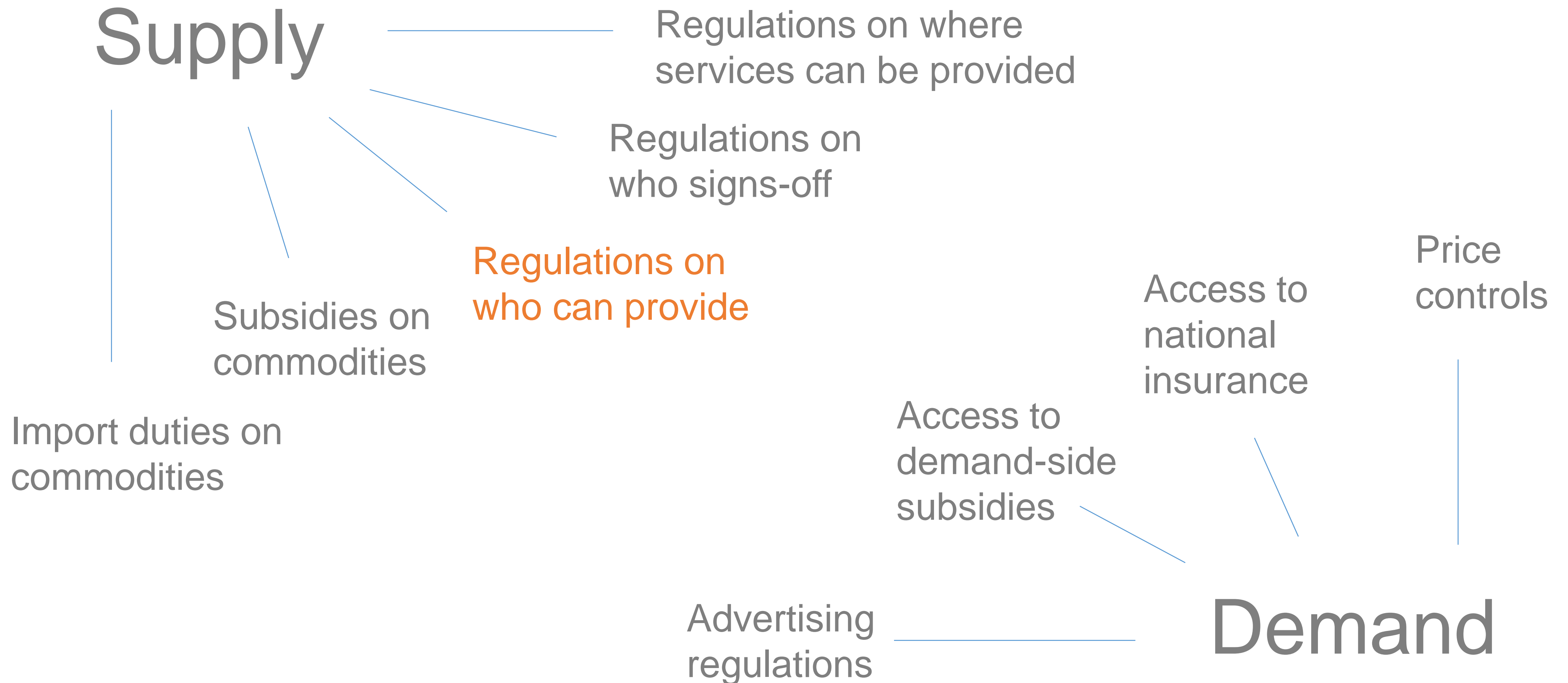
Creating a more conducive environment for LA/PM provision

The case of Task Sharing

Alex le May
Independent Consultant
Dakar | Senegal

Situating task sharing policy
Regulatory and policy settings for the private sector



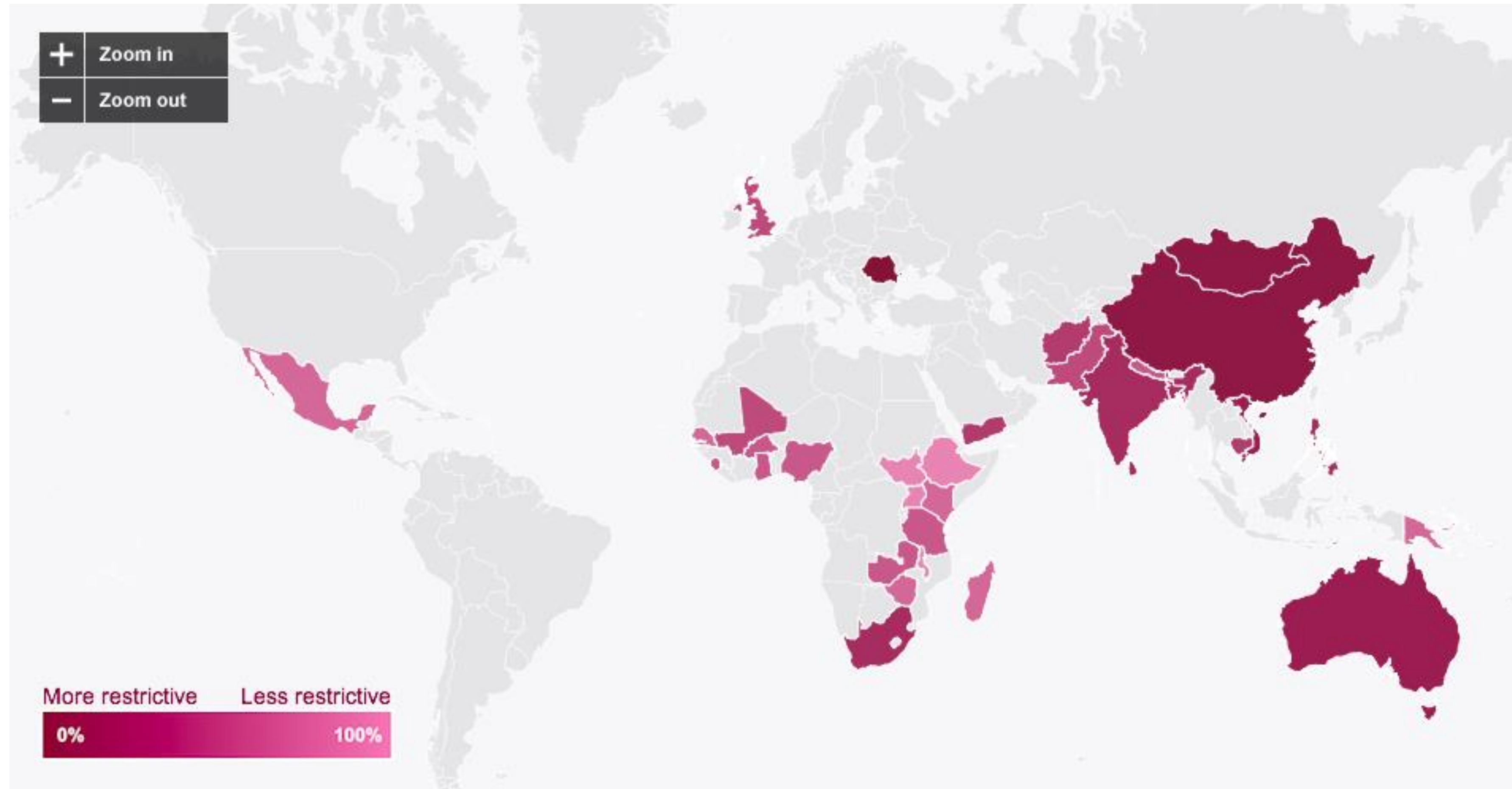
International guidelines

WHO OptimiseMNH recommendations

	LHWs	Auxiliary Nurses	Auxiliary Midwives	Nurses	Midwives	Associate Clinicians	Doctors
Tubal Ligation		Not recommended					
Vasectomy			Context of rigorous research				
IUDs				Recommended			
Implants		With targeted M&E					
Injectables							
OCPs & Condoms					Should be standard		

International policy comparisons

MSI's Task Sharing policy index



Available online:
http://www.mariestopes.org/data-research/infographics/reproductive-health-policy-index

Opposition to task sharing
Source of opposition

Opponents can come from a range of backgrounds:

Common opponents include:

- “Higher-order” professional associations
- “Lower-order” professional associations
- (Within) Ministries of Health
- Quality assurance bodies
- Medical training colleges
- Competing training or task sharing initiatives

Opposing discourses

Common concerns

TASK SHARING: POOR MAN’S SOLUTION TO THE HUMAN RESOURCE CRISIS

Task sharing ERODES quality

Task sharing: STEALING OUR MARKET SHARE!

YOUR task sharing will ruin OUR task sharing

Task sharing overburdens mid-level health workers

NEW! Task sharing.

Lets do a pilot study

Task sharing <u>NOT</u> a priority for improving health

Opposition to task sharing
Addressing concerns

Concern	Responses
Poor man's solution	**Comparison** – show how more advanced health systems are using task sharing too **Celebrate innovation** – there are lessons from task sharing in developing countries for Western countries
Quality compromised	**Evidence** – growing evidence-base on safety, even some cases where mid-level specialists are safer than more intensely trained professionals **Clarify** - the quality assurance system and build partnerships with quality assurance team at the start
Reducing doctors' market share	**Find alternative livelihoods** – e.g. supervision roles
Competing task sharing models	Difficult to overcome – evidence could offer a solution, but partnership likely to be much more powerful

Opposition to task sharing

Addressing concerns

Concern	Responses
Overburdening mid-level health workers	**Clarify** - Supportive supervision structures from the start **Recompense** - Improve working conditions, professional development and remuneration in conjunction with changing roles
Piloting	**Evidence** – clarify the wealth of evidence already available
Prioritisation	**Impact modelling** – estimate the impact of task sharing on savings to health, budgets and time

Modelling impact

Task Sharing impact estimator – "*The Taskalator*"

Compare difference across each situation:

Number of providers

Spending on salaries

Increased health impacts

Modelling impact

Task Sharing impact estimator – "*The Taskalator*"

Scenario Comparison | 1: Increase access | 2: Free up doctor time | 3: Reduce unmet need | 4: Have larger impact

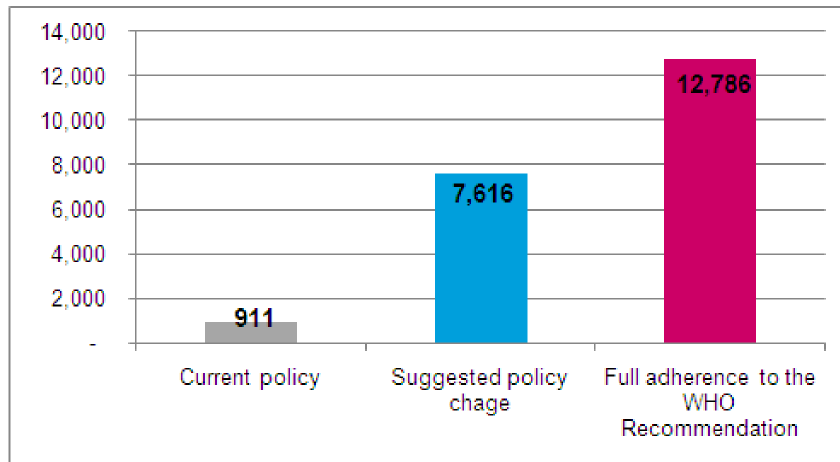
Key message 1: Task sharing has the potential to increase access

What does this mean? By allowing lower level cadre to provide services, the pool of potential providers is expanded, thus, having the potential to greatly increase access.

What this *does not* tell you: These results do not take into account if providers have time, capacity or training to provide services, or if providers are located where services are needed. It is just gives a general idea of how policy changes could potentially increase access to LAPM services.

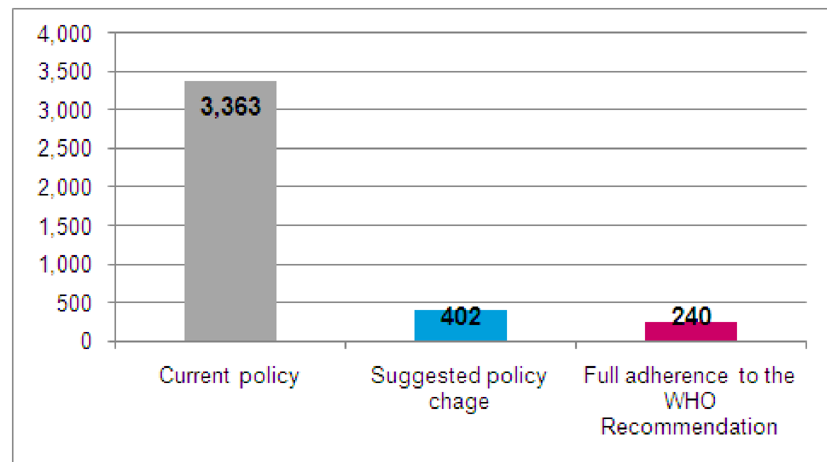
See how access could increase for: **Female sterilisation** **(pick method from drop-down list)**

Total number providers who can provide service under the law



Two ways to show this-
- on the left, population is not accounted for-- just # providers.

Coverage ratio: one provider for every xxx women of reproductive age



Inclusive approaches

Addressing concerns without excluding independent providers

- **How could we include independent providers in task sharing?**

Task sharing responses	Inclusive approaches
Quality assurance	Quality assurance/ supportive supervision that can offer coverage to independent private providers
Adapting livelihoods	Identify ways for independent providers to play a supportive-supervisory role
Impact modelling	Find ways to disaggregate impact models to demonstrate sector-specific changes in output with task sharing