

INCREASING ACCESS TO FAMILY PLANNING: The Case for Task-Shifting Female Surgical Contraceptive Services

Nearly one in five Tanzanian women have a demand to limit childbearing; among women aged 30–49, this proportion is almost one in three.

If current trends continue, the estimated number of women aged 30–49 choosing female sterilization in 2015 will be more than 44,000 annually—a 143% increase over 2005 levels.

Clinical officers comprise more than 70% of the providers in Tanzania capable of performing minor surgeries, yet they have no training to provide permanent contraception to women (i.e., through minilaparotomy).

Task-shifting minilaparotomy services to clinical officers would increase access, address unmet need, and help women meet their reproductive intentions.



Women Lack Access to Family Planning Services in Tanzania

In Tanzania, approximately 18% of married women have a demand to limit childbearing (i.e., they want no more children); of these women, more than one-third have an unmet need for family planning (NBS & ORC Macro, 2005).

Female surgical contraception—also known as female sterilization—is a safe, extremely effective, and permanent way to limit childbearing, and it is the single most popular modern contraceptive method worldwide (PRB, 2008). The simplest way to provide this method is through a procedure called minilaparotomy under local anesthesia (ML/LA). According to the World Health Organization (WHO), ML/LA is a minor surgery that can be performed in low-resource settings on an outpatient basis, with low risk of complications (WHO, 1992; Kulier et al., 2004).

Despite apparent high demand, access to ML/LA in Tanzania is extremely limited. Fewer than half of hospitals and only one-third of health centres are able to offer ML/LA services (NBS & Macro International, 2007). A lack of trained providers significantly impacts the availability of services. The Ministry of Health and Social Welfare (MOHSW) recognizes that almost all facilities in Tanzania are understaffed, with huge inequalities in the distribution of health workers between rural and urban districts (Munga et al., 2009). In Kagera, a region in Tanzania with high demand for ML/LA (EngenderHealth, 2009), there are only 1.1 clinicians (medical officers, assistant medical officers [AMOs], and clinical officers [COs]) per 10,000 people (NBS & Macro International, 2007). This is far short of WHO's estimate that 2.5 health workers per 1,000 residents are needed to reach the Millennium Development Goals (Nullis-Kapp, 2005). Furthermore, most of the

medical officers available in Tanzania are fully engaged in administrative issues as district medical officers and are not trained to perform ML/LA.

The need for female surgical contraceptive services in Tanzania is also increasing. If current trends continue, the number of women aged 30–49 choosing female sterilization by 2015 will be more than 44,000 annually—a 143% increase since 2005.¹ Moreover, if half of the current unmet need to limit future births were addressed through expanded services for and uptake of female sterilization, the number of annual clients aged 30–49 could be more than 300% higher than 2005 levels.² While the MOHSW has initiated efforts to increase the number of health workers in Tanzania, 60% of each year's new entrants to health schools merely replace departing workers rather than augment the workforce (Touch Foundation, 2009). Thus, task-shifting of ML/LA services also needs to be considered, to assist in meeting the needs of this growing community of women seeking permanent contraception.

Task-Shifting to Clinical Officers Is Needed

Task-shifting (also known as task-sharing) is a process of delegating tasks to less-specialized health workers, to reorganize work and use human resources more efficiently. Task-shifting of surgical procedures to mid-level cadres has improved access to lifesaving interventions and has been ranked as a cost-effective way to address shortages of highly skilled medical professionals and improve access to services (Hounton et al., 2009).

Task-shifting ML/LA procedures to less specialized service providers is not a new idea. Similar task-shifting initiatives have been undertaken in Bangladesh, Malawi, Mozambique, and Thailand, with nurses and clinical officers in these countries (after receiving extra training in surgery) providing care with rates of success similar to those of their higher level counterparts. This suggests that in the Tanzanian context, COs should be able to perform ML/LA with rates of success similar to those of doctors and AMOs (Fenton, Whitty, & Reynolds, 2003; Kruk et al., 2007; Cumbi et al., 2007; Satyapan et al., 1983; and Ghorbani, 1979).

Why Clinical Officers?

In Tanzania, COs are mid-level providers who offer diagnosis, treatment, and minor surgeries. They are more prevalent in rural communities than doctors and AMOs and are generally considered capable of performing minor surgical procedures.

Almost all facilities in Tanzania are understaffed, but COs vastly outnumber doctors and AMOs, representing 71% of providers able to perform surgical procedures (Figure 1) (NBS & Macro International, 2007). COs also spend more time in their positions and at facilities than do other cadres of providers, improving the chances of reliable, continued care. Finally, whereas one-third of doctors and AMOs are located in Dar es Salaam, COs are more prevalent in poorer and/or rural areas than other higher level cadres. Thus, this

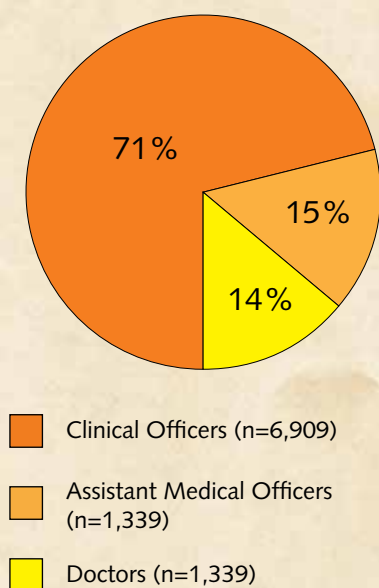
proposed task-shifting would increase access to ML/LA for many women who are most in need (NBS & Macro International, 2007).

Task-Shifting to Clinical Officers Is Feasible in Tanzania

From June to August 2009, the ACQUIRE Tanzania Project (ATP), led by EngenderHealth and supported by the U.S. Agency for International Development, assessed the possibility of task-shifting ML/LA services from medical officers and AMOs to COs (EngenderHealth, 2009). ATP reviewed national and international policies and experiences regarding provision of ML/LA by COs and conducted in-depth interviews with key informants at the national level and with 35 service providers from the Morogoro, Kagera, and Pwani regions, to assess attitudes, perceptions, and current practices. Not only have other countries allowed COs to perform ML/LA, but in Tanzania the need to expand ML/LA services is widely recognized, and task-shifting is supported by much of the reproductive health and family planning community (service providers and stakeholders).

A particular concern that arose was the lack of access to services in rural areas. One medical officer commented that “there are few service providers in the hospitals and very, very few in rural health centers,” while another key informant admitted that “when we refer them to the hospital, they do not go.” A CO in Kagera Province commented that “we need to extend our services and reach for the poor people; the COs reach the poor people in remote areas. They should be trained to do it... This service is good and many people need it, especially in rural areas, so [we] need to train COs to do this, it would really expand services.” The majority of those interviewed felt that task-shifting would increase accessibility, and one medical officer noted that COs are “trusted, they have training and have been there [in rural areas] for a long time.”

Figure 1. Proportion of different type of providers in Tanzania able to perform surgical procedures



Source:
NBS & Macro International, 2007.

Current Barriers to Task-Shifting

Although the majority of those interviewed supported task-shifting for ML/LA, several barriers were identified. Many providers mistakenly believe that there is a policy restricting COs from performing ML/LA. In Tanzania, COs are restricted from performing “major surgeries,” and there is a general confusion among providers and other stakeholders in Tanzania as to whether ML/LA is “major surgery.” Yet ML/LA can be performed as a minor surgery (Hibbard, 1978), and current policies in Tanzania are too vague on its classification as such (EngenderHealth, 2009).

“Task shifting of female surgical contraception (minilap) services to trained and qualified Clinical Officers is urgently needed to expand the availability of minilap services, especially in rural areas.”

—Dr. P. S. Muganyizi, Association of Gynecologists and Obstetricians of Tanzania (AGOTA)

Unlike doctors and AMOs, COs in Tanzania are neither registered nor licensed. This might be a significant barrier to task-shifting for ML/LA. One person interviewed by ATP stated that “as long as this cadre is not registered, we should avoid giving them work [that] involves high risk.” Some stakeholders see registration of COs as key, as it would facilitate centralized monitoring and coordination, as well as providing protection for COs themselves.

Finally, there are gaps in the training that COs receive, such as in-depth instruction on anatomy, and in the time they are allotted to practice skills, which is a prerequisite for proficient delivery of ML/LA services.

Nonetheless, attitudes about task-shifting are generally positive. Many of those interviewed supported task-shifting because they are challenged by a shortage of higher level providers. Shifting ML/LA procedures from AMOs and medical officers to COs would free up the other officers for higher level surgical needs. In

fact, the current needs of the population and the demand for female surgical contraception have resulted in some doctors and AMOs providing on-the-job training to COs in ML/LA and other services. The COs who already offer ML/LA services have all been favorably assessed by higher level providers, with no concerns regarding complications or quality of care (EngenderHealth, 2009).

Recommendations

Strengthen policies and guidelines.

The MOHSW, professional associations, and other key stakeholders should work together to clarify policies on COs’ roles in the provision of health services. Specifically, policies and guidelines

should clarify the differences between minor and major surgery and should explicitly categorize ML/LA as minor surgery. Further, Tanzania’s MOHSW needs to address the issue of registration/licensing and should move to register or license COs, both to strengthen the cadre in general and to help facilitate task-shifting efforts.

Expand ML/LA training and supervision.

Currently, ML/LA and many other family planning topics are not adequately covered in the preservice training of any service providers; preservice curricula should be revised with a focus on building ML/LA skills among AMOs and COs. Additionally, in-service training courses should be designed for COs, with the input and the endorsements of medical professional associations.

Initiate a demonstration project to generate evidence.

At some facilities, COs are already providing ML/LA services, but a more systematic approach to introducing task-shifting for ML/LA is

needed. Undertaking a more structured demonstration project and documenting its results will help the MOHSW institutionalize this approach at scale.

Equip facilities and improve referrals.

ATP’s assessment found that some facilities lacked general supplies and equipment needed to offer ML/LA (e.g., functioning sterilization equipment). To expand access to services, additional facilities will need to be properly equipped, including having a surgical contraceptive services room and receiving minilaparotomy kits. Strengthening referrals and instituting special service days and/or outreach services will also help more women access ML/LA services.

Conclusions

ATP’s feasibility analysis on task-shifting female surgical contraceptive services shows that there is a need and demand for expansion of these services in Tanzania. Task-shifting to enable COs to perform these services could be a way to meet this demand. There is great support within the health care community for task-shifting, and COs appear to be the appropriate cadre to fill the service gap. Training and equipping COs to perform ML/LA would significantly increase the number of providers offering this procedure and could expand services to previously unreached areas. This would increase access, address unmet need for family planning, and help women and couples in Tanzania meet their reproductive intentions.



The ACQUIRE Tanzania Project (ATP) works to make lasting improvements in the quality and availability of reproductive health care in Tanzania. Managed by EngenderHealth and supported by the U.S. Agency for International Development (USAID), ATP partners with Tanzania's Ministry of Health and Social Welfare, faith-based organizations, and other groups.

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1. Based on data from the 1999 and 2005 Tanzania Demographic and Health Surveys (more than 18,000 adopters in 2005) and Reality √ projections for intervening and future years.
 2. This is based on the assumption that half of the overall unmet need (among women aged 30–49) to limit (11.5%) is addressed through female surgical contraception by 2015.