In 2012, WHO convened a technical panel to review the evidence on task sharing and developed key programmatic and policy recommendations for implementing task sharing among health services providers and lay health workers. Figure 2 provides a summary of WHO's 2012 guidelines. Specifically, WHO recommends

- CHWs can initiate and resupply oral contraceptives, injectables (with targeted monitoring and evaluation), and condoms
- CHWs inserting and removing implants should be considered in the context of rigorous research
- Auxiliary nurses and auxiliary midwives can both initiate and resupply oral contraceptives, condoms, hormonal injectables, contraceptive implants (with targeted monitoring and evaluation); and (for auxiliary nurse midwives) IUDs
- Nurses and midwives can provide all non-surgical FP methods; and vasectomy and tubal ligation can be considered in the context of rigorous research

FIGURE 2. WHO TASK SHARING GUIDELINES FOR FAMILY PLANNING SERVICES



Source: WHO and HRP, 2013

4. Cadre Profiles

Formal education in francophone West Africa generally involves six years of elementary education, four years of middle/junior high school, and three years of senior high school (total of 13 years). The higher level health providers complete senior high school and continue to specialized medical training. Lower level cadres complete junior high school and then move to vocational training

The provision of health services in Burkina Faso, Mauritania, Niger, and Togo is supported by a variety of cadres of differing education levels and training. Doctors/gynecologist and midwives complete 13 years of formal education through senior secondary school (BAC) and go on to seven and two years respectively of specialized medical training. West Africa also has a cadre called accoucheuse which literally translates to (skilled) birth attendant. This cadre may require the same education as a midwife, or may fall slightly lower into the next cadre grouping, which typically includes nurses and/or auxiliaries (e.g., auxiliary nurse/aide-soignant, auxiliary midwife/achouseuse auxiliare). This second tier usually requires 10 years of education through junior secondary school (BEPC) and two years of specialized technical training. However these training requirements vary between countries, for instance in some countries nurses require the same number of years of training as midwives. Burkina Faso has a lower tier of workers called Agents Itinerants de Santé (AIS), which literally translates to itinerant health worker. AIS require six years of education through elementary school and two years of technical training.

As stated, community health workers in this region are called Agents de Santé Communautaires. This is the least professionalized health cadre, with educational requirements, training, supervision, and institutional links with the health system varying considerably; this is a phenomenon also experienced in other regions. Social marketing agents can be considered similar to ASCs, since they usually have similar qualifications and training, but their deployment is linked to social marketing campaigns managed by NGOs and their remuneration is reliant on commodity sales. Since pharmacists are also sources of FP methods, this cadre was also assessed in terms of its role in task sharing in the four countries.

Table 3: Education and Training Levels by Health Cadre in Each Country

	Burkina Faso	Mauritania	Togo	Niger
13 years of education through senior secondary school (BAC) + 7 years specialized training	Doctor/Gynecologist			
13 years of education (BAC) + 2-3 years specialized training	Midwife/*Sage Femme Diplomee d'Etat* BAC+3 Nurse (Infirmier Diplome d'Etat): BAC+3	Midwife (BAC+3) Nurse (BAC+2)	Midwife (BAC+3) *Accoucheuses auxiliaires d'Etat;* Nurses (*infirmiers diplômés d'Etat)* BAC +3	Midwife BAC+ 3 Nurse *(Infirmier Diplôme d'Etat)* BAC+ 3
10 years of education through junior secondary (BEPC) + 3 years specialized training	*accoucheuse auxiliaire;* Nurse *(infirmière brevetée)*: BEPC+2 ans	Auxiliary Nurse Infirmiers medico-sociaux: Brevet +2 ans	Nurse/*Infirmier auxiliaire* BEPC+3 ans; Accoucheuses auxiliaries: BEPC+3 ans	*Agent de sante de base:* BEPC+3
6 years of education through elementary school + specialized training	AIS (2 years of specialized training)	*Acoucheuses* (+9 months of training)	*Accoucheuse ou infirmiers permanent* (+6 months of training)	*Agent de case de sante* (+ 6 months of training)
Unspecified in policies/Varies	ASC	ASC	ASC	Relais

5. Findings

This study was primarily concerned with (1) exploring to what extent policies and practices in these four countries aligned with WHO recommendations and (2) documenting stakeholder perspectives on, and recommendations for, task sharing in their respective countries.

5.1. Policy Environment for ASC Provision of Family Planning

Globally, many countries use community-level paraprofessional health workers to promote family planning, provide counseling on various FP methods, educate women and couples on natural family planning (such as Standard Days Method), distribute condoms and CycleBeads (if available), and refer clients for other FP methods. Likewise, it is fairly common for ASCs workers to provide a resupply of pills (combined oral contraceptives [COC] or progestin-only pills [POP]). The initiation of pills (COC and POP) and the provision of injectables by ASCs are the two evidence-based practices that have taken longer for countries to put into practice. When considering the private sector, this debate also extends to the role of pharmacists in the provision of contraceptives, and their potential role to counsel and provide a variety of FP methods without the client first seeing a clinical provider. Commonly pharmacists provide pills with a prescription, but initiation of pills and injectables remains largely unaddressed in policy and practice (HIP, 2013). Pharmacist provision of FP is further discussed in Section 5.4.

Burkina Faso, Mauritania, Niger, and Togo are all at different points of providing CBD of contraceptives through ASCs, and there are slightly different profiles of ASCs in operation. Both private and public ASCs exist, but their recruitment, training, supervision, remuneration, and links to the health system vary widely, not only between the four countries, but in some cases within a country.

Burkina Faso

In Burkina Faso, both public- and private-sector ASCs exist and they are linked to and supervised by the health center (Centre de Santé et de Promotion Sociale [CSPS], in the case of public facilities) or NGOs. ASCs are authorized to counsel on family planning generally, and provide condoms, counsel on periodic abstinence (provide CycleBeads if available), and resupply COCs and POCs. They refer clients for initiating pills, and to obtain other methods such as injectables, IUDs, implants, and tubal ligation or vasectomy; they may also coordinate with mobile and outreach services provided by district teams or NGOs.

The reality on the ground is that implementation of policies are uneven. For example, some facilities do not allow their ASCs to resupply pills, whereas a recent study funded by the United Nations Children's Fund found that Prosad/GIZ[3] -supported ASCs were allowed to initiate pills through the use of a screening checklist (Seck and Valéa, 2011).

ASCs are largely voluntary, or may receive support from the community or project that selected them. According to key informants, their motivation largely comes from the prestige associated with a health worker status. In practice, ASCs may retain some funds from the sale of contraceptives and also receive per diems for their involvement in FP days or campaign activities.

[3] GIZ refers to the German aid organization, *Deutsche Gesellschaft für Internationale Zusammernarbeit.*

Mauritania

While Mauritania has started to task share FP services to ASCs, it was the least advanced in these efforts of the four countries examined. In 2012, Mauritania developed a national community health strategy, *Document national de stratégie communautaire en santé* (AMSP, 2012), which allowed ASCs to resupply pills, and provide condoms and spermicides; in the public sector, commodities are given free of charge to clients. Yet key informants reported that ASCs are not yet functioning in Mauritania as it pertains to providing even these basic methods of family planning. Many key informants stated confusion among the general public, clients, and stakeholders as to the role and existence of ASCs:

> *It has become clear that the notion of ASCs, their profile, and the tasks they are assigned are not common knowledge among actors in the family planning sector. There is confusion about whether ASCs exist or not in the field. Most respondents, whether in the public or private sector, in national or international NGOs, say that there have been few studies of ASC involvement in offering FP services. The literature on the few studies that have been undertaken doesn't seem widely disseminated among the actors.*
>
> *—Key informant, NGO, national level, Mauritania*

At the time of this study, the Mauritanian Association for Family Planning (an International Planned Parenthood Federation-affiliate) had just completed ASC training and was preparing to roll out ASC provision of FP. As well, the MOH in Mauritania was planning to pilot test CBD of condoms and resupply of pills in two regions, in the hope that results from this pilot would inform national scale-up of CBD in Mauritania (Maiga and Lo, 2012).

ASCs are generally volunteers, though in some cases the community provides some support. ASCs are trained by NGOs in collaboration with the MOH. The 2012 strategy mentions ASC training should be 45 days, with half the time spent in a practicum, however this is likely not standard yet. One key informant reported the ASC training is six days (FP and maternal health issues), and the NGO provides supervision and refresher training. ASC selection criteria may be established by the NGO and sometimes the community has input, though it was mentioned sometimes the ASC is chosen by the village chief. At a minimum, ASCs need to have basic literacy and numeracy skills. In the 2012 strategy, community health committees are supposed to play a role in supervision of ASCs.

Niger

In 2006, Niger started to scale up ASC recruitment and training with an emphasis on community management of childhood illnesses. As a result, Niger was unique among the four countries in that its ASCs are a formalized, salaried cadre within the health system. ASCs require formal education past primary school and receive six months of standardized training program. ASCs are linked to a health facility (CSPS) where they undergo a short practicum. Once deployed, ASCs have meetings every quarter (in theory) with their assigned facility supervisor, who assess their competency and reviews their activity data (service delivery statistics); these data are in turn integrated into health facility activity reports. In Niger, ASCs are able to initiate pills and injectables.

Niger also has *Relais*, who are usually members of a community health committee. *Relais* receive a short five-day training (Leon et al., 2015) and are responsible for a variety of health social behavioral change communication activities, including FP promotion, but this varies in areas depending on NGO support/involvement. *Relais* require enough literacy and numeracy to write reports, document growth measurements of children, and undertake minor accounting. They are generally volunteers, but might receive some incentives from the community or an NGO. *Relais* often have a small "kit" of health commodities and equipment, such as water treatment tablets, bed nets, treatments for diarrhea, and select contraceptives (pills and condoms). They work in collaboration with the ASC and local health facility.

Togo

Originally ASCs were limited to FP counseling and referral, but in 2011, through the USAID-funded AWARE project, Togo started to allow ASCs to initiate pills and injectables on a pilot basis. This started with two districts in Lome, and increased to seven (out of 40 districts) by 2013. By this date, Togo had trained 720 ASCs in the provision of pills and injectables. However, key informants noted this was limited to the public sector and participants who were ASCs from the private sector in Togo stated that, generally, they did not receive comparable training to ASCs in the public sector.

In Togo, the level of engagement of ASCs varied considerably, depending on their other pursuits. Key informants reported ASCs working between two and seven hours per day, or on specific days of the week. They are primarily involved in counseling and behavior change communication, both with individuals and groups (including schools) on a range of health issues. They are supervised by the head of the local health facility or the NGO they may be linked with. This includes both the supervisor's review of quarterly progress reports the ASCs submit, as well as direct supportive supervision and training where their work is observed, and they are coached as needed. ASCs may receive support via user fees or markups on commodities, or if linked to NGOs, they may receive monthly stipends.

5.2. Provision of FP by Auxiliary Health Staff

In the four countries studied, some task sharing of clinical FP methods has occurred with auxiliary cadres stationed at health centers. However WHO guidance on task sharing clinical family planning methods has not been fully implemented and specific advocacy, policy, and program efforts to expand cadre provision of implants (and EC) are particularly needed.

Burkina Faso

In Burkina Faso, auxiliary health workers stationed at health centers (CSPS), such as *l'infirmiere brevetee, l'accoucheuse auxiliaire,* and AIS, are authorized to initiate pills and injectables. Only nurses *(infirmiers d'Etat)*, midwives and doctors can provide IUDs and implants. If the health center does not have one of these cadres on staff, the woman must be referred. Only doctors can perform sterilizations.

Mauritania

In 2009, Mauritania allowed task sharing of FP services to midwives (Maiga and Lo, 2012). Since then, nurses and auxiliary health workers (accoucheuses auxiliaires) have been permitted to initiate pills and provide injectables. Midwives and gynecologists can offer IUDs and implants; while only gynecologists can provide voluntary sterilization.

Niger

In Niger, only nurses, midwives, and doctors can provide IUDs and implants, and only doctors perform sterilizations. Likewise, only doctors can provide EC, which is perhaps the most glaring disconnect between policy and current evidence. [4]

Togo

Similar to its neighbors, Togo permits only doctors to perform sterilizations; whereas IUDs, implants, and EC may be provided by doctors, midwives, nurses, and auxiliary skilled birth attendants (accoucheuses). POPs and Standard Days

[4] GIZ refers to the German aid organization, *Deutsche Gesellschaft für Internationale Zusammernarbeit.*

Method are only available at the aides-soignants level and above, not by ASCs, pharmacists, or social marketing agents. Current evidence suggests further task sharing to lower cadres of these methods.

5.3. Public and Private Sector Coordination

In all four countries, the private sector contributes to family planning provision to varying degrees. For instance, many ASCs are recruited, trained, supervised, and remunerated by private-sector organizations.

Likewise, in Burkina Faso, Niger, and Togo, FP social marketing agents also exist to promote family planning and to sell condoms, pills (POPs and COCs), and where available, CycleBeads. These distributors are managed by a local social marketing NGO and their remuneration is usually from profit on commodities sold to clients. Social marketing agents usually are similar in the education level to ASCs.

Several key informants mentioned more coordination and collaboration between the public and private sectors is needed. In particular, several mentioned that private providers did not have the same access to training as those in the public sector.

> *The government should inform pharmacists, as healthcare actors, about everything it is doing in terms of health. For example, I don't know how Confiance [oral contraceptive pill] is used. Pharmacists should be informed about the products that exist; they should be trained in the FP program; important health documents should be shared with them.*
>
> *-Owner, private pharmacy, Togo*

In Mauritania, private non-profit NGO providers of FP have a formal framework for collaboration with the MOH; the MOH must approve NGO activities. But generally the private sector is limited to the capital and other discrete areas; social marketing is also very limited.

In Togo's private sector, only doctors provide FP, and as a result, private FP services are more expensive than those in the private sector. Private midwives in clinics don't devote much time to FP services, mainly filling the prescription of a gynecologist. This encourages parallel services such as midwives offering home-based (less expensive) FP services in conjunction with other maternal and child health services.

5.4. Provision of FP by Pharmacies

Pharmacists also play a significant role in filling prescriptions and selling condoms. In Burkina Faso, private pharmacists even sell implants and IUDs to clients with a prescription, so she may then take the device to a health provider for insertion. However, it should be noted the availability of contraceptives varied among private pharmacies. Government oversight of pharmacies and quality control is sometimes an issue. In Mauritania, stakeholders acknowledged that in some cases pharmacies are not run by pharmacists and they sell contraceptives without a prescription. One respondent said the private pharmacies are a poorly organized sector and "anarchy" reigned in the price of products. The government is starting to improve regulation in this regard.

Table 4. Policy Guidelines on Provision of Different FP Methods among Various Cadres in Four Counties

	Social Marketing Agent				Pharmacist				ASC				Aides-Soignants/ AIS/Auxiliaries				Nurse				Midwife				Doctor/ Gynecologist			
Type of Service	**B**	**M**	**N**	**T**	**B**	**M**	**N**	**T**	**B**	**M**	**N**	**T**	**B**	**M**	**N**	**T**	**B**	**M**	**N**	**T**	**B**	**M**	**N**	**T**	**B**	**M**	**N**	**T**
Standard Days Method																												
Condoms male/female																												
EC																												
COCs		R							R			P																
POPs		R							R	R		P																
Depo Provera					X							P	S			S												
Noristerat					X							P	S			S												
Implant					X																							
IUD					X																							
Tubal ligation																					*			*				
Vasectomy																					*			*				

Source: Authors

Allowed in policies | **Not allowed according to policies**

* Burkinabè Association of Family Welfare in Burkina Faso and Togolese Association for Family Welfare (ATBEF) in Togo reported their midwives were trained to perform sterilizations but in public sector, midwives do not do this

X = Key informants reported pharmacies may sell commodity for client to take to health center for administration/ insertion

S = Under supervision

P = Piloting

R = Resupply only

5.5. Stakeholder Perspectives on Task Sharing

5.5.1. Policy changes

For the most part, the stakeholders interviewed were supportive of aligning national policies with WHO recommendations for task sharing, particularly for allowing auxiliary cadres to provide IUDs and implants, especially in rural health posts where higher level providers (midwives, doctors) are not available. Some stakeholders noted that task sharing was being undertaken in other health areas, such as general practitioners being trained to do cesareans when gynecologists are not available, so it stands to reason for auxiliaries to insert IUDs and implants where there is no midwife.

> *Les injectables, les implants, le DIU ne sont pas encore disponibles au niveau communautaire à cause des normes de la santé! Politique pas novatrice! Moi, je pense personnellement qu'on doit en arriver là. Les seringues préétablies sont déjà disponibles et on peut former les ASC à le faire… Comme ça les femmes peuvent recevoir leurs injections à domicile par un ASC au lieu de faire des kilomètres pour venir au CSPS. Il faut juste former les ASC et les suivre. Selon moi, l'accoucheuse doit donner toutes les méthodes sauf la ligature des trompes, qui relève d'un autre niveau. L'ASC lui doit donner tout sauf le DIU.*
>
> *Injectables, implants, IUDs are not yet available at the community level because of the health service delivery guidelines/norms! No innovative policies! I personally think we must get there. Pre-filled injectable syringes are already available, and CHWs can be trained to do it…This way, women can receive their injections at home by a CHW instead of traveling kilometers to go to the health centers. Community health workers just have to be trained and monitored. To me, midwives must provide every method to clients except the tubal ligation, which belongs to another level. The CHW should provide all methods except IUDs.*
>
> *—Gynécologue universitaire, Burkina Faso*

Although there was support for allowing ASCs to provide pills and injectables across all four countries, more reservations were expressed in Burkina Faso and Mauritania:

> *The injectable method entails risks; if it's not properly administered, the population can be demotivated. For better buy-in, it's better for the moment to reserve the injectable to qualified personnel.*
>
> *—Gynecologist, regional level, Burkina Faso*

Despite this, there were several key informants who had witness the positive effects of task sharing:

> *We [doctors and nurses] have seen that they [ASCs] have worked and that there have been no major problems. Furthermore, people seem happy with the services performed. I think we need to make this official, and that is the role of the Ministry of Health.*
>
> *—Key informant, doctor, Niger*

South-south exchanges seemed to play a role in disseminating compelling experiences on, and increasing acceptability of, ASCs' provision of pills and injectables. In Mauritania, a central-level monitoring and evaluation official remarked

> *Moi je sais que l'ASC peut offrir la pilule et l'injectable ; j'ai visité deux pays en Asie du Sud Est où les ASC font déjà l'injectable. Au Bangladesh ça a donné des effets vraiment extraordinaires. J'en ai vu des ASC qui faisaient même des implants. Mais en Mauritanie ça reste encore à convaincre le personnel médical, les décideurs et la population que les ASC peuvent offrir des contraceptifs sans toutefois avoir de diplôme de doctorat, d'infirmier ou de sage-femme. Informateur-clé, chargé de suivi-évaluation au niveau central*

"Me, I know that ASCs can offer pills and injectables…I visited two countries in South East Asia where CHW already give injectables. In Bangladesh, this has had tremendous results. There, I saw CHWs that even provided implants. But in Mauritania, we still need to convince the medical personnel, decisionmakers, and the general population that ASCs can provide contraceptives without having a doctor's, midwife's, or nurse's credentials."

5.5.2. Education, training, and supervision

A key issue raised by most stakeholders was the need to standardize criteria and training for ASCs, however the minimum education level was debated. Some key informants thought ASCs should have a minimum of 10 years of formal education (through junior secondary school), but others felt that recruiting individuals with that level of education was programmatically unrealistic. For instance, individuals with those skills might be more likely to migrate to urban areas in search of other job opportunities, and training investments would be lost. These key informants believed that with high-quality training and good supervision, it was adequate for ASC selection criteria to include the ability to read and write, do simple calculations, speak the local language, and describe contraceptive side effects to clients.

FP training for ASCs varied considerably between countries and within countries, depending on whether the ASC was linked to public facilities or NGOs. Some respondents mentioned private sector ASCs and other providers were often not included in targeted trainings provided by the government for public sector providers. In addition, many participants were concerned that ASC trainings are not sufficient to properly teach ASCs about FP methods. For example, in Togo, participants expressed concerns about the quality of training and the availability of trainers:

I don't think midwives have time to teach FP properly because pregnant women come, and sometimes we are given the FP classes in the evening. The same midwives do PNC [prenatal consultations], PCC [pre-conception consultations], and FP. This is why I say they don't have time to teach us FP and to delegate tasks. I would even say that midwives trained in FP aren't numerous like birth attendants.

—ASC, district level, Togo

Another glaring issue that emerged across all four countries was the need to strengthen supervision throughout the health system. In many instances, key informants described the level of supervision mandated by the MOH (monthly or quarterly), and admitted low adherence to these schedules. Several key informants mentioned that strengthening supervision systems must be addressed in tandem with task sharing.

5.5.3. Remuneration

A common debate regarding ASCs is how to structure incentives. Among these four countries, several stakeholders felt that ASCs should receive financial compensation to remain motivated and committed to their tasks. Niger's model of designating ASCs as formal salaried cadres in the health system was linked with their ability to provide sustained and high-quality services. Respondents felt that the remuneration ensured a more stable pool of ASCs in that they were not dropping out of the program as volunteers tend to do. They felt that this, in combination with the standardized training and more consistent supervision, lead to higher-quality services at the community level.

However, others were concerned that the public sector is already challenged to pay its health workers and this would stress public finances even further if paid ASCs were operating at scale.

I'm not sure they [CHWs] should be 100% volunteer, because they will end up burning out and giving up. Community recognition is not enough anymore, and the time has come for national reflection on which strategy we should adopt to better support CHWs.

—Director, NGO, Burkina Faso

6. Conclusions and Recommendations

Task sharing for family planning is actively promoted by WHO and the international family planning community as a safe, effective, and efficient programmatic approach to increasing contraceptive access and choice. Three years after the Ouagadougou conference on "Population, Development, and Family Planning in West Africa: An Urgency for Action," the provision of FP services at the community level has expanded. As seen in the results of this study, some ASCs in Niger, and increasingly in Togo, initiate contraceptive pills and provide injectables. However, results from this study show that overall, national policies still lag behind WHO guidance, and implementation of task sharing needs further emphasis and action. Generally speaking, ASCs, pharmacists, and auxiliary cadres are still underutilized in their potential to provide a range of FP methods.

While support for task sharing exists in each country, notable resistance remains among some key stakeholders. A more concerted and tactical effort is needed to map key pathways to change and design and execute concrete strategies to immediately advance task sharing at both the policy and programmatic level.

In particular, training and supervision of ASCs needs to be standardized and formalized in Burkina Faso, Mauritania, and Togo. Niger provides a regional example of how ASCs can be incorporated into the formal health system. West Africa can also look to other countries in East Africa and Asia for successful models of task sharing to expand access to pills, injectables, and EC. Countries should also focus on how long-acting methods (IUDs, implants) can be more readily provided by mid-level cadres. Finally, the government needs to enhance its stewardship of and coordination with the private sector, to ensure greater consistency in policy implementation, quality of training, and range of services provided through a total market approach.

Specific recommendations fall into three categories (policy and advocacy, operational, and training) and can be adapted for context by level and by country. Based on the findings of the assessment, HPP recommends that government and other FP stakeholders

Policy and Advocacy

1. Advocate for the revision of policies, standards and procedures in order to adapt to the new WHO guidelines on FP task sharing; specifically engage medical associations.
2. Develop an innovative and comprehensive community health policy that specifies and clarifies the roles of the different health providers.
3. Establish or enhance partnerships between the public and private health sectors for expanding family planning services, including innovative ways to engage pharmacists for provision of FP.

Operational

1. Scale up existing and new policies for community-based distribution of contraceptives.
2. Delegate prescription of contraceptives (pills and injections) to the community level.
3. Promote provision of long-acting methods through auxiliary cadres, nurses, and midwives

Training

1. Train all nurses and midwives on implants and IUDs; initiate pilot studies on implant and IUD provision by auxiliary cadres.

2. Increase the recruitment and training of ASCs in order to be able to initiate the supply of the pill to clients and administer injectables.
3. Establish regular training and certification for ASCs, and provide periodic refresher training for ASCs to improve their performance, taking into account the new tasks entrusted to them.

Annex A. List of Key Informants

TABLE A1: LIST OF KEY INFORMANTS IN BURKINA FASO

Répondant	Structure	Répondant	Structure
R 01	Niveau central Ministère de la Santé	R 16	MDC District Sanitaire
R 02	Niveau central Ministère de la Santé	R 17	Responsable ONG fournissant des services
R 03	Chargé Suivi Evaluation Niveau central MS	R 18	MDC District Sanitaire
R 04	Agent de santé central secteur public Gynécologue	R 19	PTF Multilatéral
R 05	Responsable service santé de district	R 20	Gynécologue Centre de santé de référence
R 06	Responsable ONG fournissant des services	R 21	Responsable central MS
R 07	PTF Chargé sécurisation produits SR	R 22	Responsable central MS
R 08	Responsable clinique privée Noucktchott	R 23	Gynécologue universitaire
R 09	Responsable ONG fournissant des services	R 24	Responsable SR District Sanitaire
R 10	PTF Coopération bilatérale	R 25	MDC District Sanitaire
R 11	Responsable service santé de district	R 26	Responsable SR PMI
R 12	Niveau central Ministère de la Santé	R 27	MDC District Sanitaire
R 13	Responsable service santé de district	R 28	Sagefemme Maternité District Sanitaire
R 14	Clinique Hôpital mère enfant de Nouakchott	R 29	Sagefemme Maternité District Sanitaire
R 15	Gérant Pharmacie privée	R 30	MDC District Sanitaire

TABLE A2: LIST OF KEY INFORMANTS IN MAURITANIA

Répondant	Structure	Répondant	Structure
R 01	Niveau central Ministère de la Santé	R 16	MDC District Sanitaire
R 02	Niveau central Ministère de la Santé	R 17	Responsable ONG fournissant des services
R 03	Chargé Suivi Evaluation Niveau central MS	R 18	MDC District Sanitaire
R 04	Agent de santé central secteur public Gynécologue	R 19	PTF Multilatéral
R 05	Responsable service santé de district	R 20	Gynécologue Centre de santé de référence
R 06	Responsable ONG fournissant des services	R 21	Responsable central MS
R 07	PTF Chargé sécurisation produits SR	R 22	Responsable central MS
R 08	Responsable clinique privée Noucktchott	R 23	Gynécologue universitaire
R 09	Responsable ONG fournissant des services	R 24	Responsable SR District Sanitaire
R 10	PTF Coopération bilatérale	R 25	MDC District Sanitaire
R 11	Responsable service santé de district	R 26	Responsable SR PMI
R 12	Niveau central Ministère de la Santé	R 27	MDC District Sanitaire
R 13	Responsable service santé de district	R 28	Sagefemme Maternité District Sanitaire
R 14	Clinique Hôpital mère enfant de Nouakchott	R 29	Sagefemme Maternité District Sanitaire
R 15	Gérant Pharmacie privée	R 30	MDC District Sanitaire

TABLE A2: LIST OF KEY INFORMANTS IN NIGER

Répondant	Structure	Répondant	Structure
R 01	Association des Sages-Femmes	R 11	Organisation des Soins PI
R 02	Nigerien office of pharmaceuticals and consumables	R 12	DGR
R 03	ANBEF	R 13	Santé de la Mère et de l'Enfant
R 04	Marie STOPES International Niger	R 14	Direction des pharmacies et Laboratoires
R 05	OSC PF pour le repositionnement de la PF	R 15	SR/PF District 1, 3, 5 NYCU
R 06	Engender Health (Programme AGIR PF)	R 16	DELIVER/USAID
R 07	Division PF	R 17	Division planification familiale
R 08	Ordre des Médecins, pharmaciens et dentistes du Niger	R 18	DRSP Niamey
R 09	SR/PF /NYCU	R 19	Division Santé Communautaire
R 10	Animas-Sutura	R 20	Population Services International-Niger

TABLE A4: KEY INFORMANTS INTERVIEWS AND FOCUS GROUPS IN TOGO

Répondant	Structure	Répondant	Structure
R 01	Direction de la Santé Familiale	R 15	ATBEF
R 02	Ministère de la Santé	R 16	ATBEF Plateaux
R 03	ATBEF	R 17	ATBEF Plateaux
R 04	ONG Vie et Santé	R 18	ATBEF Plateaux
R 05	CHU Tokoin	R 19	ATBEF Plateaux
R 06	EngenderHealth	R 20	ATBEF Plateaux
R 07	ONG FAMME	R 21	Clinique Myoren
R 08	Population Services International-Togo	R 22	Clinique Biasa
R 09	ONG Vie et Espoir, Tsévié	R 23	Clinique St Kisito
R 10	Clinique Millenium	R 24	Polyclinique St Joseph
R 11	Hospital Tsevie	R 25	Centre de Santé District No. 1
R 12	ASC ONG Jourdain Vie et Santé	R 26	Centre de Santé District No. 1
R 13	ATBEF	R 27	Division Santé Communautaire
R 14	ATBEF		

References

Association Mauritanienne de Sante Publique (AMSP). 2012. Document National de Strategie Communautaire Sante. Nouakchott : République Islamique de Mauritanie, Ministère de la santé.

Green, C. 2010. Community-Based Access to Injectables: An Advocacy Guide. Washington, DC:

Futures Group, Health Policy Initiative, Task Order 1.

Grimes, D.A., E.G. Raymond, B. Scott Jones. 2001. "Emergency Contraception Over-the-counter: The Medical and Legal Imperatives." Obstetrics & Gynecology, 98:151-155.

High-Impact Practices in Family Planning (HIP). 2013. Drug Shops and Pharmacies: Sources for Family Planning Commodities and Information. Washington, DC: USAID.

HIP. 2015. Community Health Workers: Bringing Family Planning Services to Where People Live and Work. Washington, DC: USAID.

Janowitz, B., J. Stanback, and B. Brooke. 2012. "Commentary: Task Sharing in Family Planning." Studies in Family Planning, 43 (1).

Leon, N., D. Sanders, W. Van Damme, D. Besada, E. Daviaud, et al. 2015. "The Role of 'Hidden' Community Volunteers in Community-based Health Service Delivery Platforms: Examples from sub-Saharan Africa." Glob Health Action, 8: 27214.

Maiga, M. and A. Lo. 2012. Repositioning Family Planning in Mauritania : A Baseline. Washington, DC: Futures Group and William and Flora Hewlett Foundation.

Management Sciences for Health (MSH). 2012. Community-Based Distribution of Hormonal Contraceptives in West Africa. Boston, MA: MSH, USAID-AWARE II Project.

McDavid, E. and S. Attama. 2012. Repositioning Family Planning in Niger: A Baseline. Washington, DC: Futures Group, Health Policy Project.

McDavid, E. and A. Kodjo. 2012. Repositioning Family Planning in Togo: A Baseline. Washington, DC: Futures Group, Health Policy Project.

OMS. 2012. Optimisation des rôles des agents de santé pour améliorer l'accès aux interventions de santé maternelle et néonatale clés à travers le transfert de tâches. Genève: OMS.

Population Reference Bureau. 2012. Family Planning : Francophone West Africa, A Call to Action. Consulté le 28 mai 2013 sur http://www.prb.org/pdf12/ouagadougou-partnership_en.pdf.

République du Niger. 2007. Feuille de route pour accélérer la réduction de la mortalité maternelle et néonatale au Niger, 2006–2015. Niamey : République du Niger ministère de la Santé publique et de la lutte contre les endémies, direction de la Santé de la reproduction.

Seck, A. and D. Valéa. 2011. Analyse de la santé communautaire au Burkina Faso. Burkina Faso: Ministry of Health.

World Health Organization (WHO). 2006. Working Together for Health. Geneva: WHO.

WHO, USAID, and Family Health International (FHI). 2010. Community-based Health Workers Can Safely and Effectively Administer Injectable Contraceptives: Conclusions for a Technical Consultation. Research Triangle Park, NC: FHI.

WHO. 2012a. From Evidence to Policy: Expanding Access to Family Planning.

Optimizing the health workforce for effective family planning services. Geneva: WHO. http://apps.who.int/iris/bitstream/10665/75164/1/WHO_RHR_HRP_12.19_eng.pdf

WHO. 2012b. Optimizing Health Worker Roles to Improve Access to Key Maternal

and Newborn Health Interventions through Task Shifting. Geneva: WHO.

WHO and HRP. 2013. Task Shifting to Improve Access to Contraceptive Methods. Geneva: WHO.

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