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RESEARCH INSIGHTS

Task Sharing Tubal Ligation Services with Health Officers in Ethiopia

The private health sector can affect policy change related to task sharing by demonstrating that the approach is successful in a clinical setting. Research reveals that health officers can safely offer tubal ligation services, with high acceptability among clients.

Voluntary long-acting reversible contraception (LARC) methods and permanent methods are important family planning options. However, in many developing countries, a shortage of trained health providers presents a barrier to accessing these methods. Task sharing LARC and permanent method services with mid-level clinical providers can increase family planning access and choice.

The contraceptive prevalence rate in Ethiopia has risen dramatically in the last decade, but the method mix is dominated by short-acting methods. Access to some LARCs through lower-level facilities has grown substantially since 2009 because Implanon (a subdermal progestin-only implant) was delivered using a task sharing approach with health extension workers. In 2011, the Ethiopian government allowed for tubal ligation services to be task shared with health officers.[1] Marie Stopes International Ethiopia (MSIE) is one of the main providers of tubal ligation services in Ethiopia. From 2011 to 2012, MSIE health officers received in-service training on tubal ligation provision and have subsequently delivered more than 8,000 tubal ligation procedures. Officers delivered the majority in rural public health facilities through mobile outreach.

The SHOPS project aimed to enhance understanding of the favorable conditions for revising Ethiopia's family planning policy to include task sharing tubal ligation services. The project conducted an investigation of the safety and client acceptability of tubal ligation services provided by MSIE health officers at public health facility sites.

Marie Stopes International

Women seek contraceptive information and services from an MSIE mobile outreach team.

Key Findings

- Ethiopia's progressive tubal ligation task sharing policy was due to several factors, including a positive experience with task shared family planning and obstetric services.
- Tubal ligations can be offered safely by MSIE health officers.
- Tubal ligations can be offered by MSIE health officers with high acceptability among clients.

[1] The 2011 policy allows the provision of tubal ligation services by general medical practitioners, health officers, nurses, and midwives with additional in-service training in public health centers or "medium" private clinics (classified by Ethiopia's Ministry of Health) where a general medical practitioner or health officer is available.

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Methods

Researchers conducted in-depth interviews with 20 senior policymakers, health officials, and health providers to understand the process of revising Ethiopia's family planning policy and gather opinions about future opportunities and the barriers to implementation. Interview data were coded and analyzed using key themes.

To measure safety and client acceptability of health officers conducting tubal ligation procedures, researchers undertook a quantitative survey. Of the 311 women screened to participate in the study, 276 were eligible, enrolled, and returned for follow-up. Nurses who received training on observing tubal ligations collected data on compliance with clinical protocols during the procedures. Additionally, independent data collectors with medical backgrounds collected data from clients on adverse events during the procedure, one hour after the procedure, and seven days after the procedure. They also collected client satisfaction data at the seven-day mark.

Findings

Ethiopia's progressive tubal ligation task sharing policy was due to several factors, including a positive experience with task shared family planning and obstetric services.

In-depth interviews with policymakers and health officials revealed that a range of factors at the community and national levels came together to create favorable conditions for revising the tubal ligation task sharing policy. Ethiopia's positive experience with task shared family planning and obstetrics services (Implanon to health extension workers and emergency obstetric and newborn care to health officers, nurses, and midwives) was highlighted as an important factor by all interviewees. Other factors included a strong technical working group with participation from various government ministries, representatives of medical teaching universities and professional associations, and NGOs; ambitious family planning goals; recognition of a shortage of specialists; and a perception of a growing demand for permanent methods.

Representatives of medical teaching universities and professional associations representing obstetricians, gynecologists, and midwives initially raised concerns about task sharing. However, evidence from international case studies and Ethiopia's task sharing experience helped alleviate these concerns.

The Ministry of Health delegated responsibility for developing comprehensive training and supervision guidelines for tubal ligation provision by mid-level providers to teaching hospitals and professional associations. Strong support from donors and implementing partners led to a revision of the national family planning guidelines in 2011. For-profit involvement in the policy revision process was limited. However, commercial providers interviewed for the study were enthusiastic about helping train public sector health officers.

Tubal ligations can be offered safely by MSIE health officers.

The rate of major adverse events aggregated across three time periods (during the procedure, one hour after the procedure, and seven days after the procedure), was 3 percent, which was within the expected range based on a similar study in Uganda. Major adverse events are those that require significant follow-up care or hospitalization, and in the case of tubal ligations, failure to complete the procedure. Out of a total of eight adverse events, six were failed procedures (defined as failure to ligate one or both tubes). Three clients, including one of the failed procedures, reported major pain.[2]

The Health Officer Role

Health officers receive four years of medical training and work in regional or district hospitals, large health centers that care for approximately 25,000 people, and in private clinics. They have similar roles as clinical officers in Malawi, Uganda, or Zambia; non-physician clinicians; and clinical associates. They are equivalent to the associate clinician role described by WHO and have basic competencies to diagnose and manage common medical, maternal, and surgical conditions. In most settings, they may perform minor surgery. Generally, these health workers receive three to four years of tertiary-level training. WHO's 2012 OptimizeMNCH guidance recognizes permanent methods as being within the competency of the associate clinician health worker category.

[2] Defined as pain during the procedure that is not improved by anything the provider does to ameliorate it or when the provider is unable to complete the procedure because the pain is so great.

Compliance with the clinical protocol was high. On average, the providers in the sample performed 97 percent of the checklist items correctly, and there was high adherence to most of the checklist items.

Tubal ligations can be offered by MSIE health officers with high acceptability among clients. About half of the clients enrolled in the study were under 35 (Figure 1) and the majority (57 percent) had six or more living children (Figure 2). Most clients (71 percent) had previously used a form of contraception, and about half (53 percent) were switching from a short-term contraceptive method to a permanent method. Overall, the task shared tubal ligation services provided by health officers were highly acceptable among the women enrolled in the study. Ninety-eight percent of women reported that they would recommend the facility and the procedure to a friend, and more than 97 percent agreed that the service met or exceeded their expectations.

Of the five women who reported that they would not recommend the procedure to a friend, four had a failed procedure (health officers were unable to ligate one or more tubes). Of the seven women who reported that the service did not meet their expectations, six had failed procedures.

Client Acceptability

Acceptability Measure	%
Would recommend procedure to a friend	
Yes	98
No	2
Would recommend facility to a friend	
Yes	99
No	1
Did the service meet expectations?	
Exceeded expectations	46
Met expectations	52
Did not meet expectations	3

Figure 1. More than half of clients were under 35

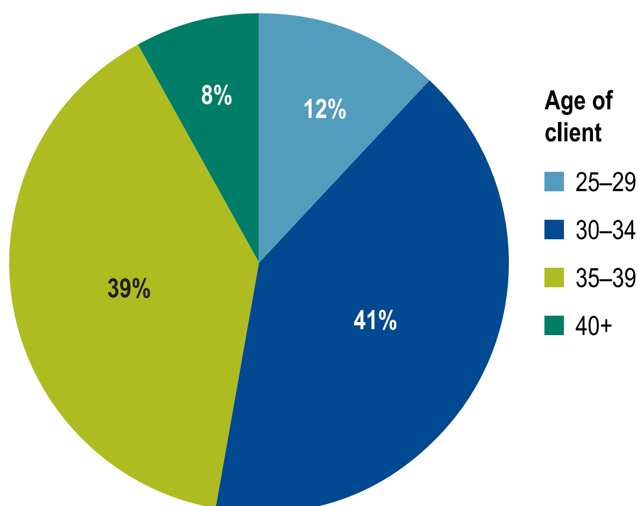
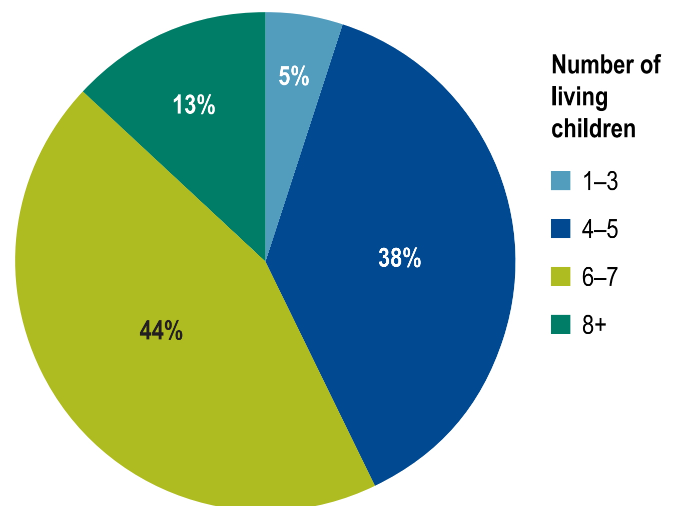


Figure 2. The majority of clients had six or more living children



Policy Implications

In light of low complication rates and high levels of client acceptability, the Ethiopian experience suggests that training health officers through focused programs[3] may be a safe and rapid way to expand access to tubal ligation services. While other studies introduced training as an intervention among mid-level staff and then observed major adverse event rates, this study observed health officers trained in previous years and captured their tubal ligation performance in a clinical setting. Levels of adherence to clinical protocols—some years after in-service training took place—were high. For areas with lower adherence, MSIE has incorporated actions to improve clinical trainings and ongoing supportive clinical supervision.

These findings, combined with the wealth of existing evidence and WHO recommendations, should alleviate concerns about task sharing tubal ligation services with associate clinicians in other countries, and advocates for task sharing tubal ligation services in other countries can take lessons from Ethiopia's experience. Certain contextual factors, such as a positive experience with task sharing other family planning methods and surgical procedures, and blending international with local evidence, help create a window of opportunity for policy change. The Ethiopian government had strong ownership of the policy process. The government assembled a range of stakeholders from across civil society and the health system to support the initiative, including those who opposed task sharing at first. The presence of a strong technical working group with inter-ministerial participation from the Ministry of Health also played an important role.

[3] Ethiopia's Ministry of Health developed a comprehensive family planning training program that covers counseling and a range of methods. The program comprises lecture-based training along with practical sessions using anatomic models, as well as training in health facilities for long-acting reversible contraceptives and permanent methods.

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Health officers at a health center in the SNNP Region of Ethiopia

Successful strategies for scaling up the task sharing of tubal ligation procedures to health officers in Ethiopia include strengthening the public sector's ability to implement task sharing and stronger engagement with private sector partners. Nonprofit partners, including MSIE, have begun training public sector providers in tubal ligation provision. Commercial health providers that administer tubal ligation procedures indicated their willingness to play a role in training. MSIE's commercial social franchisee health officers have also expressed interest in being trained and supported to provide tubal ligations as part of a broad method offering. Resource and demand-side barriers need to be addressed to scale up voluntary tubal ligation provision and realize the full potential of Ethiopia's progressive task sharing policy.

This summary is based on research conducted by the SHOPS project. For more information, contact info@shopsproject.org.

The Strengthening Health Outcomes through the Private Sector (SHOPS) project is a five-year cooperative agreement (No. GPO-A-00-09-00007-00) funded by the U.S. Agency for International Development (USAID). The project focuses on increasing availability, improving quality, and expanding coverage of essential health products and services in family planning and reproductive health, maternal and child health, HIV and AIDS, and other health areas through the private sector. SHOPS is led by Abt Associates, in collaboration with Banyan Global, Jhpiego, Marie Stopes International, Monitor Group, and O'Hanlon Health Consulting. The views expressed in this material do not necessarily reflect the views of USAID or the United States government.

For more information about the SHOPS project, visit: www.shopsproject.org

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November 2015