Task sharing for family planning services, Burkina Faso

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Abstract

Problem In Burkina Faso the coverage of services for family planning is low because of shortage of qualified health staff and limited access to services.

Approach Following the launch of the Ouagadougou Partnership, an alliance to catalyse the expansion of family planning services, the health ministry created a consortium of family planning stakeholders in 2011. The consortium adopted a collaborative framework to implement a pilot project for task sharing in family planning at community and primary health-care centre levels in two rural districts. Stakeholders were responsible for their areas of expertise. These areas included advocacy; monitoring and evaluation; and capacity development of community health workers (CHWs) to offer oral and injectables contraceptives to new users and of auxiliary nurses and auxiliary midwives to provide implants and intrauterine devices. The health ministry implemented supportive supervision cascades involving relevant planning and service levels.

Local setting In Burkina Faso, only 15% (2563/17,087) of married women used modern contraceptives in 2010.

Relevant changes Adoption of new policies and clinical care standards expanded task sharing roles in family planning. The consortium trained a total of 79 CHWs and 124 auxiliary nurses and midwives. Between January 2017 and December 2018, CHWs provided injectables to 3698 new users, and auxiliary nurses or midwives provided 726 intrauterine devices and 2574 implants to new users. No safety issues were reported.

Lessons learnt The pilot project was feasible and safe, however, financial constraints are hindering scale-up efforts. Supportive supervision cascades were critical in ensuring success.
Introduction

Family planning is recognized as a cost–effective intervention for curbing issues within sexual and reproductive health, improving women’s status and increasing women’s capacities to contribute to family income. Yet, access to and uptake of family planning services in sub-Saharan Africa remain low, resulting in many unintended pregnancies. In Western Africa, between 2010 and 2015, this low service coverage has resulted in a fertility rate as high as 5.5 children per woman and poor maternal and child outcomes. To address the situation and catalyse the expansion of family planning services, nine francophone African countries, including Benin, Burkina Faso, Côte d’Ivoire, Guinea, Mali, Mauritania, Niger, Senegal and Togo, launched the Ouagadougou Partnership in 2011.

The common challenges of low service coverage for family planning and shortage of qualified human resources prompted the partnership to identify task sharing as a promising intervention to reduce the high levels of unmet need in family planning. All partnership countries included task sharing for family planning into their priority commitments and defined strategic steps to boost policy changes and field implementation.

This article reports key lessons from Burkina Faso. We used the World Health Organization’s (WHO’s) *A guide to identifying and documenting best practices in family planning programmes* to document task sharing activities, drawing from reports, meeting notes and proceedings, project data, and interviews with key stakeholders at national and regional levels.

Local setting

In Burkina Faso, only 15% (2563/17,087) of married women used modern contraceptives in 2010, with 20-percentage points difference between urban (31%) and rural areas (11%). The unmet needs for family planning were estimated at 24% (4069/17,087) with also a rural versus urban gap. Expanding coverage of family planning services was therefore needed, particularly in rural settings, where major challenges include geographical access to health facilities, and predominantly low- and middle-level qualified health-care providers. For example, in 2015, national statistics showed that 48% (87/181) of non-physician staff working in the 39 primary health-care centres of the rural Tougan health district were auxiliary nurses and auxiliary midwives, while in the rural Dandé health district, this figure was 54% (66/122) for 29 primary health-care centres.

Some form of task sharing in family planning have existed in the country since the Declaration of Alma Ata in 1978. At the community level, community health workers
(CHWs) can counsel clients, distribute condoms and resupply women with oral contraceptives. At the primary health-care centre level, auxiliary nurses or auxiliary midwives can provide short-acting contraceptive methods, including injectable contraceptives. However, health policies and clinical care standards prohibited them to perform more complex tasks. CHWs could not prescribe oral contraceptive pills to new users and provide injectable contraceptives, and auxiliary nurses or midwives could not insert and remove implants or intrauterine devices.

**Approach**

Following the Ouagadougou Partnership launch in 2011, the health ministry created a consortium of family planning stakeholders comprising nongovernmental organizations (NGOs), including *Association Burkinabé pour le Bien-Être Familial, Équilibre et Populations* and Marie Stopes International. Partners agreed on a framework centred on collaboration and committed to specific responsibilities in their respective areas of expertise, such as advocacy, capacity development of CHWs, auxiliary nurses and auxiliary midwives and monitoring and evaluation.

Between 2017 and 2018, the consortium conducted a pilot project for task sharing in family planning in Tougan and Dandé, two rural districts located in different regions of the country. A total of 25 primary health-care centres and their catchment areas were included in both districts. The strategic approach encompassed an advocacy strategy for changes in policies and clinical care standards; community outreach activities to increase the demand for services; and staff capacity strengthening at both community and primary health-care centre levels. All the activities were conducted in close collaboration with the district level health ministry.

**Policy and standard changes**

To change health policies and clinical care standards for supporting task sharing in family planning, the consortium developed an advocacy strategy in 2012, which was based on the regular review of scientific evidence, including data from the field, during consortium meetings. The consortium established a steering committee to oversee the entire project. In addition to senior representatives of the health ministry and implementing NGOs, this committee comprised key partners at country level, including WHO, the United Nations Population Fund and the United States Agency for International Development. The consortium shared evidence on task sharing in family planning, through oral presentations and written summaries with the committee and during meetings with authorities at provincial,
regional and national levels before the project started as well as providing new results on the project’s feasibility, effectiveness and patient safety during the project.

**Demand creation activities**

*Association Burkinabé pour le Bien-Être Familial* was responsible for demand creation activities by training CHWs to conduct more home visits and discussions with increased focus on family planning at community level. CHWs learnt counselling and the delivery of key messages during the capacity strengthening workshops. CHW's visited community congregation, such as market days, to deliver the key messages to relevant audience. Demand creation was also facilitated by strengthening the capacity of auxiliary nurses and midwives for quality counselling at facility level, which was included in their capacity strengthening workshops.

**Capacity strengthening**

*CHWs*

With the support of the other members of the consortium, *Association Burkinabé pour le Bien-Être Familial* led the training of CHWs. These providers were already working in different programmes, such as home management of malaria or undernutrition screening, and had been recruited by the health ministry. Their monthly incentive approximates 40 United States dollars and they did not receive additional payment for the additional tasking sharing. The association organized two sessions in Dandé and three in Tougan. During the two-week workshops, for which the participants had to leave work, they received training on family planning counselling and the provision of condoms and oral and injectable contraceptives. The training method included interactive presentations, group work, role-play and practical sessions in health facilities.

*Auxiliary nurses and midwives*

*Marie Stopes International* facilitated the training of auxiliary nurses and midwives on implant and intrauterine device counselling, insertion, and removal. Two workshops were organized in Dandé and three in Tougan. Each workshop lasted two weeks, had full training days and used interactive presentations, group works and practical sessions.

**Monitoring and evaluation**

*Équilibre et Populations* coordinated the implementation of the agreed monitoring and evaluation plan, which included monitoring service provision issues on both client and provider sides, reviewing periodic and final project reports and ensuring the implementation of recommendations.
Supportive supervision
The health ministry and NGOs created a supportive supervision strategy, cascading from the national level to the community and primary health-care centre levels (Fig. 1). This cascade strengthened the management system at the health district and regional levels, as well as the service provision activities at the level of primary health-care centres and CHWs. The health district team supervised the activities of the trained auxiliary nurses and midwives quarterly and the director of each primary health-care centre supervised the work of CHWs monthly. Each director was also engaged in the supervising health district team as to ensure the follow-up of the recommendations of the health district team. The regional team supervised the activities at the district level, and a national steering committee oversaw the entire process.

Relevant changes
The advocacy process raised awareness of relevant actors, which contributed to the adoption of new policies and clinical care standards allowing CHWs to prescribe oral contraceptives and provide injectable contraceptives to new users at the community level and auxiliary nurses and midwives to offer implants and intrauterine devices at primary health-care centres.

Between January 2017 and December 2018, the consortium trained a total of 79 CHWs and 124 auxiliary nurses and midwives and implemented the pilot project that resulted in an increase in the numbers of new family planning users in both districts. From February 2017 to December 2018, CHWs provided injectables to 3698 new contraceptive users and auxiliary nurses or midwives provided 726 new intrauterine devices and 2574 new implants (Table 1). During the project period, the uptake of family planning services from trained providers remained relatively steady at both community and primary health-care centre levels, and no safety incidents were reported. CHWs were able to identify and manage contraceptive side-effects and to refer clients to primary health-care centres if needed. In 2018, CHWs referred 60 contraceptive users for further management of side-effects.

Lessons learnt
Gathering different family planning stakeholders within the same country to plan and act collaboratively contributed to increasing access for women and couples to a wider range of contraceptive methods and to meeting the demand of women and couples for family planning.

The iterative evidence-based advocacy efforts proved useful in changing policies and clinical care standards. The pilot project reinforced the existing evidence\textsuperscript{6} that injectables can be safely administered by CHWs and implants and intrauterine devices by auxiliary nurses and midwives. The supportive supervision approach, combined with the engagement of the
steering committee, was considered critical to ensure the success of the project as the supervision allowed a continuous and dynamic process of contribution, enrichment and nurturing among all consortium stakeholders, including the health ministry (Box 1).

There were challenges to the task sharing project. First, the high turnover of auxiliary nurses and midwives in the project areas was an issue, which the consortium addressed by offering training sessions to newly arrived auxiliary nurses and midwives. This issue will likely have less impact once this task sharing is implemented in the whole country. Second, the long-term sustainability of task sharing in family planning at the community level requires further study, as CHWs are not yet fully integrated into the formal health system and their voluntary contribution and limited salary incentives affect their motivation. Third, primary health-care centre providers equipped with additional competencies may legitimately wish a better salary, which could burden the health system. Fourth, following the overall positive processes and outcomes of the pilot project, stakeholders agreed to scale up the project nationwide in 2018. Although financial constraints are delaying the scale up, the country adopted a scaling-up plan for task sharing in family planning in late 2018, for which funding for its operationalization needs to be identified.

Countries facing similar challenges in coverage of family planning service and human resources for health could implement an equivalent strategy so that women and couples can have access to a wider range of safe contraceptive services that better meet their demand.

Competing interests:
None declared.

References


**Box 1. Summary of main lessons learnt**

- Task sharing in family planning was feasible and safe at both community and primary health-care centre levels.
- Mobilizing key stakeholders catalysed changes in health policies and clinical care standards related to task sharing in family planning.
- Participatory supervision cascades under the leadership of the health ministry was critical in ensuring the success of the project.
Table 1. Provision of contraceptives to new users by provider, Burkina Faso, 2017–2018

<table>
<thead>
<tr>
<th>Period</th>
<th>Dandé district</th>
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<tr>
<td></td>
<td>No. of injectables</td>
<td>No. of pills</td>
<td>No. of intrauterine devices</td>
<td>No. of implants</td>
<td>No. of injectables</td>
<td>No. of pills</td>
<td>No. of intrauterine devices</td>
<td>No. of implants</td>
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<td>2017-Q1</td>
<td>20</td>
<td>1</td>
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<td>303</td>
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<td>58</td>
<td>127</td>
<td>291</td>
<td>91</td>
<td>32</td>
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<td>2017-Q4</td>
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<td>77</td>
<td>41</td>
<td>163</td>
<td>417</td>
<td>93</td>
<td>115</td>
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<tr>
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<td>168</td>
<td>53</td>
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<td>207</td>
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<td>85</td>
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<td>2018-Q2</td>
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<td>1353</td>
<td>421</td>
<td>325</td>
<td>1351</td>
<td>2345</td>
<td>518</td>
<td>401</td>
<td>1223</td>
</tr>
</tbody>
</table>

CHW: community health worker; Q: quarter.

* Includes auxiliary nurses and midwives.
Fig. 1. **Supervision cascade related to task sharing in family planning, Burkina Faso**

<table>
<thead>
<tr>
<th>Composition of supervising team</th>
<th>Action</th>
</tr>
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| Steering committee: health ministry at the highest hierarchy level, NGOs at the highest hierarchy level,\(^a\) technical and financial partners (WHO, USAID, UNFPA) | - Examination of health regional level supervision reports  
- Review of system-related outcomes  
- Organization of services  
- Management of funding issues  
- Field visits to a sample of primary health-care centres and CHWs |
| Regional teams: staff from health regions, NGOs, and health districts | - Examination of health district level supervision reports  
- Management of operational issues at the district level  
- Visit to a set of primary health-care centres and CHWs  
- Frequency: quarterly |
| Health district teams: staff from health districts, NGOs, and primary health-care centres | - Examination of supervision reports by the directors of primary health-care centres on community task sharing  
- Direct observation of service provision by auxiliary nurses, auxiliary midwives, and CHWs  
- Assessment of adherence to clinical care standards  
- Supervision of all trained providers in all primary health-care centres and a set of CHWs  
- Frequency: quarterly |
| Providers trained to offer long-acting methods | - Supervision of all CHWs of the catchment area  
- Examination of CHWs’ reports  
- Direct observation to assess adherence to clinical care standards  
- Frequency: monthly |
| Teams of primary health-care centres: director of the facility | |
| CHWs delivering family planning at community level | |


\(^a\) NGOs included were Association Burkinabé pour le Bien-Être Familial and Marie Stopes International.