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Delivering contraceptive vaginal rings—Task shifting and task sharing in the delivery of family planning services: Experiences from Kenya

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DELIVERING
CONTRACEPTIVE
VAGINAL RINGS

Task shifting and
task sharing in the
delivery of family
planning services:
Experiences from
Kenya

Wilson Liambila
Saumya RamaRao
Heather Clark





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List of Abbreviations

| | |
|--------|--|
| AIDS | Acquired Immunodeficiency Syndrome |
| BTL | Bilateral tubal ligation |
| CBD | Community-Based Distributor |
| CBS | Central Bureau of Statistics |
| CHEW | Community Health Extension Worker |
| CHW | Community Health Worker |
| CM | Community Midwife |
| COC | Combined Oral Contraceptives |
| CPR | Contraceptive Prevalence Rate |
| DMPA | Depot Medroxyprogesterone Acetate |
| DRH | Division of Reproductive Health |
| FHI360 | Family Health International 360 |
| FIGO | International Federation of Gynecology and Obstetrics |
| FP | Family Planning |
| GHI | Global Health Initiative |
| HIV | Human Immunodeficiency Virus |
| ICPD | International Conference on Population and Development |
| IUCD | Intrauterine Contraceptive Device |
| KDHS | Kenya Demographic and Health Survey |
| KEPH | Kenya Essential Package for Health |
| KHSSP | Kenya Health Sector Strategic Plan |
| KNBS | Kenya National Bureau of Statistics |
| KOGS | Kenya Obstetrical and Gynaecological Society |
| LAPM | Long-acting or Permanent Method |
| LARC | Long-acting and reversible contraceptives |
| MDGs | Millennium Development Goals |
| MNH | Maternal and Newborn Health |
| MOH | Ministry of Health |
| MOMS | Ministry of Medical Services |
| MOPHS | Ministry of Public Health and Sanitation |
| MYWO | Maendeleo Ya Wanawake Organization |
| NCPD | National Council for Population and Development |
| NGO | Non-governmental Organization |
| PCVR | Progesterone Contraceptive Vaginal Ring |
| RHCO | Reproductive Health Clinical Officer |
| TFR | Total Fertility Rate |
| UNFPA | United Nations Population Fund |
| USAID | United States Agency for International Development |
| VMMC | Voluntary Male Medical Circumcision |
| WCG | Woman Care Global |
| WHO | World Health Organization |

Executive Summary

Expanding the provision of contraceptive methods by mid and lower-level health workers with varying levels of knowledge and skills can significantly improve access to contraception for all individuals and couples. Many countries with a shortage of human resources are implementing various forms of task sharing or task shifting as a strategy for delivering contraceptive methods within communities and in health care facilities. This report describes the task shifting and task sharing policies and experiences that are relevant to the provision of family planning services in Kenya and the potential place for contraceptive vaginal rings. The exercise sought to document the feasibility, effectiveness and acceptability of mid and lower-level providers in the provision of family planning services and the extent to which these activities have been implemented.

A review of the way reproductive health services, including family planning, are provided shows that many health workers are already implementing task sharing and task shifting approaches with varying degrees of success. Three examples are addressed in this report: provision of bilateral tubal ligation by clinical officers, provision of depot medroxyprogesterone acetate (DMPA) by CHWs, and sustaining community-based MNH and family planning services through task sharing activities between community midwives and community health workers.

The report also highlights how the provision of integrated RH/FP/HIV services could be delivered by various levels in the national health care system through task sharing. Opportunities for facilitating the delivery of progesterone contraceptive vaginal rings (PCVR) within the national health care system in Kenya are also described. For example, key Ministry of Health policy makers view the PCVRs as a very useful product that can broaden the contraceptive options for breastfeeding women in the postpartum period. Other opportunities include interest and engagement in the ongoing PCVR acceptability study by key audiences in Kenya including the Kenya Obstetrical and Gynecological Society (KOGS), having in place a supportive policy environment for task sharing activities, the availability of resources for health providers such as training curriculums for PCVR, and job aids which can easily be adapted for the roll out phase.

Despite the many opportunities that are available to facilitate the delivery of PCVRs within the national health care system, there are a number of challenges to be addressed. For instance, there will be a need for additional resources to support demand generation. Building demand will be a critical step at the inception of the service delivery phase. Most of the resources for demand creation will go towards meeting the costs of behavior change communication and marketing activities. In addition, there will be a need to identify and plan for a financing strategy to address the initial costs associated with the PCVR supply chain (from manufacturing to the end user).

In conclusion, the case studies highlighted in the report show that Kenya has in place relevant policies that allow lower and mid-level health workers to deliver contraceptive methods including conducting specialized surgical contraception procedures. Thus, task shifting approaches are likely to lead to a more rational distribution of responsibilities among different cadres of health workers in Kenya with regard to the provision of reproductive health services, including eventually contraceptive vaginal rings.

Introduction

Family planning (FP) is a cost-effective intervention but health workforce shortages and restrictive policies on the roles of mid and lower-level cadres can limit user access to effective contraceptive methods in many settings [1]. Expanding the provision of contraceptive methods to other health worker cadres (Figure 1) can significantly improve access to contraception for all individuals and couples. Many countries have already enabled mid- and lower-level health workers to deliver a range of contraceptive methods, utilizing these workers either alone or as part of teams within communities and/or health care facilities. The WHO recommendations on *Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting* supports a more rational distribution of tasks and responsibilities among health workers through sharing or shifting of tasks[2].

COUNTRY SNAPSHOT

Population size: **43 million**

Total fertility rate: 4.6

Rate of natural increase: **2.6%**

Contraceptive prevalence rate: 46%

Unmet need for FP: 26%

Maternal mortality ratio:
488 per 100,000 live births

Infant mortality rate: 52

Figure 1: Optimize MNH summary of recommendations for task sharing family planning

| | Lay Health Workers | Auxiliary Nurses | Auxiliary Nurse Midwives | Nurses | Midwives | Associate Clinicians | Advanced Level Associate Clinicians | Non-Specialist Doctors |
|--|--------------------|------------------|--------------------------|--------|----------|----------------------|-------------------------------------|------------------------|
| Contraceptive delivery | | | | | | | | |
| 1.1–1.13 Promotion of maternal, newborn and reproductive health interventions | | | | | | | | |
| 12.2 Initiation and maintenance of injectable contraceptives – standard syringe | | | | | | | | |
| 12.3 Insertion and removal of intrauterine devices | | | | | | | | |
| 12.4 Insertion and removal of contraceptive implants | | | | | | | | |
| 12.5 Tubal ligation | | | | | | | | |
| 12.6 Vasectomy | | | | | | | | |

| | | | | | |
|--|--|--|--|--|--------------------------------|
| | Recommended | | Consider in context of rigorous research | | Accepted as within competency |
| | Recommended with monitoring and evaluation | | Recommend against | | Accepted as outside competency |

Source: Task shifting to improve access to contraceptive methods, summary of the WHO Optimize MNH guidance, 2013.

Strategies to optimize tasks and roles for the implementation of effective interventions have achieved variable success. This is partly because the effects of these strategies are dependent on local health system contexts. The use of task shifting strategies is viewed as one of the promising approaches in the delivery of contraceptive vaginal rings, including the progesterone contraceptive vaginal ring (PCVR) which can play a key role in increasing access to contraception for millions of women, especially in contexts where a majority of women breastfeed their babies. PCVR is a new contraceptive designed for use by breastfeeding women. It is user-controlled and releases 10mg of natural progesterone per day. It acts by thickening the cervical mucus and inhibiting sperm penetration into the uterus. Effectiveness of 98.5% has been reported (Sivin et al, 1997). It is currently registered and sold in Latin America. At the moment, a study to assess the acceptability of PCVR as a contraceptive among women in sub-Saharan Africa (Kenya, Nigeria and Senegal) is ongoing. Autonomous self-use of the PCVR and other vaginal rings is an attractive and important feature of these devices. Furthermore, service providers do not require extensive training on the use of vaginal rings, and most of the focus is on user education and counselling about the ring.

This report contains the results of a landscaping exercise that was conducted to review the available in-country evidence especially for the policy support on task sharing activities with regard to the provision of family planning services in Kenya. Specifically, the exercise sought to document the feasibility, effectiveness and acceptability of mid and lower level providers in the provision of family planning services, the extent to which these activities have been implemented, emerging lessons and the implications for introducing the PCVR and other vaginal contraceptive rings [3]. Policy-level support, health system issues as well as other factors which are likely to affect the implementation of task sharing activities are also discussed.

DEMOGRAPHIC PROFILE

The population of Kenya more than doubled over a period of three decades from 10.9 million in 1969 to 28.7 million by 1999 (CBS 1970; CBS 2001). In 2009, it was 38.6 million (with a growth rate of 2.8%) and is projected to reach 64 million by 2030 (KNBS 2010). Nearly two-thirds (63%) of the population is under the age of 25 years while 43% are aged below 15 years [4]. Kenya's fertility rate has remained largely unchanged at about 4.6 per woman in the past decade, from 1998 to 2009 [4]. Kenya's key demographic and health indicators are outlined in Box 1 below.

Box 1: Key indicators from the Kenya Demographic and Health Survey 2008/2009

Fertility:

- Total fertility rate (TFR): 4.6 children per woman
- Percent of births unwanted: 17; percent of mistimed births (wanted later): 26
- Percent of married women who want no more children or who have been sterilized: 54

Family Planning

- Contraceptive prevalence rate: 46%
- Contraception discontinuation: 36% discontinue use within 12 months of adopting a method
- Unmet Need for FP : 26% of currently married women

Maternal Health:

- Percent of women receiving ANC from a medical professional: 92
(Percent of health facility deliveries: 43; Percent of home deliveries: 56)

Child Health and Nutrition:

- Percent of children 12-23 months fully vaccinated:77
- Percent of children breastfed: 97; median duration of breastfeeding: 21 months
- Percent of new-born children less than two months receiving complementary foods other than water: 24
- Median duration of exclusive breastfeeding is estimated at less than one month
- Bottle-feeding is common (25% of children under 6 months are fed with bottles with teats)
- Use of infant formula milk is minimal; only a tiny fraction of children below six months receive commercially produced infant formula

Barriers in accessing family planning services

Users and non-users of family planning services face different sets of barriers. Barriers are defined as the constraining factors standing between women and the availability of the technologies and correct information they need to decide whether and when to use contraception [5]. Users or those who intend to use family planning services face broad health system barriers. Some of these include:

- Physical or geographic barriers such as long distances to service sites
- Service barriers such as lack of commodities in health facilities and inadequate skills
- Financial and affordability barriers including high travel costs
- Knowledge and attitude barriers including misinformation and rumors
- Social-cultural barriers and gender relationship including negative traditional practices and desires such as preference for sons as security in old age

Those who do not intend to use contraception in the future cite mainly method-related factors such as fear of side effects and health concerns. Appendix 1 contains details of various health system and non-use barriers.

HUMAN RESOURCE PLANNING AND MANAGEMENT

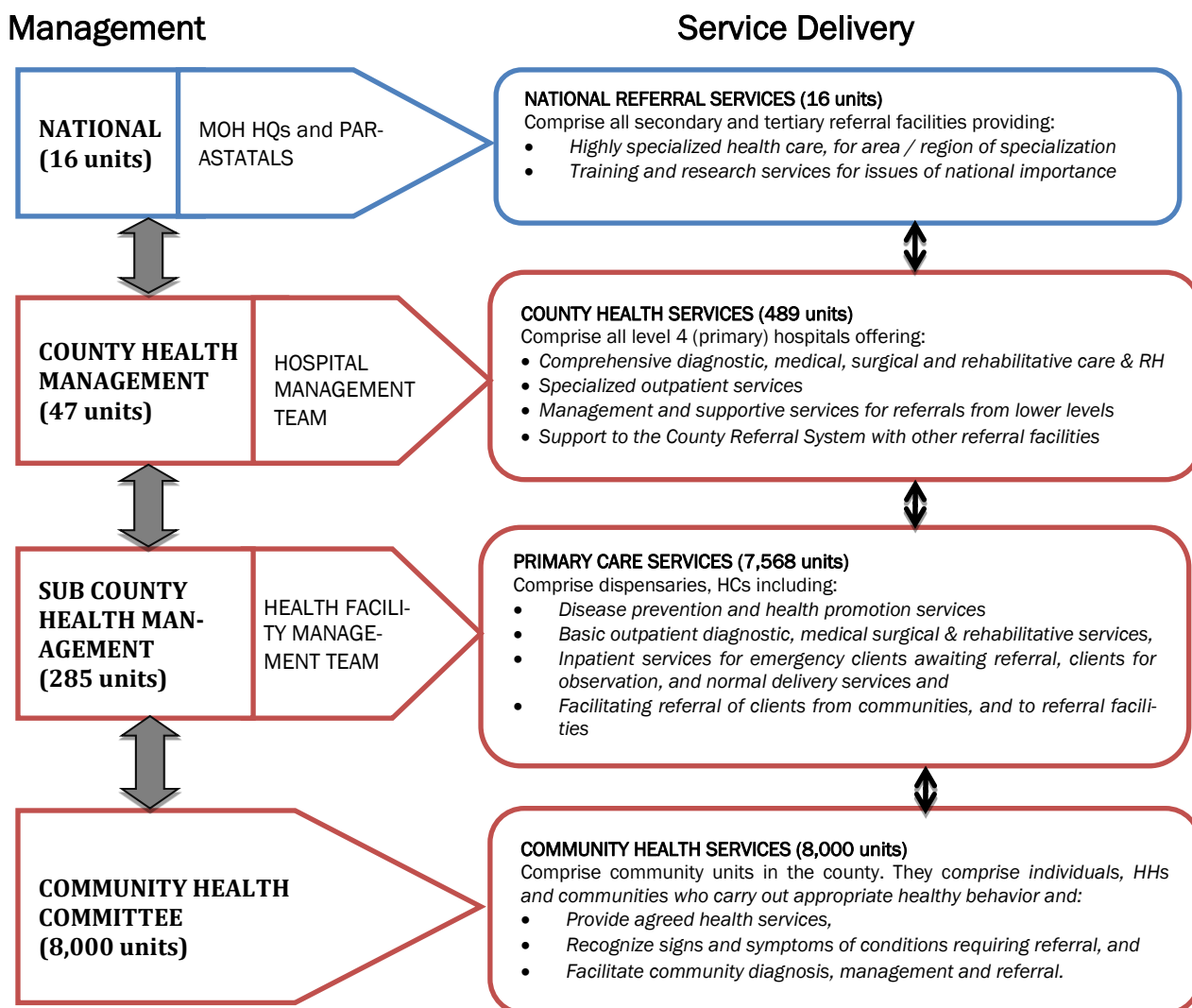
Human resources is one of the most important inputs required in achieving many of the goals set by the government, private, mission or NGO-sectors in Kenya. Adequacy of human resources encompasses numbers, skills mix, competence, and appropriate attitudes of health providers. The system in which health services are managed and organized in Kenya including the hierarchy of skill-mix for providers [6] is described in the next section.

Organization of health services and hierarchy of skill mix for providers

This section provides a brief description of the Kenyan health pyramid, staffing at various levels, current roles and responsibilities of the staff and their training. In accordance with the devolved system of government, four levels or tiers of care are recommended. Figure 2 outlines how health services are organized at these four levels. The Kenya health policy framework defines the priority services that are necessary to be provided at the following 4 distinct levels or tiers of care:

- **Community level:** Services at this level are mainly offered by Community Health Workers (CHWs), Community Health Extension Workers (CHEWs) and Community Midwives. The range of services includes education and information on preventable and promotive activities and basic curative care interventions. Community Midwives are often compensated by their clients for the services they offer since they are self-employed, unlike CHWs who are volunteers. Community Health Extension Workers (CHEWs) are salaried government employees who are deployed at the community level.
- **Primary care level:** The first level of the health system, comprising all dispensaries, health centers and maternity/nursing homes. Most clients' and patients' health needs are addressed at this level. The majority of health providers at this level are nursing officers and clinical officers. Nursing officers are midlevel health professionals trained to provide various aspects of nursing services. In Kenya, nursing officers are trained for a period of three and a half years. Clinical officers are mid-level health professionals who are trained to provide curative, preventive, promotive and rehabilitative health services. In Kenya, clinical officers are trained for a period of four years including internship. After successfully completing the basic training, they are awarded a diploma in clinical medicine. Those who wish to pursue further training in reproductive health undergo an 18-month course at a referral and teaching hospital. Cadres such as public health officers and nutrition field workers provide services at the community level from their respective primary health care facilities.
- **County level:** This is the first level of hospitals whose services complement those provided at the primary health care level. A majority of health providers at this level are general specialists such as pediatricians, gynecologists, and common cadres such as medical officers, nursing officers and clinical officers.
- **National level:** This level comprises all tertiary and referral hospitals, which provide specialized health care and training opportunities for both undergraduate and post graduate students. The facilities also serve as research centers.

Figure 2: Organization of health services delivery in Kenya



Source: KHSSP July 2012 – June 2018 (Draft). Ministry of Medical Services and Ministry of Public Health & Sanitation

The hierarchy of health facilities and the available skill-mix allow clients with various needs to be seen by either one health provider or more through facilitated referral(s) regardless of whether the client is seen at the community level or within a health facility. Table 1 shows human resource investment targets for the health sector in Kenya. Only those cadres that are likely to provide a family planning service are shown. The rest of the cadres are listed in Appendix 2.

Table 1: Human Resource Investment Targets for the Health Sector in Kenya

| Staff Cadre (a) | Requirements for 2017 (b) | Current (2013) numbers (c) | Human Resource Gap (d) | % of gap (c/b*100) |
|----------------------------------|---------------------------|----------------------------|------------------------|--------------------|
| Medical Officers | 2,830 | 1005 | 1,825 | 36 |
| Clinical Officer (Spec) | 1,229 | 1086 | 143 | 88 |
| Clinical Officers (Gen) | 9,827 | 1635 | 8,192 | 17 |
| BSN Nursing officers | 4,793 | 3344 | 1,449 | 70 |
| Registered Nurses | 7,654 | 7260 | 394 | 95 |
| Enrolled Nurses | 29,975 | 12303 | 17,672 | 41 |
| Public Health Officers | 11,765 | 1718 | 10,047 | 15 |
| Pharmacists | 561 | 329 | 232 | 59 |
| Pharm. Technologist | 5,098 | 505 | 4,593 | 10 |
| Trained Community Health Workers | 250,020 | 18,038 | 231,982 | 7 |

Adapted from: Accelerating attainment of Health Goals: The Kenya Health Sector Strategic and Investment Plan – KHSSP July 2012 – June 2017 Published by: Ministry of Medical Services and Ministry of Public Health & Sanitation

As shown in Table 1, the health sector still faces a significant human resource shortage especially in the public sector, mainly because of the freeze in recruitment of the staff that has been in place for slightly over five years. During the medium-term plan period (July 2012 – June 2017), the national as well as the county governments intend to address the issue of human resource shortage by:

- making available appropriate and equitably distributed health workers
- attracting and retaining the required cadres of health workers
- improving institutional and health worker performance, and
- building the capacity of the existing and future health workforce through targeted competency-based training.

Need for Task Sharing and Task Shifting

In 2006, the Ministry of Health in Kenya published the Community Health Strategy [7] with the aim of empowering Kenyan households and communities to take charge of improving their own health. Implementing the community strategy has over the years contributed to increased demand for various health services including antenatal care and family planning services. Increased demand for some of the services has tended to occur against a background of almost no increase in the number of skilled providers. Hence, task sharing has been necessary to enable lower cadres such as CHWs to assume non-clinical roles such as creating awareness, education, counselling, basic family planning and others aspects of reproductive health services, leaving clinical aspects to health workers with higher technical skills.

Task shifting, defined as delegating tasks to existing or new cadres with either less training or narrowly tailored training, or *the rational redistribution of tasks among health workforce team*, has been widely endorsed by international institutions such as the World Health Organization (WHO) and national authorities including ministries of health [8,9]. One of the main challenges in the provision of maternal and newborn health services including family planning is the shortage of health workers, especially in sub-Saharan Africa (SSA), Kenya included, where there are fewer than 2.3 health professionals per 1,000 people [10].

The lack of trained health workers severely limits women's access to contraceptive services. Human resource shortages in the health sector are widely acknowledged as a threat to the attainment of the health-related Millennium Development Goals (MDGs). Attempts to optimize the potential of the existing health workforce are therefore crucial. A more rational distribution of tasks and responsibilities among health workers is seen as a promising strategy for improving access and cost-effectiveness within health systems. For example, access to care may be improved by training and enabling mid-level and 'lay' health workers to perform specific interventions that might otherwise be provided only by cadres with longer (and sometimes more specialized) training. Such task shifting strategies might be particularly attractive to countries such as Kenya that lack the means to improve access to care within a short period of time. Integrated community-level services for RH/FP, MNCH, and HIV/AIDS is recommended as a key strategy for national health systems strengthening within WHO's "Framework for Action" and is highlighted in the US Government's Global Health Initiative (GHI) [11].

It has long been recognized that hospitals and health centers alone cannot serve the health needs of the large and dispersed rural populations in developing countries. In the 1960s, to bring services outside the clinic walls, family planning (FP) programs began experimenting with community-based distribution (CBD) of contraceptive services [12]. CBD programs provided non-professional workers with short periods of training and used various compensation models (unpaid volunteers, salaried workers, and sellers working on a commission basis).

CBD providers educate community members about FP, distribute non-clinical contraceptives (primarily pills and condoms), and make referrals for clinic-based contraceptives. Rapid increases in the use of FP associated with small-scale CBD programs in the 1970s–90s contributed to their widespread introduction in countries with emerging and relatively weak clinic-based FP programs; by 1999, most countries in SSA had some form of CBD program [13].

The concept of Community Health Workers (CHWs), first popularized at the 1978 Alma-Ata International Conference on Primary Health Care (PHC), has been central to the development of health programs in developing countries ever since. A wide variety of CHW programs have been implemented, with CHWs functioning as a “bridge” between the health system and communities by serving two roles: as “service extenders” who increase access to services beyond those available from facility-based professionals; and as “agents of change” who educate communities on the benefits of using health services, thereby increasing demand for services. Together, both roles are expected to increase program effectiveness, efficiency, and equity [14].

The task shifting approach represents a return to the core principles of health services that are accessible, acceptable, equitable, and of good quality. Task shifting provides a framework in the context of primary health care in which access to health services can be extended to all people in a way that is effective and sustainable. Thus, task shifting is also seen as an approach that offers long-term potential for all primary health-care services and for overall health systems strengthening [15]. In addition, sharing reproductive health tasks including FP has the potential to free up time for higher level providers, improve the quality of care, increase the use of contraceptives and reduce the cost of providing services [16].

Task Sharing activities by various cadres of health providers

In this report two health worker categories are covered, namely the lay health workers and the mid-level health workers such as clinical officers, midwives and nurses.

Lay Health Workers

According to the National Curriculum for CHWs [17], family planning services are a key determinant of a mother’s and baby’s health outcomes. The curriculum also acknowledges that family planning services contribute significantly to the achievement of national development goals. Given the importance of family planning, the national curriculum emphasizes the need for CHWs to have basic knowledge of all family planning methods so that they can effectively advise their clients, provide select family planning methods and make timely referrals for other FP methods. The following tasks have largely been shifted from nurses to CHWs:

- Discussions on the benefits of healthy timing and spacing of pregnancies with various community groups in order to promote the use of FP services;
- Discussions on basic information about all family planning methods including their effectiveness, advantages, non-contraceptive benefits and expected side effects;
- Basic counselling on family planning services;
- Discussions with various community teams with a view to dispelling myths, rumors and misinformation about family planning services;
- Discussions with HIV -positive clients about their contraceptive options;
- Making requisitions for FP commodities and other supplies which CHWs are authorized to dispense and maintaining records of field activities;
- Making appropriate and timely referrals; and
- Provision of selected FP methods such as condoms and combined oral pills at the community level. The national curriculum recommends that condoms and the combined oral pills be dispensed by CHWs.

Mid-Level Health Workers

The following activities constitute examples of services which initially were provided by highly trained health providers such as gynecologists and obstetricians but are now being given by middle level workers such as midwives, nurses and clinical officers. These activities are presented below by cadre.

(a) Nurses and Midwives

As outlined in the Nursing Council of Kenya's curriculum for the Bachelor of Science in Nursing (BScN), nurses (including midwives) are required to perform the following family planning tasks [18]:

- Insertion and removal of IUCD
- Insertion and removal of implants

(b) Clinical officers

The revised basic curriculum for clinical officers' training [19] requires that clinical officers perform the following family planning procedures:

- Implant (insertion and removal)
- Intra-uterine contraceptive device (insertion and removal)
- Female sterilization (Bilateral Tubal Ligation)
- Male sterilization (Vasectomy)

The services outlined above are additional to the range of FP methods that these health providers dispense routinely.

CURRENT TASK SHARING AND TASK SHIFTING POLICIES

In April 2009, the Ministries of Public Health and Sanitation as well as Medical Services launched the National Human Resources for Health Strategic Plan for the period 2009-2012 [20]. Towards the end of the plan period, much of the content of this plan had been included in the 2012-2017 Ministry of Health medium-term strategic plan. The document addresses the community strategy and task sharing issues.

The policy anticipates that the implementation of the community strategy in Kenya will increase the demand for various reproductive health services including family planning activities due to strengthened health promotion activities and increased access to hitherto underserved populations. In supporting task shifting initiatives, the document states:

'Task shifting initiatives will have significant implications for the health workforce as significant changes in roles, responsibilities and scope of practice of health providers in the health sector and the community is envisaged. There will be need for review of relevant policies and training curricula to support the implementation of these initiatives.' –page 8

Besides this policy that focuses on the provision of health services at the community level, the Ministry of Health has also developed specific policies on task sharing and task shifting. Some of these policies focus on the provision of reproductive health services including family planning. For instance, in November 2008, the Ministry of Health published a policy allowing clinical officers who had successfully completed a higher diploma in reproductive health from the Kenya Medical Training Centre (KMTC) to perform some of the functions that were previously handled by consultant gynecologists/obstetricians [21]. This circular appears in this report as Appendix 3. The circular empowers clinical officers to perform caesarean section procedures, bilateral tubal ligation (BTL), dilatation and curettage (D & C), Manual Vacuum Aspiration (MVA), McDonald stitch insertion among other tasks. In 2011 the Ministry of Health published policy guidelines that allow community health workers to provide DMPA to women who choose this method of contraception [22]. This circular appears in this report as Appendix 4.

SUCCESSFUL TASK SHARING AND TASK SHIFTING ACTIVITIES

This section provides three sets of examples on successful task shifting and task sharing activities in Kenya. The first part addresses an example of a successful task sharing activity in a clinical area regarding the provision of bilateral tubal ligation services by clinical officers in health facilities. The second part focuses on provision of depot medroxyprogesterone acetate (DMPA) by CHWs, while the third focuses on sustaining community midwives' and CHWS' operations through task sharing activities in rural Kenya.

1. Provision of bilateral tubal ligation (BTL) services by clinical officers

Previously, bilateral tubal ligation operations for permanent contraception were carried out by consultant gynecologists/obstetricians. At the moment, these services are also being offered by clinical officers. This section highlights key findings of an evaluation that assessed clinical officers' knowledge and skills in providing BTL in Kenya [23]. Conclusions and recommendations of the evaluation are outlined in Box 2.

Introduction and Background

Long-acting family planning (LAFP) methods, reversible and/or permanent address the unmet needs of some women [24, 25]. The use of long-acting permanent methods (LAPM) in Kenya is at present estimated at 5% of all contraceptive users [26]. A shortage of doctors coupled with the desire to increase the use of LAPM prompted the Government of Kenya to issue a ministerial circular [23] to all regions and health facilities in 2008 on the need for task shifting and task sharing in gynecology and obstetrics, medicine and surgery. The circular authorized clinical officers with additional training in reproductive health to provide bilateral tubal ligation, caesarean section and other essential reproductive health services.

Approach followed

In April 2012, the Division of Reproductive Health (DRH) in the Ministry of Health in consultation with other partners such as Clinical Officers Council, Kenya Medical Training Centre (KMTC), UNICEF, FHI 360, and Marie Stopes Kenya, made a decision to conduct a rapid assessment to review the task sharing activities that were being performed by clinical officers since 2008. Study participants were 39 RH clinical officers, 13 policy makers, 42 implementers (nurses, midwives and doctors) and two staff from KMTC.

Results

A majority (56%) of the reproductive health clinical officers (RHCOs) interviewed had completed their RH/BTL courses less than five years prior to the interview. The rest were trained before 2007. More than half (24 out of 39) had received some form of update training within the three years preceding the assessment. Nearly two-thirds of RHCOs reported having attended an update or refresher course in the year preceding the assessment. Overall, 82 percent of the RHCOs rated their curriculum as adequate. Nearly two-thirds (64 percent) of RHCOs reported that the RH training period was adequate. One-third reported the duration to be too short.

Policy makers were more likely than the implementers to report that RHCOs provided RH services (Table 2). This difference may represent a difference between what the policy allows the RH-COs to provide and what they are allowed by the implementers to provide once they are deployed at the facilities. The lower proportion of implementers reporting that RHCOs provide RH services may be a reflection of the resistance to task sharing by the implementers interviewed, as shown in Table 2. More than half of the implementers reported the following concerns over the provision of BTL services by RHCOs:

- Existence of competent obstetricians/gynecologists to provide these services
- Inadequate experience among RHCOs to perform procedures such as BTL
- Inadequate legal framework for RHCOs to perform RH procedures such as BTL

Table 2: RH procedures offered by RHCOs as reported the implementers and policy makers

| RH service/procedure | Implementers (n=42) | Policy makers (n=13) |
|--|---------------------|----------------------|
| | Yes (%) | Yes (%) |
| Caesarean section | 50.0 | 76.9 |
| Bilateral Tubal Ligation (BTL) | 59.5 | 84.6 |
| Vasectomy | 7.1 | 53.8 |
| Voluntary Male Medical Circumcision (VMMC) | 31.0 | 53.8 |
| Mac Donald Stich | 42.9 | 69.2 |
| Pap Smear | 54.8 | 76.9 |
| Visual Inspection with Acetic Acid/ Visual In- | 66.7 | 53.8 |
| Manual vacuum aspiration | 81.0 | 84.6 |
| Deliveries | 59.5 | 84.6 |
| Ectopic pregnancy | 19.0 | 61.5 |
| LARCs (Implant and IUCDs) | 66.7 | 84.6 |

Republic of Kenya (2013): Bilateral Tubal Ligation (BTL) Rapid Assessment Provision of BTL and other reproductive health services by Reproductive Health Clinical Officers in Kenya; Ministry of Health, Republic of Kenya, November 2013, Nairobi.

Box 2: Summary Conclusions and Recommendations

Conclusions

The rapid assessment report of RH Clinical Officers' knowledge and skills concludes that:

- There is a positive policy environment for RHCOs to provide BTLs including other RH services. However, awareness among policy makers and implementers of the existing policy documents in support of RHCOs providing the above-mentioned RH services is still inadequate.
- RHCOs are providing BTLs and other RH services in lower level facilities and during out-reach.
- Motivation for the RHCOs is not addressed adequately.

Recommendations

The assessment report recommends that there is need:

- To strengthen appropriate policies for RHCOs to enhance task sharing and increase access to LAPMs and LARCs;
- To disseminate the policy guidelines governing RHCOs' training and their role in the provision of LAPMs and other RH services;
- To deploy RHCOs at the county hospitals where they can utilize their RH skills;
- To equip operating theatres to facilitate provision of BTL /other RH services; and
- For KMTCC to deploy additional gynecologists to strengthen the RHCOs' BTL training program.

2. Provision of depot medroxyprogesterone acetate (DMPA) by CHWs

Box 3 highlights a task sharing activity which was previously performed by nurses and midwives. However, through a pilot project that was implemented by the MOH through the support of FHI360, Jhpiego and USAID, it was shown that community health workers are able to provide Depot Medroxyprogesterone Acetate (DMPA) to clients who sought this FP method [27].

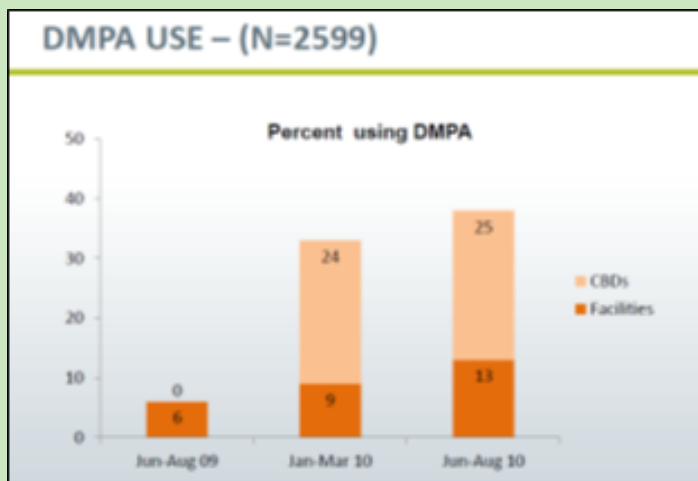
Box 3: Provision of DMPA by Community Health Workers (CBDs) in rural Kenya

Depot medroxyprogesterone acetate (DMPA) is a popular contraceptive method in Kenya. A pilot project was conducted from August 2009 to August 2010 to assess the feasibility of using community-based distributors (CBDs) or CHWs in Tharaka N'thi County to provide DMPA. The CHWs underwent both classroom and practical training for three weeks. Classroom training involved a review of FP basics, including counseling on all FP methods, infection prevention procedures, safe-injection techniques, record-keeping, and referrals.

Classroom and practical training were followed by a two-week clinical practicum to allow CBDs to provide FP services to clinic clients under the supervision of a nurse. The CBDs had to achieve pre-determined competence standards, including correct administration of injections, before being certified to administer injections on their own. The CBDs were supervised by project staff and by community health extension workers (nurses). Client records were reviewed and data on the project outcomes were compiled. Service-delivery data were also compiled from three health facilities with which the CBDs were affiliated.

Project results showed that the pilot project reached 1,245 women with a range of FP services. More than two-thirds (67%) of the women either initiated or continued using DMPA through CBD. Twelve percent of these women were new DMPA users who had never used any FP method before, and 14% had switched to DMPA from oral contraceptive pills or other methods. About three-quarters (74%) of the DMPA clients had previously received DMPA from a clinic but were now opting to receive it from CBDs. Fig. 3 compares the use of DMPA from CBDs (CHWs) and health facilities. Proportions of FP clients using DMPA by provider type continuation rates for DMPA were high, with more than two-thirds (68%) of DMPA clients having received their fourth on-time injection by mid-September 2010.

Figure 3: Proportion of FP clients using DMPA by provider type



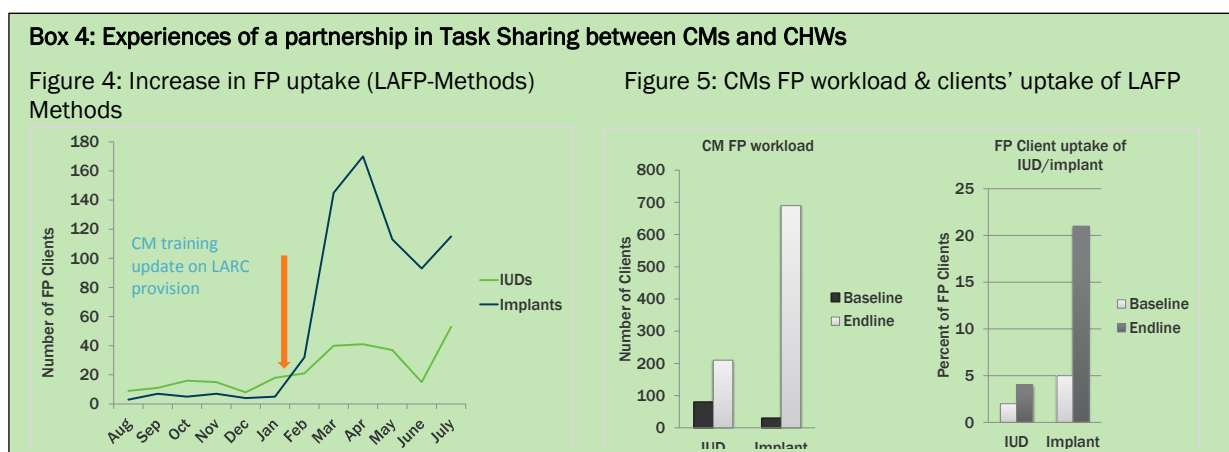
Source: Olawo et al: Task Sharing in Reproductive Health: Community-Based Distribution of Depot Medroxyprogesterone Acetate in Kenya: Findings from a Pilot Project in Tharaka District- Presentation made at the 2011 FP Conference, Dakar-Senegal

The study team concluded that the pilot project generated evidence that confirmed the safety, acceptability, feasibility, and effectiveness of providing DMPA at the community level in Kenya. The study built on previous evidence from Africa and on technical guidance from the World Health Organization that documented the importance of this approach for increasing access to FP. On the basis of these results, the Ministry of Health has since authorized CHWs to provide DMPA at the community level in selected counties.

3. Sustaining CMs' and CHWs' Operations through task sharing activities

Under the USAID-APHIAII OR project, implemented from 2009 to 2011, community midwifery activities were expanded to include FP [28]. However, community midwives (CMs) were expected to obtain FP commodities from the government health facilities that were close to them. CMs are self-employed skilled providers. As shown in Box 4, after their initial training in January 2011, CMs were supplied with adequate quantities of IUDs and implants to last three months. However, at the beginning of May 2011, these commodities started running out and the nearby government health facilities did not have any in stock except for a few intermittent supplies that CMs received in June 2011 (Figure 4). Despite the erratic supply of commodities, the number and proportion of clients using IUD and implant increased at the endline (Figure 5). Thus, Figures 4 and 5 show the uptake of these FP methods when provided by CMs.

Concerned about the need to sustain the operations of reproductive health activities including family planning services at the community level, CMs and CHWs formed a task sharing partnership in early 2013 (29).



In early 2013, the CMs' and CHWs' partnership was designed as a dual cadre task sharing and task shifting project that sought to address the problem of erratic supplies and sustain the operations of the community midwifery model. The project was supported by USAID and implemented by the Population Council and MOH. The core intervention of the project was strengthening the capacity of CMs and CHWs in financial literacy & business skills [29].

The main objectives of the task sharing project were to:

- Equip participants with entrepreneurship skills and related concepts required to manage successful community midwifery IGAs
- Equip the participants with financial record keeping and management skills
- Equip participants with financial literacy skills
- Sensitize participants on the process of developing a business plan
- Assist participants to develop work plans for their community midwifery business drawing on the knowledge and skills gained from the course.

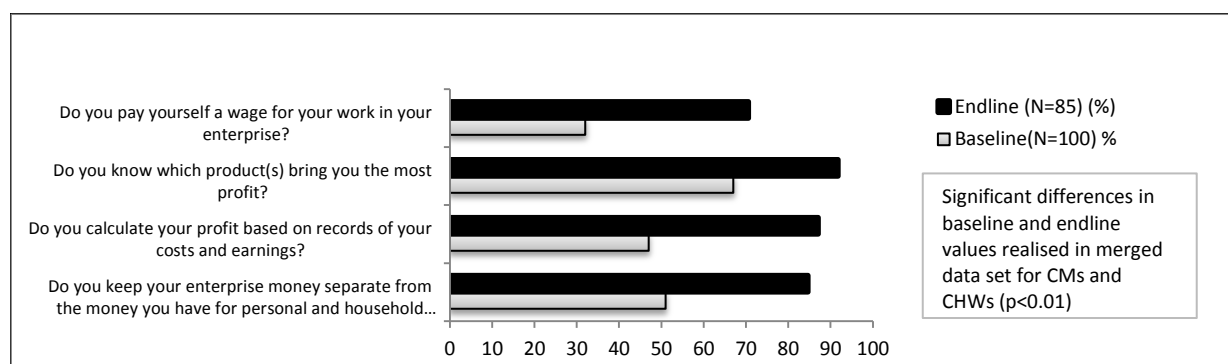


A section of community midwives and CHWs displaying their certificates awarded to them by the Ministry of Health.

At the project inception, CMs and CHWs formed ‘working pairs’ and agreed among themselves on the specific roles they were to play in carrying out various reproductive health services including family planning. For instance, CHWs are responsible for marketing the activities of CMs, educating community members on various ways to prevent diseases, health promotion activities, dispensing condoms and FP pills as well as referring clients to either CMs or health facilities depending on individual client needs. On the other hand, CMs were expected to carry out more complex tasks such as inserting and removing implants and IUDs.

Besides undertaking RH/FP task sharing activities, CMs and CHWs ensured that they also applied the knowledge and skills they had received from a training program that sought to strengthen their financial literacy and business skills with a view to sustaining the community midwifery model in accordance with the national guidelines on the provision of community-based maternal and newborn health services [30]. Among other outcomes, significant changes in the way CMs and CHWs managed their income occurred between the baseline and endline measurements (Fig.6). In addition, the proportion of FP clients using implants since their last delivery increased from 5% to 21% [29].

Figure 6: The proportion of CMs and CHWs who responded in the affirmative to the following financial literacy and business skills questions



Results from the study showed that CMs and CHWs gained critical skills and substantial knowledge in financial literacy and in business-building, which could help sustain community midwifery services. The study demonstrated not only the feasibility of CMs and CHWs working in partnership to take MNH/FP to women’s homes, but also on how to sustain the operations of the community midwifery model agreed upon through task sharing and task shifting activities.

Apart from these three examples, Appendix 5 highlights broadly the need for task shifting and task sharing in sub-Saharan Africa, especially among the mid-level health care providers.

PROVISION OF PCVR IN THE CONTEXT OF NATIONAL TASK SHARING POLICIES

As demonstrated in the preceding sections, the policy environment in Kenya is supportive of task sharing and task shifting in the health sector. For instance, mid-level providers such as clinical officers who have additional training in reproductive health have now been allowed to conduct bilateral tubal ligations among other procedures which were hitherto handled by gynecologists and obstetricians. In addition, community health workers are now able to provide Depot Medroxyprogesterone Acetate (DPMA) to clients who seek this FP method.

Furthermore, both the national and county-level governments in Kenya are promoting the establishment of working partnerships between community midwives and community health workers such that the latter focus on creating community health education, health promotion activities, delivering disease prevention messages, accompanying referred clients, provision of pills and condoms to clients, while the former focus on the provision of mainly clinical family planning methods such as IUD and implants.

On the 29th May 2014, Population Council and the Ministry of Health teams hosted a one-day meeting of health providers from the sites implementing Kenya's component of the PCVR study. The purpose of the meeting was to share positive experiences and lessons learned, challenges, and future plans for the roll-out of the programme within their respective counties and sub-counties. The providers shared experiences regarding the uptake of this particular FP method in their facilities. Some of the discussions touched on the local task sharing policies and in particular how to effectively counsel women so as to be able to use PCVR on their own.



Providers from PCVR implementing sites undergoing training in October 2014-Thika Town-Kiambu County, Kenya



Provider using BCS Cards to counsel a client on various FP methods in Feb. 2014 at Ngoliba HC-Kiambu County, Kenya

During the meeting, the providers said that once they explained to their clients how to use the PCVR, the women were able to insert or re-insert the ring on their own without any help from the providers. Thus, being woman-initiated and easy to use, the ring could serve as an empowerment tool for women to take charge of their health decisions. Furthermore, service providers do not require extensive training to be able to counsel women on how to use PCVR.

The implications of the discussion were that PCVR could potentially be dispensed by a range of providers including community health workers who will then educate women on how to use this method.

Thus, the providers discussed a form of task sharing that doesn't stop with health providers. Rather, they envisioned a form of task sharing that involves a provider and a woman or PCVR user.

Besides the ease of use of PCVR, providers also highlighted other features of the method that would help accelerate its uptake if made available in Kenya. For instance, a majority of the users (about 70%) were 18-26 years of age. It is likely that future users of PCVR will be young women most likely in their 20s. Since PCVR is user controlled, these young and educated women are likely to read the information packs and follow instructions about insertion and removal. PCVR increases the FP method-mix available to postpartum women [31], a point also emphasized recently by the head of reproductive health services in the Ministry of Health. PCVR was seen as having the potential to expand contraceptive choice in the postpartum period.

During the PCVR introductory and sensitization meetings held in April and May 2012 with a number of stakeholders in the family planning sector, the civil society groups and the national representatives of women organizations said that women in remote places should be able to access PCVR without any restrictions. In addition, some of the stakeholders said that PCVR should be made available through the public, the private and NGO sectors.

The policy implication of what the stakeholders said is that PCVR should reach potential users at all levels of the national health care delivery system. This goal will obviously not be achieved if task sharing or task shifting activities are not prioritized and carried out effectively to reach the target population. Stakeholders also noted that there is need to address potential barriers such as disrespect and abuse that are likely to prevent women from accessing PCVR especially in the public sector.

Although some of the stakeholders advised that Kenya should avoid parallel systems of administering PCVR (in both the public and the private sector), the main message during the introductory and sensitization meetings seems to have been that the product should be made available to all women who wish to use it, using multiple channels, including over the counter at pharmacies or chemists. Thus, drawing from the initial discussions during the PCVR introductory and sensitization meetings as well as the recent health provider meeting, the use of multiple channels to access women who wish to use PCVR is likely to facilitate the local task sharing policy regarding the uptake of PVR in their facilities.

Given the shortage of human resources for health and the need to scale up reproductive health activities including FP services, the use of non-clinical providers such as CHWs to improve access to PCVR should the product become available is likely to be the most feasible strategy in the short and medium term.

INTEGRATION OF SERVICES

The Kenya Essential Package for Health (KEPH) seeks to ensure that all health programmes are integrated into a single package. Similarly, the National Reproductive Health Policy, while echoing the objectives and principles of the National Health Sector Strategic Plan (NHSSP) II and the Kenya Health Policy Framework 1994, emphasized that SRH and HIV and AIDS services offer certain advantages if provided in an integrated manner.

The National RH-HIV integration strategy has outlined the framework of service delivery at the six KEPH levels - community, dispensary, health center, and county hospital, regional hospital, and the

national or tertiary level [32]. Different sets of skills, knowledge and equipment are required at each of these levels depending on the package of services to be implemented. Provision of integrated services also depends on the category of health workers who are recognized within the existing health care system at the community and facility level for RH and HIV provision. In this document only two levels are highlighted, namely the community level and the facility level. The latter incorporates KEPH levels 2-5.

Since integration is about combining different kinds of services or operational programmes to ensure and maximize collective outcomes, the approach is likely to serve as an opportunity for enhancing access to quality and sustained FP and other RH/HIV services [33]. Integration is most likely to be an effective mechanism for maximizing collective outcomes given that the risk factors for unintended pregnancies and sexually transmitted infections, including HIV, are addressed together.

Viewed broadly, service integration is likely to enhance efficiency since both FP and HIV services require similar inputs such as skills. Other benefits of delivering an integrated package of services include savings in providers' and clients' time (mainly due to a reduction in the number of provider-client interactions and travel costs on the part of clients). Integration of services also enhances HIV and STI preventive efforts including promotion of dual protection. With supportive Ministry of Health policies on task sharing, integration should be seen as a strategy that enhances efficiency and staff productivity.

Community-Based RH HIV Integration Services (Level 1)

The services provided are essentially at the household level. The basic services include: FP, HIV testing and counselling, maternal and child health including immunization and messages on cervical cancer screening. These services are predominantly promotive; however, a few are preventive and curative in nature.

The promotive service includes critical messages directed to community members to effect behavior change and practicing healthy behaviors at the household level. Preventive services include distribution of Long Lasting Insecticidal Treated Nets, zinc, folic acid and iron supplementation. The designated cadre mandated to provide these services is the CHW.

Facility-based RH-HIV Integrated Services (Level 2-5)

In the past, services at the facility level were offered as a singular service. Now, provision of integrated services requires that the delivery of SRH and HIV and AIDS services be done within the same setting. The services would be available during the same hours and providers would encourage clients/patients of one service to take up the other service within the facility, community-based setting or through a facilitated referral. At the facility level, integrated RH HIV services are provided at the outpatient department, MCH/FP unit, maternity, in-patient wards, comprehensive care centers and youth-friendly service sites.

Therefore, the provision of integrated services and implementing task sharing and task shifting activities can be carried out in the same settings and by the same providers since they are mutually supportive.

IMPLICATIONS FOR POLICY AND PROGRAMMES

This section addresses three components, namely: opportunities, challenges and conclusions.

Opportunities

There are many opportunities for facilitating the delivery of PCVRs within the national health care system in Kenya.

First, Ministry of Health policy makers view the PCVR as a very useful product that is meant to widen or broaden the contraceptive options for breastfeeding women in the postpartum period. At the moment, health providers have the progestin-only pill or the mini-pill to offer breastfeeding women in the postpartum period. The other alternative, namely the CU-IUD, require training and proper infrastructure for it to be used on a large scale.

Second, key audiences in Kenya including the Kenya Obstetrical and Gynecological Society (KOGS) and development partners are aware of the ongoing PCVR acceptability study.

Third, as demonstrated earlier, the policy environment in Kenya is supportive of task sharing and task shifting activities. For instance, the national community midwifery guidelines recommend a dual-cadre working approach between community midwives (CMs) and lower-level community health workers (CHWs) to more effectively meet the maternal health care needs of women.

There are ongoing programmes to strengthen the dual-cadre model. For instance, capacity-building needs of community midwifery providers are now being addressed (since the lack of these skills hinders the sustainability of the community midwifery model). The county governments are promoting the establishment of working partnerships between CMs and CHWs in communities where the community midwifery model is (or will be) implemented.

A recent study that evaluated the uptake of task shifting as a community strategy in Kenya [34] recommended that voluntary counselling and testing, community health education, hygiene, referrals and family planning services should be shifted to community health workers (CHWs).

Fourth, key documents such as training curriculum for PCVR, BCS cards and method brochures are in place. These materials could easily be adapted for the roll-out phase.

Fifth, in previous meetings with stakeholders many of them suggested that PCVR could be distributed or channeled through multiple routes (public, private and NGO sectors). These possibilities imply that PCVR has the potential to 'fit' in all healthcare market delivery systems which has implications for accessibility goals.

Sixth, from preliminary results, a majority of clients felt that the PCVR was easy to use and was perceived to have fewer side effects. These findings have implications for the service delivery phase. Perceived safety of the product and being user controlled could increase demand and coverage for PCVR.

Box 5 highlights some of the available opportunities for facilitating the delivery of progesterone contraceptive vaginal rings within the national health care system in Kenya.

Box 5: Opportunities for institutionalizing and scaling up PCVR in Kenya

QUOTE
Gladys Someren-23rd October 2014

"Breastfeeding women in Kenya have very limited Family Planning options. With the introduction of PCVR, women will now have another alternative FP method to choose instead of relying only on Microlut"

Dr. Kigen Bartol (Head, RMHSU- MOH, Kenya)
2nd September 2014

Progesterone vaginal ring (PVR)
A new user-controlled contraceptive for Breastfeeding women

Health Providers Counseling Card

Progesterone vaginal ring (PVR)
A new user-controlled contraceptive for Breastfeeding women

Client Brochure

PROVIDER TRAINING CURRICULUM
A STUDY TO ASSESS THE ACCEPTABILITY OF A PROGESTERONE VAGINAL RING (PVR) AS A NEW CONTRACEPTIVE OPTION FOR LACTATING WOMEN IN SUB-SHARAN AFRICA

DAVY OCHIENGA
WILSON LAMBELE
SALISO ENANGI
HEATHER CLARK
COURTNEY FLANN

PlanDev Council

Challenges

There are a number of challenges to be addressed. First, although the Ministry of Health in Kenya has expressed willingness to include PCVR in the national contraceptive method mix, additional resources will be required to support demand generation. Building demand for a new method type will be critical as a preliminary step during the service delivery phase. Most of the resources for demand creation will go towards meeting the costs of behavior change communication and marketing activities.

Second, the initial costs associated with the PCVR supply chain (from manufacturing to the end user) could pose a challenge unless thought through well in advance. Third, in the next few years there is a possibility of having many vaginal rings in the health care market. High-profile campaigns and tailor-made educational materials will have to be developed to minimize potential confusion that could easily arise especially among the end users.

Conclusions

The case studies highlighted in this report illustrate that Kenya has in place relevant policies that not only allow lower and mid-level health workers to deliver a range of contraceptive methods but also to conduct specialized surgical contraception procedures. Thus, task shifting approaches are likely to lead to a more rational distribution of responsibilities among different cadres of health workers in Kenya. The case studies have also documented the feasibility, effectiveness and acceptability of mid- and lower level providers in the provision of family planning services and the extent to which these activities have been implemented.

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Appendices

Appendix 1: Barriers to the use of FP and reasons for non-use of contraception

| Common barriers to contraceptive use include*: | Reasons for not intending to use contraception in future** (married women age 15-49 years) |
|---|---|
| <p><i>Physical/Geographic barriers</i></p> <ul style="list-style-type: none"> • Long distances travelled • Some populations e.g. urban poor live in informal settlements that are excluded from services such as FP • Many rural and urban poor people are ‘time poor’, reducing their ability to access services <p><i>Service barriers</i></p> <ul style="list-style-type: none"> • Lack of key supplies from health facilities • Inadequate skills by some providers (both public & private) • Provision of poor quality services • The barriers include limited method choice <p><i>Financial and affordability barriers</i></p> <ul style="list-style-type: none"> • High travel costs • Some private providers charge high user fees for FP methods • High cost of living discourages the poor from paying for the cost of contraceptives (due to competing priorities) <p><i>Knowledge and attitude barriers</i></p> <ul style="list-style-type: none"> • Misinformation and rumors • RH knowledge levels are low in some regions • Ignorance by the poor regarding family planning use <p><i>Social-cultural barriers and gender relationship</i></p> <ul style="list-style-type: none"> • Negative traditional practices and desires such as naming relatives; and preference for sons as security in old age. • Factors that put adolescent girls at high risk of unplanned pregnancies e.g. early sex, transactional sex, gender-based violence and age asymmetry of sexual partners. • Lack of agreement on contraceptive use and on future reproductive intentions. Preference by women ignored given their low status in some communities. • Partner’s attitude on his role as a decision maker; <p>*Source: Westoff, Charles F. 2006. <i>New Estimates of Unmet Need and the Demand for Family Planning</i>. DHS Comparative Reports No. 14. Calverton, Maryland, USA. Macro International Inc.</p> | <p><i>Fertility-related reasons</i></p> <p>Infrequent sex/no sex</p> <p>Menopausal/had hysterectomy</p> <p>Sub fecund/infecund</p> <p>Wants as many children as possible</p> <p><i>Opposition to use</i></p> <p>Respondent opposed</p> <p>Husband/partner opposed</p> <p>Others opposed</p> <p>Religious prohibition</p> <p><i>Lack of knowledge</i></p> <p>Knows no method</p> <p>Knows no source</p> <p><i>Method-related reasons</i></p> <p>Health concerns</p> <p>Fear of side effects</p> <p>Lack of access/too far</p> <p>Cost too much</p> <p>Inconvenient to use</p> <p>Interferes with body’s normal process</p> <p>** Source: Kenya National Bureau of Statistics (KNBS) and ICF Macro.2010. <i>Kenya Demographic and Health Survey 2008–09</i>. Calverton, MD: KNBS and ICF Macro.</p> |

Appendix 2: Kenya's Human Resource Investment targets for Health

| Staff Cadre (a) | Requirements for 2017 (b) | Current (2013) numbers (c) | Human Resource Gap (d) | % of gap (c/b*100) |
|---|------------------------------|-------------------------------|---------------------------|-----------------------|
| Specialists | 2,684 | 728 | 1,956 | 27 |
| Medical Officers | 2,830 | 1005 | 1,825 | 36 |
| Dentists | 537 | 215 | 322 | 40 |
| Dental Technologists | 561 | 134 | 427 | 24 |
| Community Oral Health Officers | 489 | 134 | 355 | 27 |
| Clinical Officer (Spec) | 1,229 | 1086 | 143 | 88 |
| Clinical Officers (Gen.) | 9,827 | 1635 | 8,192 | 17 |
| BSN Nursing officers | 4,793 | 3344 | 1,449 | 70 |
| Registered Nurses | 7,654 | 7260 | 394 | 95 |
| Enrolled Nurses | 29,975 | 12303 | 17,672 | 41 |
| Public Health Officers | 11,765 | 1718 | 10,047 | 15 |
| Public Health Technicians | 11,765 | 1817 | 9,948 | 15 |
| Pharmacists | 561 | 329 | 232 | 59 |
| Pharm. Technologist | 5,098 | 505 | 4,593 | 10 |
| Lab. Technologist | 4,549 | 1646 | 2,903 | 36 |
| Lab. Technician | 1,992 | 1145 | 847 | 57 |
| Orthopaedic technologists | 537 | 168 | 369 | 31 |
| Nutritionists | 597 | 563 | 34 | 94 |
| Radiographers | 1,026 | 474 | 552 | 46 |
| Physiotherapists | 1,026 | 623 | 403 | 61 |
| Occupational Therapists | 513 | 331 | 182 | 65 |
| Plaster Technicians | 525 | 220 | 305 | 42 |
| Health Record & Information Officers | 708 | 500 | 208 | 71 |
| Health Record & Information Officers | 1,132 | 447 | 685 | 39 |
| Social health workers | 1,026 | 504 | 522 | 49 |
| Medical engineering technologist | 537 | 239 | 298 | 45 |
| Medical engineering technicians | 513 | 256 | 257 | 50 |
| Mortuary attendants | 537 | 258 | 279 | 48 |
| Patient attendants | 10,076 | 1902 | 8,174 | 19 |
| Drivers | 5,801 | 2158 | 3,643 | 37 |
| Clerks | 2,337 | 671 | 1,666 | 29 |
| Cleaners | 1,252 | 511 | 741 | 41 |
| Security | 5,158 | 365 | 4,793 | 7 |
| Accountants | 626 | 271 | 355 | 43 |
| Administrators | 752 | 513 | 239 | 68 |
| Cooks | 1,527 | 535 | 992 | 35 |
| <i>Trained Community Health Workers</i> | <i>250,020</i> | <i>18038</i> | <i>231,982</i> | <i>7</i> |
| TOTAL (with trained CHW's) | 382,537 | 64,551 | 317,984 | 1,584 |

Appendix 3: Involvement of Clinical Officers in Task shifting activities


(3)

MINISTRY OF MEDICAL SERVICES

Telegrams: "MINIHEALTH", Nairobi
Telephone : 2717077

AFYA HOUSE
CATHEDRAL ROAD
P.O. BOX 30016
NAIROBI

When replying please quote:



Ref. No. ST/GEN/9/3/1

17th November 2008

To all Provincial Director of Medical Services


Nyanza Province
Western Province
Rift Valley Province
Nairobi Province
Eastern Province
Coast Province
Central Province
North Eastern Province

RE: CLINICAL OFFICERS IN REPRODUCTIVE HEALTH

In order to address the Millennium Development Goal No.5, the Ministries of Health has recognized the skills and competencies of Clinical Officers in Reproductive Health. Their training started at KMTC in the year 2002 so as to address various obstetric emergencies especially where there is no Obstetrician/Gynaecologist. This will go a long way in reducing Maternal Mortality and improving maternal health.

Under the transfer of skill policy, Clinical Officers in Reproductive Health can perform the following procedures:- Caesarean section, bilateral tubal ligations, Dilatation and curettage, MVA, Macdonald stitch insertion, running of GOPC/High Risk Clinics conducting Ward rounds and any other Reproductive Health duties assigned to them by the Obstetrician/Gynaecologist.

Please accord them all the necessary support.



Dr. F. M. Kimani
DIRECTOR OF MEDICAL SERVICES

17/11/08



Bilateral Tubal Ligation(BTL) Rapid Assessment

Provision of BTL and other Reproductive Health (RH) services
by Reproductive Health Clinical Officers in Kenya

November 2013



FOREWORD

The Family Planning (FP) program in Kenya has seen a reversal of the negative trends of the Contraceptive Preference Rate (CPR) that featured in the Nineties and early twenties. The recent Kenya Demographic and Health Survey (KDHS) of 2009 showed a CPR of 46 % up from 39% in 2003. Whereas this is commendable, the bulk of the contribution to this uptake came from short acting methods as the national method mix is heavily skewed towards these methods. Use of LAPMs is currently estimated at 5% of all contraceptive users with the majority using longer acting and reversible contraception (LARC). In addition one in four (26%) Kenyan women continue to have an unmet need for contraception.

For Kenya to have a more cost – effective FP program and also to foster a more sustainable method mix and ensure women and couples have access to the contraceptive method of their choice, there is need to increase access to LAPMs. Given the limited number of doctors, this goal can only be achieved through task shifting of the provision of LAPMs to other cadres with adequate training and supervision. An example of this approach is the successful task shifting of the provision of implant services to nurses.

To address this need, the Director of Medical Services, issued a circular authorizing RH-COs to be trained and provide Tubal Ligation (BTL), Caesarian Section (C/S), McDonald's stitches and other essential RH Services in 2008. This was followed by training and deployment of RH-COs to provide these services at the district and health center levels.

Since the issuing of the circular, training and deployment of the RH-COs, the MOH has not systematically evaluated the program. Recognizing this, the MOH, commissioned an assessment on the provision of BTLs by RHCos. Findings from this assessment provide good information on the RH CO's role and what needs to be done to improve LAPM use and other RH services. The assessment also provides information about Higher Diploma training of RH COs by department of Reproductive Health of the Clinical Medicine section at the Kenya Medical Training College (KMTC). The training includes surgical contraception (BTL) and other RH services.

I would like to extend my appreciation to the taskforce and the writers who worked tirelessly in the development and implementation of the assessment and preparation of this report. My expectation is that this report's recommendations will be implemented to enhance uptake of FP. This will not only help the MOH to achieve the CPR goal of 58 % by 2020 but also contribute towards achieving broader MDGs and Vision 2030.

The Ministry of Health acknowledges the funding received from United States Agency for International Development (USAID) through the PROGRESS project under FHI360 in supporting this Rapid assessment of RH COs providing BTL and other RH services in Kenya.

Dr. Francis Kimani
Director Medical Services

Appendix 4: Provision of DPMA by Community Health Workers in Kenya



MINISTRY OF PUBLIC HEALTH AND SANITATION OFFICE OF THE DIRECTOR

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NAIROBI

REF: MOPHD/ADMN/2/VOL.I

27th November, 2011

All Provincial Directors of Medical Services
All Provincial Directors of Public Health and Sanitation

PROVISION OF DEPOT MEDROXYPROGESTERONE ACETATE (DMPA INJECTABLE CONTRACEPTIVE) BY TRAINED COMMUNITY HEALTH WORKERS (CHWs)

The Ministry of Public Health and Sanitation, and the Ministry of Medical Services remain committed to improving access to quality family planning services. As outlined in Reproductive Health Strategy 2009 to 2015, the Ministries of Health as well as the Ministry of State for Planning, National Development and Vision 2030 have set a goal of significantly increasing the number of Kenyans utilizing family planning services, with a target of 56% contraceptive prevalence rate by 2015.

From August 2009 to August 2010, the Ministries of Health supported a demonstration project to evaluate whether trained Community Health Workers can safely provide depot medroxyprogesterone acetate (DMPA) at the community level. The demonstration project was conducted in Tharaka District of Eastern Province, with oversight from the Division of Reproductive Health, Ministry of Public Health and Sanitation, and the participation of several key partners.

Based on the findings of the successful demonstration project, and subsequent consultations with key stakeholders, the Ministries of Health hereby amend the National Family Planning Service Provision Guidelines to permit the provision of injectable contraceptives (DMPA) by trained Community Health Workers in under-served / hard-to-reach areas of Kenya. Examples of under-served areas include Baringo, Garissa, Mandera, Marsabit, Narok, Samburu, Tana River, Turkana, Wajir, and West Pokot, Kajiado, Kilifi, and Isiolo.

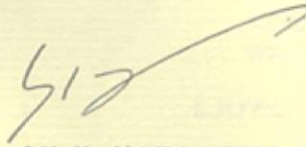
Only Community Health Workers who have been trained and certified by the Division of Reproductive Health shall be authorized to provide injectable contraceptives (DMPA).

Community Health Workers are not permitted to offer any other injections at this time. All Community Health Workers who provide injectable contraceptives will receive on-going supportive supervision by a Community Health Extension Worker who should be preferably a trained nurse or other cadre who would be adequately trained in the supervision of provision of DMPA by CHWs. Community Health Workers providing injectable contraceptives will liaise with their supervisor to access commodities, including sharps boxes, for proper disposal of medical waste and also make timely returns to the Anchor facility.

This information should reach all the PHMTs, DHMTs, HMTs, District Reproductive Health Coordinators, Pharmacists, Community Health Extension Workers, and all those working in family planning, including those in the private sector.



Dr. Francis M. Kimani
**DIRECTOR OF MEDICAL
SERVICES**



Dr. S.K. Sharif, MBS, MBChB, M. Med. DLSHTM, MSc.
**DIRECTOR OF PUBLIC HEALTH AND
SANITATION**

Appendix 5: Task Sharing experience in sub-Saharan Africa

Many initiatives are taking place in sub-Saharan Africa to address the shortage of human resources for health. Some of these are highlighted in this report to demonstrate the fact that the examples reported in Kenya are part of the wider efforts to address the issue of human resource shortage on the continent. For instance, the first African Regional Meeting on "Human Resources for Maternal Survival: Task-shifting to Non-Physician Clinicians" which took place in Addis Ababa from 29 June - 2 July 2009, focused on seeking strategies to develop and deploy non-physician clinicians (NPCs) as an important means of reducing maternal death and disability in Africa¹.

In the Addis Ababa meeting, some 350 participants, including Ministers of Health, senior government officials, health programme managers, clinicians and heads of health training institutes, from 36 African countries, gathered together for the four-day conference. *The conference was a collaborative effort of the Ethiopian Ministry of Health, Averting Maternal Death and Disability (AMDD) Program, UNFPA, UNICEF, and WHO.*

Opening the conference, Ethiopia's Minister for Health, Dr. Tedros Adhanon Ghebreyesus, emphasized the need to expand and strengthen Africa's health workforce so as to improve the survival and health of mothers and children. The minister underscored the fact that there are fewer than five doctors for every 100,000 people in the continent; and each year, 20,000 health professionals abandon their posts in rural areas in pursuit of more lucrative jobs in urban areas or abroad. Also speaking during the occasion, Dr. Werner Haug of UNFPA stressed the need to ensure universal access to reproductive health by 2015. "The challenge is to produce health professionals with the right skills and in sufficient numbers to provide FP services in every community and basic and comprehensive emergency obstetric and newborn care in every district².

The basis of the meeting was that mid-level providers already exist in most countries in Africa and yet they are seldom the focus of human resource strategies. Initial research reports had shown that mid-level providers expand cost-effective quality services to under-served areas and do produce similar outcomes to doctors. In addition, midlevel providers have excellent retention rates, especially in rural areas. The conference noted that their services are regarded highly and viewed as having a stabilizing effect in the provision of health services especially among the rural and peri-urban communities³.

The conference built on efforts by the 'Realizing Rights' Health System Strengthening for Equity (HSSE) team. The team focuses on drawing on the power and potential of mid-level providers to support equitable access to healthcare and stronger health systems in Africa.

¹ Realizing Rights -The Ethical Globalization Initiative (2009): Conference on Human Resources for Maternal Survival: Task-shifting to Non-Physician Clinicians, Addis Ababa | July 8th, 2009.

² UNFPA (2009): Maternal Health Thematic Fund Annual Report 2009 (Accelerating Progress towards MDG Number 5..

³ Global Health Workforce Alliance (2012): WHO/HSS/HWA/Strategy2013-2016/ENG ; World Health Organization (acting as the host organization for, and secretariat of, the Global Health Workforce Alliance), 2012.



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