TASK-SHIFTING AND TASK-SHARING POLICY FOR ESSENTIAL HEALTH CARE SERVICES IN NIGERIA

FEDERAL MINISTRY OF HEALTH

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FOREWORD

One of the major barriers of access to essential health care services in Nigeria is shortage and inequitable distribution of the appropriate cadres of the health workforce to deliver the services where they are most needed. In Nigeria, there is a shortage of virtually all cadres of health care workers resulting in poor utilization of thousands of health facilities in the country for essential services, ranging from antenatal, delivery, postnatal, infant welfare, HIV, malaria, tuberculosis and other basic services.

Even though, Nigeria continues to invest in pre-service education of these cadres to address these shortages, it has become apparent that it will take decades for the country to reach the desired threshold of health workforce to deliver quality services. To further complicate this situation, many State Governments have frozen employment in the civil service sector because of rising overhead costs devoted mostly to salaries and wages.

Unfortunately, when the older health care workers are retiring, they are not being replaced. Conversely, in some parts of the country, there are many employed but under-utilized health care workers who can be trained to competency and given specific responsibilities for the care of vulnerable Nigerians in hard to reach areas. Community health extension workers belong to this group.

The development of this National Task Shifting and Sharing Policy is a major leap towards the scaling up of access to effective and evidence-based essential health services in Nigeria. It is aimed at increasing access to services currently included in the essential health package in an effort to significantly reduce Nigeria's unacceptably high mortality ratio/rates and to achieve set Millennium Development Goal (MDG) targets for the country.

Its approval will lead to curriculum changes for pre-service education and in-service trainings of different cadres of staff and production of more knowledgeable and skilled health care workers. For example, female CHEWs can be trained to provide normal delivery services and to identify and initiate the management of the common complications of pregnancy and childbirth. Midwives can be trained to provide long-acting reversible contraception like intrauterine devices and implants while NYSC doctors can be trained to perform manual removal of a retained placenta. Volunteer health workers can be trained to counsel pregnant women about the benefits of HIV testing in pregnancy and to support those on antiretroviral therapy.

These measures are temporary and are not designed to take away tasks from any professional groups but rather to make the best use of the cadres of staff currently employed and deployed to our health facilities. The implementation of this policy will be reviewed every five years as more health care workers are produced and employed in the sector.

The Federal Ministry of Health is committed to the policy implementation on Task Shifting/Task sharing at the national and sub-national level while it is expected that all the 36 States of Nigeria and the FCT will take appropriate steps to adapt the policy for implementation.

Prof. C. O. Onyebuchi
Honorable Minister of Health

ACKNOWLEDGEMENT

ACKNOWLEDGEMENT PAGE (BY DHPRS) FOR TASK SHIFTING

Task shifting/Task sharing is one of the strategies for accelerating the progress towards achievements of the health MDGs 4, 5 and 6. Therefore, the policy focuses on key priority areas such as Family and Reproductive Health, Maternal and Child Health services (RMNCH), as well as HIV, TB, Malaria and other communicable and non-communicable diseases in the Essential health services package.

The Nigeria Presidential Summit Declaration of March 2014 on Universal Health Coverage (UHC), recognizes shortage and mal-distribution of human resources for health among the key health system challenges for achieving UHC and recommended that Government at all levels should ensure the minimum quantity and skill mix of HRH at each facility with competency-based training of all health professionals around priority health needs, while addressing mal-distribution of health workers through appropriate policies including strategies for staff retention in underserved areas.

The National Task Shifting/Task sharing Policy will promote rational redistribution of tasks among existing health workforce cadres and allow for moving specific tasks, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available health workers to improve access to services for the Nigerian people.

This policy would not have been completed without the contributions of all the stakeholders. This include the Development Partners, Health Regulatory Bodies, NPHCDA, other MDAs, the States of the Federation, the FCT and the members of the Technical Working Group. To them I owe my gratitude.

I am highly indebted to the Country Director, Jhpiego, Prof. Emmanuel Otolorin, who as our lead Technical Partner in this project and through his good initiatives kick started the process in collaboration with the Federal Ministry of Health departments of Planning, Research and Statistics; Family Health; Hospital Services (Nursing Division); and Public health. Through funding from MacArthur Foundation two TWG meetings were fully sponsored and Eight States equally funded to the National Stakeholders meeting which was

aimed at harmonizing the process of policy development. The Federal Ministry of health is highly indebted to MacArthur foundation for providing this assistance through Jhpiego.
Many thanks to other the Development Partners for their acceptance to work as members of the Technical Working Group (TWG), and for sponsoring the National Stakeholders meeting. They include WHO, Women 4 Health, Marie Stopes, Capacityplus Project and Save the Children International. I also wish to acknowledge the contributions of Dr. David Olayemi who accepted the responsibility of chairing the Harmonized Technical Committee that fine-tune the document to align with WHO standard, to Dr. Eileen Petit-Mshana who provided technical support to the Committee on alignment.

My thanks also go to my hardworking staff in Human Resources for Health Branch of the Department of Planning, Research and Statistics, the Head/HSS, Mrs. Vashti Said, Head/HRH, Ibiene Roberts for providing policy direction and the Desk Officer, Dr. Tony Udoh who did the work of coordination on behalf of the department to ensure that this document is concluded.

From the depth of my heart, I want to appreciate the Honourable Minister of Health, Professor C. O. Onyebuchi Chukwu, the Permanent Secretary, Federal Ministry of Health, Mr. Linus Awute for giving me the platform to carry on with the development of this Policy. To my colleague, Dr. Wapada Balami who joined hand together with my department by responding at all times to advise when need arise, I owe my thanks.

For the Honourable Commissioners who represented the six geopolitical zones in the Technical Working Group and all Directors of Planning, Research and Statistics from the States and FCT I say a very big thank you, and to all others too numerous to mention in this piece of acknowledgement who contributed in no little means to the success of this document, may the good Lord reward, richly bless and replenish you all.

Mrs. Ansa Boco Ogu
Director, Health Planning, Research and Statistics
Federal Ministry of Health

ACRONYMS

ACCESS	Access to Clinical and Community Maternal, Neonatal and Women's Health Services
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
BPCR	Birth Planning and Complication Readiness
CDD	Community Directed Distributor
CHEWs	Community Health Extension Workers
CHO	Community Health Officer
CHPRBN	Community Health Practitioners Registration Board of Nigeria
CHW	Community Health Worker
CIDA	Canadian International Development Agency
CME	Continuing Medical Education
CPD	Continuing Professional Development
CPR	Contraceptive Prevalence Rate
CTC	Core Technical Committee
EHA	Environmental Health Assistant
EHO	Environmental Health Officer
FMOH	Federal Ministry of Health
FP	Family Planning
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
IMNCH	Integrated Maternal, Newborn and Child Health
IPTp	Intermittent Preventive Treatment in Pregnancy
IUCD	Intrauterine Contraceptive Device
LDHF	Low-dose high-intensity
LGA	Local Government Area
LHW	Lay Health Worker

MCHIP	Maternal and Child Health Integrated Program
MD	Medical Doctor
MDG	Millennium Development Goal
MIP	Malaria In Pregnancy
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MRA	Medical Records Assistant
MRO	Medical Records Officer
MSS	Midwifery Service Scheme
MVA	Manual Vacuum Aspiration
NCH	National Council of Health
NDHS	Nigeria Demographic and Health Survey
NMCN	Nursing and Midwifery Council of Nigeria
NMEP	National Malaria Elimination Program
NMR	Neonatal Mortality Rate
NPHCDA	National Primary Health Care Development Agency
PATHS 2	Partnership for Transforming Health Systems
PHC	Primary Health Care
PLWHA	People living with HIV/AIDS
PRS	Planning, Research and Statistics
RN	Registered Nurse
SBA	Skilled Birth Attendant
STIs	Sexually Transmitted Infections
TBA	Traditional Birth Attendant
TSWG	Task-Shifting Working Group
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

INTRODUCTION AND RATIONALE

The most recent information on numbers and density of health workers is available in the "Nigeria Health Workers Profile as of December 2012", published in 2013. This information is based on the various health profession registries. Unfortunately, there are huge discrepancies between total numbers in the registries and those deemed to be "in good standing", the latter far more likely reflecting the numbers of the various cadres actively practicing in Nigeria. As of December 2012, a total of 20,284 medical doctors were in good standing, densities per 100,000 populations, ranging from 50.5 (FCT) to 1.9 in Yobe State, the median state having 8.9 medical doctors per 100,000 (Sokoto). Unfortunately information on the aggregate number of Nurses and Midwives who are in good standing was not available. Information by States revealed densities of nurses and midwives taken together per 100,000 population and ranges from 5.9 (Zamfara State) to 96.5 (Imo State), with 24.7 per 100,000 (Niger State) as median.

These "medians" are not strictly statistical medians, but simply the health worker densities in the states that figured in the middle of the 37 states (36 States plus FCT), arranged in order of the respective health workforce densities. Combining the MD/population and NMW/population ratios for these "median" states gives 0.336 health workers per 1,000 populations, which is almost an order of magnitude below the absolute minimum requirement of 2.28 per 1,000 mentioned in the 2006 World Health Report. This is an issue of great concern.

To make things worse, the increase in numbers of some cadres – in particular nurses and midwives is not keeping pace with population growth. This has partly been attributed to massive external migration of medical doctors and nurses that reached its peak between 2002 and 2007. Migration has since diminished drastically, but still represented some 38% of the annual training output of medical doctors in 2012. A seemingly similar negative trend in number of medical-doctors-in-good-standing versus population was attributed to backlogs with the updating of the registries.

In response to these issues, the national Strategic Plan for 2010-2015 listed HRH as one of the eight priority areas with task-shifting as one of the key activities to increase access to health care service. Additionally, the National HRH Forum has been established, also HRH information Technical Working Group is in place and the establishment of the National Health Workforce Registry is on-going. The National Health Workforce Registry will enhance tracking and accounting for all health workers in the country, and is also meant to improve planning and management of HRH.

To complement these initiatives, and as part of on-going efforts to address the health workforce shortage problem, this National Task Shifting and sharing policy has been developed for adaptation and implementation at all levels of the national health system.

Policy Goal

The goal of the task shifting and sharing health policy is to meet the universal health coverage and the health needs of the Nigerian population through the mobilization of available human resources to ensure equity, accessibility, and effectiveness in the delivery of essential health care services.

Broad Policy Objectives

- Actualize HRH workforce needs of the country in the delivery of essential health care services
- Outline the essential health care service-related tasks that can be performed by different cadres of frontline HCWs attending to needs of the Nigerian population
- Provide a framework for empowering a wider range of health care workers to rapidly expand access to essential health care services to meet the set MDG targets
- Promote the best use of competency and expertise of well-trained mid-level cadres to meet the Nigerian population health needs
- To promote efficiency and effectiveness in the utilization of financial and non-financial resources in scaling-up access to essential health care services delivery in Nigeria

The task shifting policy will promote rational redistribution of tasks among existing health workforce cadres. It will allow moving specific tasks, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available health workers and to improve access to services for the Nigerian people.

Task shifting/sharing policy is very much in line with the goals and priorities of the national health policy on human resources for health. This has been stipulated in a number of national documents such as the National Health Strategic Development Plan (2010-2015) and Nigerian National Health Bill (April 2014). The National Health bill recommends the development of policies and guidelines that facilitate adequate distribution of human resources; provision of appropriately trained staff at all levels of the national health system in an effort to meet the population's health care needs; and the effective and efficient utilization of available human resources for health.

The Nigeria Presidential Summit Declaration of March 2014 on Universal Health Coverage (UHC), also recognizes shortage and mal-distribution of human resources for health among the key health systems' challenges for achieving UHC. The declaration further recommends that Governments at all levels should ensure that their health facilities have the minimum quantity and skill mix defined for HRH at each level. They should also conduct competency-based training of all health professionals around priority health needs while addressing mal-distribution of health workers through appropriate policies including strategies for staff retention in underserved areas. The National Task Shifting Policy aims to contribute to meeting these UHC recommendations.

The development of Nigeria's National Task Shifting policy is based on the results of extensive consultation with a wide range of individuals and organizations in and outside the health sector. It is a public health initiative and takes a comprehensive approach, with intentions to address the heath workforce requirements of all priority health programmes in the country. Additionally, task shifting is among strategies for accelerating the progress towards achievements of the health MDGs 4, 5 and 6. Therefore, the policy focuses on key priority areas such as Family and Reproductive Health, Maternal and Child Health services (RMNCH), as well as HIV, TB, Malaria and other communicable and non-communicable diseases in Essential health services package. The essential health services shall include the following (as itemized in the National Health Strategic Development (NHSDP) 2010-2015:

Family Health	• Ante-natal care, delivery and new-born care; post-natal care; • Family planning; • Child health – integrated Management of Childhood Illnesses (IMCI); growth monitoring and essential nutrition; immunization; • Adolescent reproductive health
Communicable diseases	• Tuberculosis (TB) and leprosy; • HIV/AIDS and sexually transmitted infections; • Epidemic diseases (including malaria surveillance); rabies
Basic curative care	• Treatment of major chronic conditions
Hygiene and environmental health	• Hygiene, Water-borne diseases;
Health education	• Health education and communication

Source: NHSDP 2010 – 2015, FMoH, 2010

The delivery of each component of the essential health services requires a specific approach of shifting tasks among health worker cadres as will be specified per each priority programme or service delivery guidelines. The guideline provides the flexibility that allows removal of existing tasks or adding new tasks.

RECOMMENDATIONS

The following WHO recommendations will guide the adaptation and implementation of National Task shifting policy (or task sharing) in Nigeria:

A. Recommendations on adopting national task shifting policy in Nigeria as a public health initiative

Recommendation 1:

Nigeria Government through Federal Ministry of Health in collaboration with relevant stakeholders and partners have reached consensus in implementing a National Task Shifting Policy where access to priority health services, are constrained by health workforce shortages. Task shifting in Nigeria is considered as an interim measure, and will be implemented alongside other efforts to increase the numbers of skilled health workers.

Recommendation 2:

In all aspects concerning the adaptation of National task shifting policy, relevant parties should endeavor to identify the appropriate stakeholders, including but not limited to health workers associations and regulatory bodies, Civil Society Organizations that promote community health, and others who will need to be involved and/or consulted from the beginning.

Recommendation 3:

Task shifting approach in Nigeria, will be supported by a nationally endorsed framework to ensure harmonization and provide stability for the priority services that are provided throughout the public and private sectors.

Recommendation 4:

Task shifting implementation will be evidence-based and informed through regular updating of national and states health workforce profiles, also through undertaking periodical HRH situational analysis that will provide information on
the demography of current human resources for health in both the public and private sectors; the need for services under priority programmes (FH, RH, MCH,HIV, TB, Malaria and others); the gaps in service provision; the extent to which task shifting is already taking place; and the existing human resource quality assurance mechanisms.

B. Recommendations on creating an enabling regulatory environment for Implementation of national task shifting policy.

Recommendation 5:

Task shifting in Nigeria will ensure a thorough assessment and consider using existing health workers regulatory mechanisms and approaches (laws and proclamations, rules and regulations, policies and guidelines) where possible, or undertake revisions as necessary, to enable cadres of health workers to practice

according to an extended scope of practice, based on the proposed shifting or sharing of tasks among existing cadres of health workers. The code of ethics of the responsibility that are shifted will apply to the personnel having the new tasks

Recommendation 6:

A fast-track strategy will be adopted to produce essential revisions to the regulatory approaches (laws and proclamations, rules and regulations, policies and guidelines) where necessary. If necessary (after a period of 3-5 year implementation of this task shifting policy), based on the outcome of HRH situational analysis, a long-term reform will be pursued to support task shifting on a sustainable basis within a comprehensive and nationally endorsed regulatory framework, that will allow among other measures, where necessary, creation of new mid-level cadres within the health workforce in Nigeria

C. Recommendations on ensuring quality of care

Recommendation 7:

As part of task shifting policy implementation Nigeria will adapt human resources for health quality assurance mechanisms to support the task shifting or task sharing approach. These will include processes and activities that define, monitor and improve the quality of services provided by all cadres of health workers.

Recommendation 8:

The roles and the associated competency levels required will be defined both for existing cadres that are extending their scope of practice, and for those cadres that are being newly created or assigned additional/new tasks under the task shifting policy approach. These standards should be the basis for establishing or reviewing recruitment, training and evaluation criteria.

Recommendation 9:

A systematic approach to harmonized, standardized and competency based training that is needs-driven and accredited will be adopted so that all health workers are equipped with the appropriate competencies to undertake the tasks they are to perform.

Recommendation 10:

Training programmes and continuing educational support for health workers will be tied to certification, registration by relevant regulatory agencies and career progression mechanisms that are standardized and nationally endorsed.

Recommendation 11:

Supportive supervision and clinical mentoring will be regularly provided to all health workers within the structure and functions of health teams. It will be ensured that Individuals or Staff who are tasked with providing supportive supervision or clinical

mentoring to health workers to whom tasks are being shifted will themselves be competent and have appropriate supervisory skills.

Recommendation 12:

Systems, mechanisms and guidelines will be adapted to ensure that the performance of all cadres of health workers can be assessed against clearly defined roles, competency levels and standards.

D. Recommendations on ensuring sustainability

Recommendation 13:

Measures such as financial and/or non-financial incentives, performance-based incentives or other methods will be introduced as means by which to retain and enhance the performance of health workers with new or increased responsibilities, commensurate with available resources in a sustainable manner.

Recommendation 14:

Nigeria recognizes that essential health services cannot be provided by people working on a voluntary basis if they are to be sustainable. While volunteers can make a valuable contribution on a short term or part time basis, trained health workers who are providing essential health services, including community health workers, will receive adequate wages and other appropriate incentives as will be defined by the relevant parties.

Recommendation 15:

The Government of Nigeria in collaboration with key stakeholders and partners will ensure that task shifting plans are appropriately cost and adequately financed so that the services are sustainable

E. Recommendations on the organization of clinical care services

Recommendation 16:

Nigeria will consider the different types of task shifting practice and will adopt, adapt, or extend, those models that are best suited to its specific country situation (taking into account health workforce demography, disease burden, and analysis of existing gaps in service delivery).

Recommendation 17:

Nigeria will ensure that efficient referral systems are in place to support the decentralization of service delivery in the context of a task shifting approach. Health

workers will be supported to be knowledgeable about available referral systems and trained to use them.

Recommendation 18:

Non-physician clinicians can safely and effectively undertake specific clinical tasks for which they are trained (as outlined in Annex ---table 3) in the context of service delivery according to the task shifting approach.

Recommendation 19:

Nurses and midwives can safely and effectively undertake a range of clinical tasks under priority programmes as outlined in Annex/Table 3 in the context of service delivery according to a task shifting approach.

Recommendation 20:

Community Health Extension Workers, Junior Community Health Extension Workers and Community Health Officers can safely and effectively provide specific services (as outlined in Annex/table 4), both in a health facility and in the community in the context of service delivery according to the task shifting approach.

Recommendation 21:

People living with HIV/AIDS (and other chronic/long term conditions) who are not trained health workers will be empowered to take responsibility for certain aspects of their own care. People living with HIV/AIDS can also provide specific services that make a distinct contribution to the care and support of others, particularly in relation to self-care and to overcoming stigma and discrimination.

Recommendation 22:

Cadres, such as pharmacists, pharmacy technicians or technologists, laboratory technicians, records managers, administrators and others, will be included in a task shifting approach that involves the full spectrum of health services.

F. Recommendations on the Service delivery at the Community Level

Recommendation 23:

Nigeria will consider the different types of task shifting practices and will adopt, adapt, or extend, those models that are best suited to its community level situation (taking into account of availability of local resources, disease burden, and community referral to strengthen community-clinic linkages) that would strengthening the health system

THE SITUATION OF HUMAN RESOURCES FOR HEALTH IN NIGERIA

Even though a National Policy on Human Resources for Health (HRH) was adopted in 2008 by the National Council on Health, many states have not yet adopted or adapted the framework to guide the planning and management of the workforce. A 2011 study by the Centre for Development and Population Activities (CEDPA), funded by the MacArthur Foundation, found that there was neither a clear definition of an SBA in Nigeria, nor criteria for accrediting facilities as maternity homes. At a subsequent meeting in Abuja to disseminate the study findings with stakeholders, consensus was reached on a definition of an SBA in Nigeria. The recommended definition, modified from the WHO's definition, states:

"A skilled birth attendant is an accredited health professional such as a doctor, midwife, nurse **or a community health worker (CHO and CHEW) who has been trained to proficiency** in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and the newborn."

For this definition, the cadre referred to as community health workers (CHEWs) will be those who have undergone a 36-month course in a training institution approved by the Community Health Practitioners Registration Board of Nigeria (CHPRBN).,These exclude the Junior Community Health Extension Workers (JCHEWs). These cadres under reference are also sometimes referred to as Senior CHEWs. The curriculum of CHEWs currently covers 90 hours of didactic lectures and competency-based trainings. The goal of the reproductive health (RH) course is "to equip the student with the knowledge and skills to provide reproductive health care." The general objectives of the RH course are to understand:

- Anatomy and physiology of the male and female reproductive systems
- Concept of reproductive health and rights, including FP
- Process of pregnancy
- Management of labor according to acceptable standards
- Care of the mother and child during the puerperium
- HIV diagnosis and care for mothers and children
- Population dynamics and the benefits of FP
- Abortion and its possible complications
- Concept of infertility
- Menopause and andropause
- Concept of female genital mutilation (FGM)
- And recognize the "at-risk" pregnant woman for prompt referral

This curriculum does not make enough provisions for developing the skills of CHEWs as SBAs. CHEWs have not been generally welcome in delivery rooms where necessary lifesaving skills can be developed. Hence, most exit from their schools without the requisite skills to manage most of the life-threatening complications of pregnancy and childbirth. When certificated CHEWs find themselves alone in remotely located primary health care centers (PHCs) where the communities have great expectations, by necessity, they must perform lifesaving procedures for which they have not been trained or allowed to practice by regulation. The consequence of such forays into the unknown is generally mismanagement of complicated pregnancies and childbirth. As stated by Dogba and Fournier, professional competence can be achieved by using a more skilled-based training approach, supported by regular clinical supervision and mentoring.

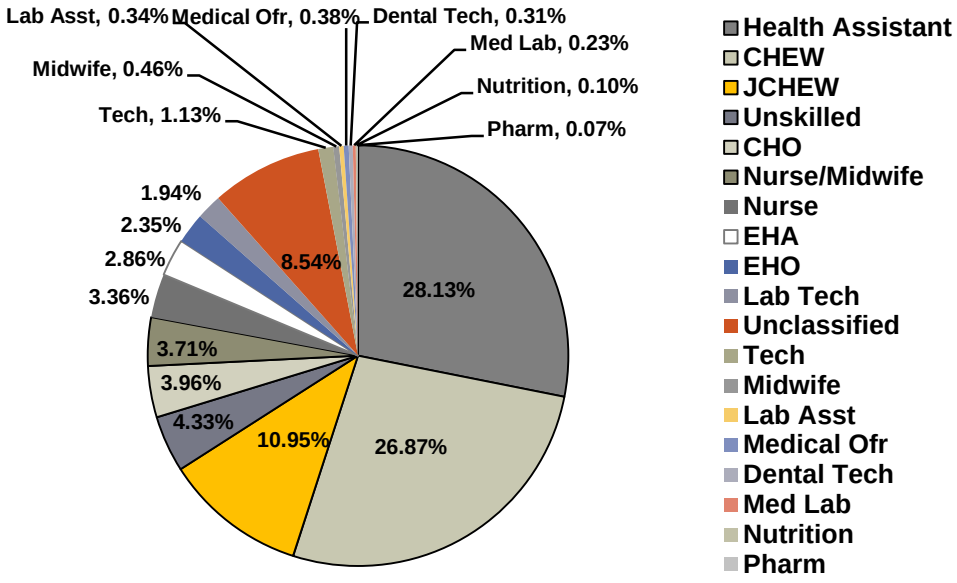
In Nigeria, the health care worker (HCW) to population density per10, 000 population is below the WHO recommendations of 23 per 10,000,[1]. In addition, the health workers in Nigeria are poorly distributed and in favor of urban, southern, tertiary health care facilities, and curative care. For some cadres of health workers, more than 50% work in the Southwestern part of the country with the majority living in the commercial city of Lagos.

Nigeria has approximately 20 CHEWs per population of 10,000, representing a largely untapped resource for maternal and child health care. It is also noteworthy that the states with the lowest density of SBAs have the highest MMRs in the country, thereby necessitating the need to empower CHEWs to provide much-needed maternity services that many of them are already providing, albeit with poor quality.

A baseline survey conducted by the National Primary Health Care Development Agency (NPHCDA) in 2009 for the Midwives Service Scheme (MSS) showed that there were 36,737 CHWs working in the PHCs and only 5,604 SBAs (doctors, nurses and midwives). Figure 1 shows the distribution of human resources at the PHCs, where 28% were health assistants, 27% are CHEWs, 11% are Junior CHEWs, and 4% are CHOs. Of note, less than 8% were nurses or nurse/midwives, or midwives. The survey also revealed that 90% of deliveries at the PHCs were conducted by CHEWs. An assessment of the knowledge and skills of the CHEWs showed that even though 70.3% of them had some basic theoretical knowledge of midwifery, only 31% could correctly assess fetal well-being while only 56% knew about the routine tests to be done during ANC, indicating serious gaps in their level of skills.

[1] WHO: Global Atlas of the Health Workforce, August 2010.

Figure 1: Distribution of Health Care Workers in Primary Health Care Centers



Note: Nurses-midwives are HCWs with double qualifications as a registered nurse and a registered midwife.

Source: NPHCDA

A TASK-SHIFTING POLICY FOR NIGERIA

What is Task Shifting and Sharing?

The WHO describes task shifting as involving "the rational redistribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health."[2] Task sharing is allowing a wider range of cadres to offer certain services, when this can be done safely and effectively as a means of rapidly expanding access and improving health care. The goal of task shifting or sharing is simply **"to get the right workers with the right skills in the right places doing the right things"**[3] without necessarily abandoning other methods of increasing the number of qualified health workers.

[2] WHO: Task Shifting-Global Recommendations and Guidelines. 2008. Available at: http://www.who.int/healthsystems/TTR-TaskShifting.pdf.

[3] World Health Organization (WHO). Working together for health: the World Health Report. 2006. Geneva, Switzerland: World Health Organization, 2006. Available at: http://www.who.int/whr/2006/whr06_en.pdf.

Task shifting has been used in a number of countries to address the human resource shortages that militate against the provision of critical services such as HIV testing and treatment with antiretroviral drugs. other uses include community distribution of injectable contraceptives, misoprostol, or performing malaria rapid diagnostic tests (*mRDTs*) and dispensing of ACTs to those with positive *mRDTs* results. In Malawi, Uganda, Lesotho, Swaziland, South Africa, Zimbabwe and other countries, the care and treatment package for people living with HIV/AIDS (PLWHA) has been designed to be delivered by non-specialist doctors, clinical officers or nurses. This has allowed rapid scale up and complete coverage of PMTCT services, including ART initiation, refills and monitoring for all pregnant women, and community treatment of malaria. Complex cases are referred to higher level care, but the vast majority of women and infants receive comprehensive care at the primary care level. These professionals are supported by CHWs and PLWHA and other categories of volunteers such as Community Owned Resource Persons (CORPs)/Village Health Workers who have been trained as expert clients and mentor mothers[4] In many countries, these auxiliary cadres perform the HIV testing and counseling under the supervision of the nurses at the facility.

Already, the National Guidelines for the Integration of Reproductive Health and HIV Programs, published by the FMOH in 2008, recommends that CHWs (CHEWs, Community Health Officers [CHOs]) can be trained to provide certain services at PHCs. Also the National Guidelines for the integrated Community Case Management of Malaria published by National Malaria Elimination Program 2014, recommends that CORPs/village Health Workers can be trained to deliver malaria services at the community level. These services include advocacy, mobilization and awareness creation about malaria, HIV/AIDS, health education about malaria, HIV/AIDS, HIV counseling and testing using rapid diagnostic tests (RDTs) as well as malaria Rapid diagnostic test (*mRDTs*), universal precautions for infection control and referral of HIV-positive clients to secondary facilities.[5] This is the first formal documentation of task shifting related to HIV/AIDS and malaria care in Nigeria. Formal documentation and policy guidance has lagged behind what is necessary and possible on the ground.

The health indicators in Nigeria have remained below country targets, therefore additional efforts to strengthen and improve the national health systems to improve access to critical services using the task shifting and sharing policy is designed to

[4] Samb B, Celletti F, Holloway J, Van Damme W, Lawson L, De Cock K, Dybul M. 2007. Task shifting: An emergency response to the health workforce crisis in the era of HIV. Lessons from the past, current practice and thinking. *N Engl Med* 357;24.

[5] FMOH. 2008. National Guidelines for the integration of reproductive health and HIV programs in Nigeria.

focus on the following key priority areas, and may be increased with time as positive progress is recorded:

Priority-1: Reproductive health, Maternal, Child and Newborn health (RMNCH)

Priority-2: Tuberculosis, Malaria and HIV

PRIORITY-1: TASK-SHIFTING RECOMMENDATIONS FOR REPRODUCTIVE HEALTH, MATERNAL AND NEWBORN HEALTH (RMNCH) IN NIGERIA

Burden of pregnancy-related deaths in Nigeria

Nigeria's health and development indicators have been generally unsatisfactory, especially in the country's Northern states. Even though Nigeria contributes only 2.4% to the world's population of seven billion, it contributes over 14% to the global maternal mortality burden[6]. In total numbers, the burden of maternal mortality in Nigeria, which is 40,000 deaths annually, is only second to India in its contribution to the global burden while 1 in every 15 Nigerian children die before the first birthday and 1 in eight die before their fifth birthday (NDHS, 2013). Nigeria has one of the highest number of people infected with HIV, with national prevalence rate (Adult HIV) of 4.1 percent[6], while estimated annual incidence of tuberclosis (TB) is 293 cases per 100,000 persons making her the 4th highest number of TB cases in the world.

While Malaria still remains a leading cause of death among children under five years of age, and contributes to aneamia in children and pregnancy; diarrhea and pneumonia are responsible for about 400,000 child deaths annually in Nigeria. Non communicable diseases burden has continued to soar and contributes significantly to the national disease burden, communicable diseases remains the major causes of annual deaths and illnesses (NSHDP 2010-2015).

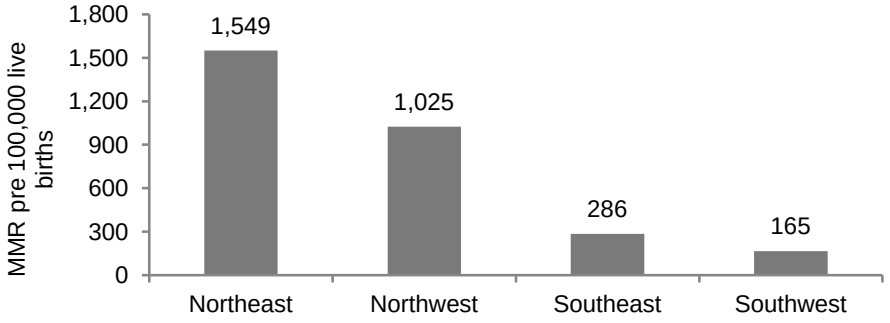
According to the 2008 Nigeria Demographic and Health Survey (NDHS), the national **maternal mortality ratio (MMR) is estimated at 545 per 100,000 live births**.[7], the 2013 NDHS concludes that there is no evidence to suggests that MMR changed between the two surveys (NDHS 2008 and 2013).However, the data generated in the 2008 DHS were inadequate to allow for the determination of state and regional maternal mortality ratios for the purposes of regional comparison. Hospital data in

[6] National AIDS Control Agency: 2012 Nigeria Global AIDS Response Progress Report
[7] National Population Commission [Nigeria] and ICF Macro. 2009. *Nigeria Demographic and Health Survey 2008.* Calverton, Maryland.

Nigeria have shown MMRs ranging from 270[8] to 2,420[9] per 100,000 live births. Furthermore, **for every woman or girl who dies, another 20 to 30 women and girls suffer short- or long-term disabilities,** such as obstetric fistula, ruptured uterus, obstetric neuropathy, chronic pelvic pain resulting from pelvic inflammatory disease and secondary infertility.

Also, previous estimates had shown a significant disparity between MMRs in the Northern states of Nigeria compared to the Southern states (see Figure 2). It can be seen that for every woman who dies in South west Nigeria as a result of pregnancy and childbirth, 6 to 10 women die in the Northern States[10]. Among the reasons given for this disparity is a lack of human resource for health, specifically skilled birth attendance in these regions, primarily due to a preference for home births, which are conducted mostly by unskilled birth attendants (e.g., self, family members or traditional birth attendants [TBAs]). Other reasons for the disparity include ignorance, illiteracy, poverty, a cultural/traditional reluctance to use modern contraceptives partly due to a preference for large families, and the non-availability of contraceptives for those who wish to use them.

Figure 2: Maternal Mortality Ratios by Geopolitical Zones in Nigeria[10]



With respect to **newborn mortality**, the 2013 NDHS revealed that the neonatal mortality rate (NMR) was estimated at 37 per 1,000 live births. This translates to less than 241,000 newborn deaths out of the 5.9 million babies born in Nigeria annually. In addition, approximately 30 stillbirths occur per 1,000 live births, leading to a total of 163,400 stillbirths annually. The under-five child mortality fell from 199 in 1990 to 128 deaths per 1,000 in 2013. This trend has not changed significantly over the last

[8] Okaro JM, Umezulike AC, Onah HE, Chukwuali LI, Ezugwu OF, Nweke PC. 2001. Maternal mortality at the University of Nigeria Teaching Hospital, Enugu, before and after Kenya. *Afr J Reprod Health* 5(2): 90-7.

[9] Adamu YM, Salihu HM, Sathiakumar N, Alexander GR. 2003. Maternal mortality in Northern Nigeria: A population-based study. *Eur J Obstet. Gynecol. Reprod. Biol.* 109(2): 153-9 (ISSN: 0301-2115).

[10] Federal Ministry of Health, 2000

couple of decades. Therefore, if Nigeria is to reduce its under-five mortality, it must tackle the problem of newborn mortality.

Skilled Birth Attendance and Maternal Mortality

In a systematic review of human resources and the quality of emergency obstetric care in developing countries, Dogba M. and Fournier P. (2009) concluded that staff shortages are a major obstacle to providing good quality maternal and child care and that women are often dissatisfied with the care they receive during childbirth.[11].

The World Health Organization (WHO) has defined a skilled birth attendant (SBA) as "an accredited health professional such as a doctor, midwife, nurse **who has been trained to proficiency** in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and the newborn." There is evidence that there is a relationship between skilled attendance at delivery and maternal death and disability (see Figure 3). This argument goes further to support the impact of lack of human resource for health to service delivery in the developing countries like Nigeria.

Figure 2 illustrates the inverse relationship between maternal mortality ratios and proportion of births delivered by SBAs. The higher the proportion of women delivered by SBAs, the lower the maternal mortality ratio for that country.

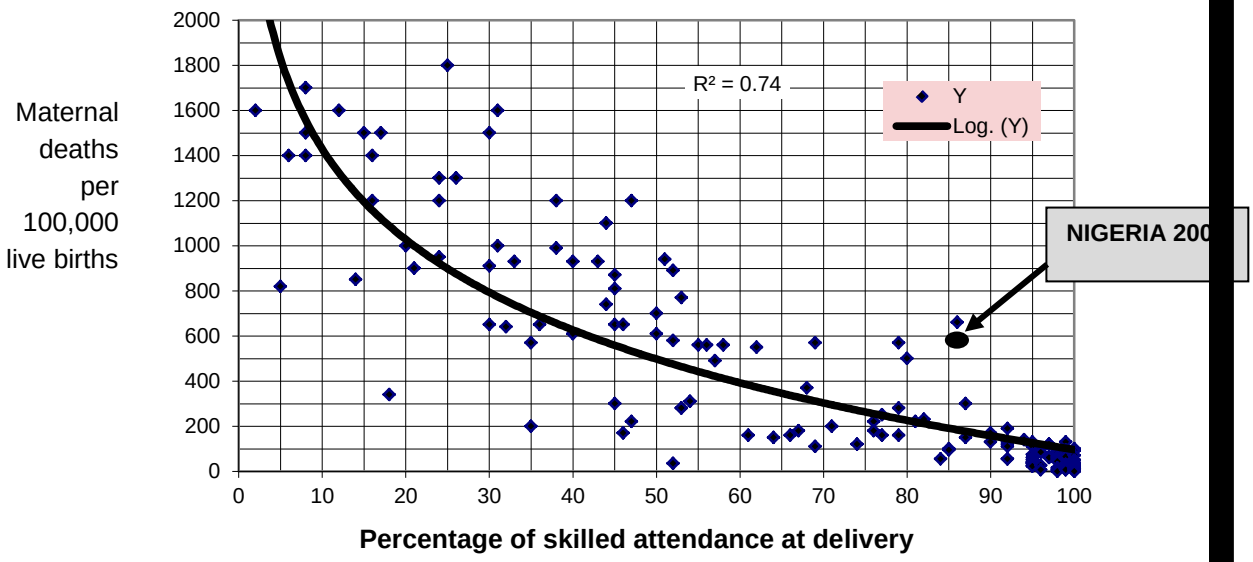
In figure 3, the bigger black dot represents Nigeria, where only 39% of women are delivered by SBAs, while, as mentioned previously, 545 maternal deaths occur per 100,000 live births (2008 NDHS). Therefore, in order for Nigeria to achieve the target set for MDG 5, which aims to *improve maternal health* by reducing MMRs by three-quarters from the 1990 figure, the country will need to increase the proportion of women delivered by SBAs to about 85%. At this level, Nigeria's MMR will decrease from the 1990 figure of 800 to 200 deaths per 100,000 live births. However, a recent review in the *Lancet* has suggested that at the current rate of change (-1.5% annually), Nigeria is unlikely to achieve this target until the year 2040,[12] which will be 25 years after the current MDG target date.

Skilled attendance at birth in the Northwest is the lowest of all six geopolitical zones in the country, where only 9.8% of women delivered with an SBA in 2008 compared to 38.9% nationally (NPC and ICF Macro 2009). As shown in Figure 4, the Southwest and Southeast regions with high skilled birth attendance rates have much

[11] Dogba M and Fournier P. 2009. Human resources and the quality of emergency obstetric care in developing countries: A systematic review of the literature. *Human Resources for Health* 7:7 doi: 10.1186/1478-4491-7-7.
[12] *Source*: www.thelancet.com Vol 378 September 24, 2011.

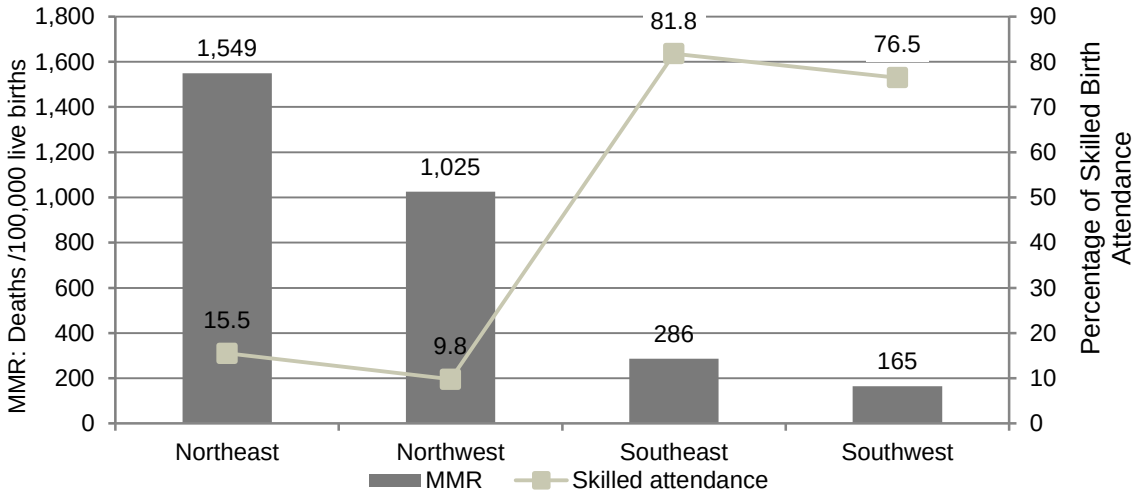
lower MMRs than the Northeast and Northwest regions with low skilled birth attendance.

Figure 3: Correlation between Skilled Birth Attendance Rate and Maternal Mortality Ratio*



* Each diamond in the figure represents a country.

Figure 4: Maternal Mortality Ratio by Geopolitical Zone and Skilled Birth Attendance in Nigeria



Source: Based on data from 2008 NDHS and FMOH 2000.

Similarly, only 31% of pregnant women in the Northwest Zone received antenatal care (ANC) from a trained health provider (compared to 57.7% nationally). This means that a majority of pregnant women in these regions do not receive the benefits of ANC, including: tetanus immunization; prevention of malaria in pregnan

(MIP); prevention of mother-to-child transmission (PMTCT) of HIV; detection and management of hypertensive disorders of pregnancy; detection and prompt treatment of sexually transmitted infections (STIs), such as syphilis: nutritional supplementation with iron and folic acid; deworming where hookworms are endemic; and birth planning and complication readiness education.

With its large population and low coverage of PMTCT services, Nigeria accounts for nearly 32% of new paediatric infections globally[13]. Despite a recent increase in PMTCT coverage from 19.7% in 2012 to 25% in 2013, this coverage remains one of the lowest in sub-Saharan Africa and a source of preventable morbidity and mortality among Nigeria's 221,129 HIV-positive pregnant women (in 2011) and their HIV-exposed infants[14].

Despite abundant evidence that **healthy timing of pregnancy and childbirth through the use of family planning (FP) saves the lives of mothers and newborns**, the total contraceptive prevalence rate (CPR) in the Northwest of Nigeria is 4.3%, with only 3.6% of married women using a modern FP method[14]. The corresponding figures for all of Nigeria are: 15.1% and 9.8% for all methods and modern methods respectively. What this really means is that 98%[15] of women of reproductive age in Northern Nigeria do not use contraceptives. While a majority may be ignorant of the benefits of FP, at least 20% of them who are aware and willing to use contraceptives have no access to them. This gap is what is referred to as the *unmet need* for FP. The resulting effect is that the region has the highest number of children per woman (total fertility rate) in the country, 6.7 compared to the national average of 5.5 children per woman[13].

Educational levels of females in Nigeria are low, with only about 62.2% having at least some primary school education (only 30.6% in the Northwest Zone)[13]. This variable as well as rural residence and low wealth quintile (poverty) are known to be associated with use or non-use of health services.

Objectives of the Task-Shifting Policy for RMNCH

The overall goal of this task-shifting and sharing policy is to reduce the maternal and newborn morbidity and mortality in Nigeria in accordance with the set national MDG targets. Specifically, the objectives are to:

- Increase access of pregnant women in hard-to-reach areas to skilled attendance at birth
- Outline the RMNCH-related tasks that can be performed by different cadres of frontline HCWs attending to pregnant women and their babies at PHCs

[13] National AIDS Control Agency: 2012 Nigeria Global AIDS Response Progress Report
[14] Nigeria 2013 Demographic and Health Surveys (NDHS)
[15] NPHCDA, 2009

- Provide framework for empowering CHWs (CHOs and CHEWs) and other cadre of health workers to provide quality maternal and newborn care services, health records, and drug management especially at Primary health care community levels

Justification for a Task-Shifting and Task-Sharing Policy for maternal and child health in Nigeria

The shortage of skilled health cadres in Nigeria is accentuated by a misdistribution of available cadres skewed in favor of urban locations in the country's Southern states. Other factors responsible for this shortage include a freeze on employment in the public service of some states, and poor working environments, leading to external and internal brain drain to other professions. At the Local Government Area (LGA) level, there appears to be a preference for hiring CHEWs rather than nurses and midwives because of their lower remuneration package. This hiring practice is seen despite the fact that these CHEWs have not been trained to competency to provide comprehensive maternal and newborn care services.

Given the fact that the PHC is the nearest level of health care delivery to the community, it is of utmost importance that basic maternity services, basic emergency obstetric and newborn care (BEmONC) services and PMTCT services should be available 24 hours a day/7 days a week in such centers if Nigeria's high maternal and newborn mortality and HIV rates are to be significantly reduced. Regrettably, very few doctors, nurses and midwives can be found at this level of health care delivery. Rather, most PHCs are staffed by CHEWs and other lower skilled cadres who have not been trained to proficiency in BEmONC or in PMTCT, partly because there has been no clear policy on their role in the fight against maternal and newborn mortality. As can be seen in Figure 4, CHWs (CHOs, CHEWs and Junior CHEWs) constitute 42% of all human resources at the PHC level with nurses and midwives constituting less than 8%. To address this shortage of skilled cadres at this level, a clear policy on task shifting and task sharing in Nigeria should be put in place to guide the different cadres of HCWs (especially CHEWs) on how they can best contribute to the reduction of maternal and newborn mortality and the national target for the elimination of new pediatrics infection and meeting the MDGs.

A few in-country programs have demonstrated the fact that CHEWs can be trained to proficiency to provide routine and basic EmONC , IMCI, PMTCT, and FP services at PHCs. Examples of such projects include: projects implemented through the ACCESS Program and the Maternal and Child Health Integrated Program (MCHIP) in Zamfara, Kano and Katsina States; the ongoing TSHIP project in Bauchi and Sokoto States, the DfID-funded PATHS2 project; the CIDA-funded project to strengthen Schools of Health Technology; the MSS Project of the Government of Nigeria and the PEPFAR program in Nigeria. Some of these projects have

demonstrated that CHEWs, when trained to competency, can provide focused ANC, normal delivery care, prevention and initiation of treatment for postpartum hemorrhage, initiation of treatment and referral for eclampsia, manual vacuum aspiration for incomplete miscarriage, health promotion for safe motherhood and healthy timing and spacing of pregnancies, HIV testing and counseling, and initiation and monitoring of ART drugs.

For example, in the ACCESS/MCHIP projects, trained CHEWs working in 23 PHCs provided delivery services to 651 women in Fiscal Year (FY) 08, increasing to 1,177 in FY09, 1,285 in FY10 and 2,144 in FY11[16] A recent study in Nigeria followed 1,421 women who used misoprostol during home births, either self-administered or administered by a lay health worker (LHW), such as a TBA. Postpartum interviews confirmed that 1,394 women (98%) took three tablets as directed and 1,248 (88%) used the correct timing and suggested route of administration (oral)[17] Also in a malaria in pregnancy (MIP) program in Akwa Ibom State, the use of Community-Directed Distributors who are voluntary health workers increased access to the recommended interventions for the control of malaria in pregnancy. The effects of the CDI programme were largest for intermittent preventive therapy with two doses of Sulphadoxine-Pyrimethamine (IPTp) adherence, increasing the fraction of pregnant women taking at least two SP doses during pregnancy by 35.3 percentage points [95% CI: 0.280, 0.425], p-value < 0.001) relative to the control group[18].

Revised Obstetric and Newborn Signal Functions

The expectations of health care managers in charge of any maternity units (be it primary, secondary or tertiary) is that the frontline HCWs are trained to proficiency in the prevention, detection and/or treatment of complications during pregnancy, labor/childbirth or in the puerperium, as well as prevention, detection and management of complications arising in the newborn. Signal functions are indicators of the level of care being provided at a maternity care center.

Table 2 lists proposed obstetric and newborn signal functions that will enable frontline HCWs to fulfill maternity care expectations. Therefore, it is critical that in the absence of physicians and nurses and midwives, who have been trained to proficiency to provide these services, CHEWs can be trained to share the tasks for routine care and BEmONC as outlined in Table 2.

[16] ACCESS/MCHIP project database 2011.
[17] Ejembi C, Prata N. 2010. Prevention of postpartum hemorrhage at home births in five communities around Zaria, Kaduna State, Nigeria: Technical Report. Population and Reproductive Health Partnership & Venture Strategies Innovations.
[18] Okeibunor et al. Malaria Journal 2011, 10:227 (http://www.malariajournal.com/content/10/1/227)

TABLE 1: PROPOSED MATERNAL AND NEWBORN SIGNAL FUNCTIONS*

Maternal Care	Newborn Care
Routine care for all mothers and newborns	
Monitoring and management of labor using the partograph	Thermal protection
Infection prevention measures (hand washing, use of gloves)	Immediate (within one hour of birth) and exclusive breastfeeding
Active management of the third stage of labor (AMTSL)	Infection prevention including hygienic cord care and application of chlorhexidine to prevent umbilical cord sepsis
HIV testing and counseling	
Care for HIV-positive mothers and HIV-exposed newborns	
Use of antiretroviral drugs for PMTCT if mother is HIV-positive	Use of antiretroviral drugs for HIV-exposed babies
Basic emergency care (for mothers and babies with complications)	
Parenteral administration of magnesium sulfate for severe pre-eclampsia and eclampsia	Antibiotics for preterm or prolonged premature rupture of membranes to prevent infection
Assisted vaginal delivery (e.g., vacuum extraction)	Corticosteroids in preterm labor
Parenteral antibiotics for maternal infection	Resuscitation of non-breathing baby (using bag and mask)
Parenteral administration of oxytocic drugs for hemorrhage	Kangaroo Mother Care for premature/very small babies
Manual removal of placenta for retained placenta	Alternative feeding if baby is unable to breastfeed
Removal of retained products of conception	Injectable antibiotics for neonatal sepsis
Comprehensive emergency care (functions in addition to basic)	
Surgery (e.g., Cesarean section, laparotomy for ectopic pregnancy) including provision of anesthesia	Intravenous fluids
Blood transfusion	Safe administration of oxygen

Source: Modified from Gabrysch S, Civitelli G, Edmond KM, Mathai M, Ali M et al. (2012). New signal functions to measure the ability of health facilities to provide routine and emergency newborn care. *PLoS Med* 9(11): e1001340. doi:10.1371/journal.pmed.1001340.

List of Maternal and Newborn Health Care Tasks for Different Cadres of Skilled Birth Attendants

The tasks listed in Table 2 are just the critical tasks needed for quality MNH care. More comprehensive lists of tasks can be viewed in Table 3. These recommended

tasks have been developed for the four available cadres of HCWs, namely CHEWs, nurses , midwives and Medical Officers, who can manage maternal and newborn problems. The expectation is that in areas with significant human resource shortages (Northern Nigeria and rural areas of Southern Nigeria), the available cadre (mostly CHEWs) will be trained to proficiency to provide routine MNH care and BEmONC services including referral for comprehensive EmONC services when needed. In any case, the reality on the ground in many of the country's PHCs is that CHEWs are currently performing many of the tasks listed below without having been trained to proficiency or formally approved, resulting in frequent adverse consequences for the clients and under-reporting of services provided in the facility to hide the information. Hence, the formal approval of this policy recommendation will provide the framework for the review of the pre- and in-service training curricula of CHEWs and adaptation of appropriate training materials and methods.

TABLE 2: TASK-SHIFTING/SHARING POLICY RECOMMENDATIONS FOR FRONTLINE HEALTH CARE WORKERS PROVIDING REPRODUCTIVE, MATERNAL, NEWBORN AND CHILD CARE

Task	CORPs/ VILLAGE HEALTH WORKERS	CHEWs	Nurse	Midwives, Nurse/ Midwives	Medical Officers
OVERARCHING TASKS					
Communicates effectively cross culturally to be able to provide holistic ''women-centered'' care	√	√	√	√	√
Establishes and fosters linkages between the community and the health facility	√	√	√	√	√
Promotes a culture of shared responsibility and partnership with individual women and families	√	√	√	√	√
Educates TBAs on role as advocates for institutional delivery	√	√	√	√	√
Collects and reports relevant data and collaborates in data analysis, case audits	√	√	√	√	√

Task	CORPs/ VILLAGE HEALTH WORKERS	CHEWs	Nurse	Midwives, Nurse/ Midwives	Medical Officers
and use of data for decision-making					
ANC TASKS					
Identify and refer pregnant women in the community to go to the antenatal clinic	√	√	NO	NO	NO
Takes appropriate history by asking relevant questions	NO	√	√	√	√
Conducts physical examination	NO	√	√	√	√
Assesses needs of women and her family	√	√	√	√	√
Gives appropriate advice and guidance	√	√	√	√	√
Calculates the expected date of delivery	NO	√	√	√	√
Performs routine screening tests including voluntary counseling and testing for HIV	NO	√	√	√	√
Provide information on Early Infant Diagnoses for HIV Exposed Babies	NO	√	√	√	√
Provide couples counselling and HIV testing	√	√	√	√	√
Initiate first line ART for HIV positive pregnant women without complications	NO	NO	√	√	√
Send and receive CD4 lab test	NO	√	√	√	√

Task	CORPs/ VILLAGE HEALTH WORKERS	CHEWs	Nurse	Midwives, Nurse/ Midwives	Medical Officers
Maintain (or refill) ART in HIV positive pregnant women without complications	NO	√	√	√	√
Initiate and maintain ART in HIV positive pregnant women with any complication (i.e. medical or obstetric)	NO	NO	NO	NO	√
Provide adherence education and support for HIV positive pregnant women on ART	√	√	√	√	√
Educate pregnant women and their families in danger signs in pregnancy and child birth and assist birth planning and complication readiness	√	√	√	√	√
Provide preventive medication to pregnant women during ANC period (Iron/folic acid, TT, IPTp-SP, LLITN …)	√ (orals only in the home)	√	√	√	√
Educates a women and their families regarding self-care during pregnancy, childbirth and the postnatal period	√	√	√	√	√
Identifies signs of prenatal complications (anemia, pre-eclampsia, eclampsia, bleeding, malaria, other medical complications), performs first-line management, lifesaving procedures and ensures effective	NO	√	√	√	√

Task	CORPs/ VILLAGE HEALTH WORKERS	CHEWs	Nurse	Midwives, Nurse/ Midwives	Medical Officers
referral					
Manages severe pregnancy complications (anaemia, pre-eclampsia, eclampsia, bleeding, malaria, other medical complications)	NO	NO	NO	√	√
Manages foetal mal-presentation	NO	NO	NO	√	√
Manages multiple gestation	NO	NO	NO	√	√
LABOR AND DELIVERY TASKS					
Performs vaginal examination	NO	√	√	√	√
Identifies onset of labor	√ (and refer)	√	√	√	√
Initiate and/or Continue ARV for HIV positive pregnant women	NO	√	√	√	√
Uses partograph to monitor progress of labor, maternal and fetal well-being and takes appropriate action, including referral where required	NO	√	√	√	√
Identifies signs of labor complications (mal-presentations, prolonged and/or obstructed labor, hypertension, bleeding, and infection), performs first-line management, lifesaving procedures and ensures effective referral	NO	√	√	√	√
Manages labor	NO	NO	NO	√	√

Task	CORPs/ VILLAGE HEALTH WORKERS	CHEWs	Nurse	Midwives, Nurse/ Midwives	Medical Officers
complications (mal-presentations, prolonged and/or obstructed labor, hypertension, bleeding and infection)					
Post-miscarriage: Screens women for STIs/HIV, takes first-line measures and ensures effective referral	NO	√		√	√
Post-miscarriage: Supports women living with HIV/AIDS, including through antiretroviral therapy	√	√		√	√
Provides supportive care including support by companion of choice	√	√	√	√	√
Promotes infection prevention	√	√	√	√	√
Provides appropriate pain relieving medication	NO	√	√	√	√
Performs guarding of the perineum to prevent routine episiotomy	NO	√	√	√	√
Performs episiotomy	NO	√	√	√	√
Manages normal vaginal delivery	NO	√	√	√	√
Performs vacuum extraction delivery	NO	NO	NO	√	√
Performs outlet forceps delivery	NO	NO	NO	NO	√

Task	CORPs/ VILLAGE HEALTH WORKERS	CHEWs	Nurse	Midwives, Nurse/ Midwives	Medical Officers
Performs Caesarean	NO	NO	NO	NO	√
Provides anaesthesia during Caesarean	NO	NO	NO	NO	√
IMMEDIATE POSTNATAL TASKS					
Performs AMTSL	NO	√	√	√	√
Administers uterotonic (oxytocin or misoprostol)	NO	√	√	√	√
Performs manual removal of retained placenta with active bleeding	NO	√	√	√	√
Refers woman with retained placenta and no active bleeding	√	√	√	√	√ (if in doubt of skills)
Performs bi-manual compression of uterus in case of uncontrolled haemorrhage	NO	√	√	√	√
Applies an anti-shock garment in case of uncontrolled haemorrhage	NO	√	√	√	√
Starts and maintains administration of IV fluids	NO	√	√	√	√
Repairs episiotomy	NO	√	√	√	√
Repairs a simple vaginal laceration	NO	√	√	√	√
Repairs a complex vaginal laceration	NO	NO	NO	√	√
Repairs a cervical laceration	NO	NO	NO	√	√

Task	CORPs/ VILLAGE HEALTH WORKERS	CHEWs	Nurse	Midwives, Nurse/ Midwives	Medical Officers
Provides blood transfusion	NO	NO	√	√	√
Identifies pre-eclampsia/eclampsia, performs first-line management and ensures effective referral	NO	√	√	√	√
Manages pre-eclampsia and eclampsia	NO	NO	NO	√	√
Continue ARV for HIV positive women	NO	√	√	√	√
Educate women on exclusive breast feeding, breast care and care of the perineum	√	√	√	√	√
IMMEDIATE NEWBORN CARE TASKS					
Provides basic essential newborn care (warm, dry, wrapping, cord care)	√ (at home delivery)	√	√	√	√
Helps the baby breath in the first one minute from birth (use of Ambu bag with cup, Penguin bulbs syringes and mask)	NO	√	√	√	√
Promotes initiation of breastfeeding and educate mother positioning and attachment for breast feeding	√ (at home delivery)	√	√	√	√
Identifies newborn complications (asphyxia, low birth weight, anomaly), performs first-line	NO	√	√	√	√ (if in doubt of skills)

Task	CORPs/ VILLAGE HEALTH WORKERS	CHEWs	Nurse	Midwives, Nurse/ Midwives	Medical Officers
management, lifesaving procedures and ensures effective referral					
Continues management of newborn complications	NO	NO	NO	NO	√
Provides early infant male circumcision	NO	NO	NO	√	√
Initiate ARV prophylaxis in HIV-exposed newborn	NO	√	√	√	√
Provide essential newborn care (immunization, Vit K, silver nitrate/TTC eye ointment, take biometric measurements)	NO	√	√	√	√
POSTNATAL CARE TASKS					
Provides information and counselling on self-care, nutrition, safer sex, breastfeeding, family planning, healthy lifestyle	√	√	√	√	√
Assesses maternal well-being including maternal nutrition	NO	√	√	√	√
Supports exclusive breastfeeding	√	√	√	√	√
HIV testing and counselling	NO	√	√	√	√
Supports women living with HIV/AIDS including antiretroviral therapy	NO	√	√	√	√
Collects blood samples	NO	√	√	√	√

Task	CORPs/ VILLAGE HEALTH WORKERS	CHEWs	Nurse	Midwives, Nurse/ Midwives	Medical Officers
for determining HIV status of HEI at 6weeks using DNA PCR and refer to higher level if positive					
Maintain ARV therapy in the postnatal period	NO	√	√	√	√
Screens women and families for signs of domestic and sexual violence, takes first-line measures and ensures effective referral	√	√	√	√	√ (if in doubt of skills)
Takes preventive measures against malaria	√	√	√	√	√
Identifies postnatal complications (puerperal sepsis, cord sepsis, depression, anaemia, mastitis), performs first-line management, lifesaving procedures and ensures effective referral	NO	√	√	√	√
Manages mild to moderate anaemia, mild puerperal depression, mastitis and uncomplicated malaria), referring when necessary	NO	√	√	√	√
POST-MISCARRIAGE CARE					
Provides contraceptive method or refers as necessary	NO	√	√	√	√
Provides emergency contraceptive	√ (orals only)	√	√	√	√

Task	CORPs/ VILLAGE HEALTH WORKERS	CHEWs	Nurse	Midwives, Nurse/ Midwives	Medical Officers
Screens women and families for signs of domestic and sexual violence, takes first-line measures and ensures effective referral	√	√	√	√	√
Identifies complications to miscarriage (bleeding, sepsis), performs first-line management, lifesaving procedures and ensures effective referral	NO	√	√	√	√
Manages complications due to miscarriage (bleeding, sepsis)	NO	NO	NO	√	√
Performs uterine evacuation (manual vacuum aspiration) for incomplete miscarriage	NO	NO	NO	√	√
Screens women for STIs/HIV, takes first-line measures and ensures effective referral	NO	√	√	√	√
Provide Syndromic Management of STIs	NO	√	√	√	√
Supports women living with HIV, including through antiretroviral therapy	NO	√	√	√	√
Initiate and maintain ART for eligible women and those who are already on treatment	NO	NO	√	√	√
Manages ectopic pregnancy	NO	NO	NO	NO	√
FAMILY PLANNING TASKS					

Task	CORPs/ VILLAGE HEALTH WORKERS	CHEWs	Nurse	Midwives, Nurse/ Midwives	Medical Officers
Provide FP education/counselling and help women choose preferred method of contraception	√	√	√	√	√
Promote dual protection for HIV positive women	√	√	√	√	√
Provides contraceptive method or refers as necessary	NO	√	√	√	√
Performs tubal ligation	NO	NO	NO	NO	√
Performs vasectomy	NO	NO	NO	NO	√
Inserts and removes contraceptive implant	NO	√	√	√	√
Inserts and removes intrauterine contraceptive device (IUCD)	NO	√	√	√	√
Initiation and maintenance of injectable contraceptives	NO	√	√	√	√
Community level services					
Perform malaria test using rapid diagnostic test kits	√	√	√	√	√
Provide treatment of malaria using ACTs	√	√	√	√	√
Provide treatment of diarrhoea using ORS and zinc	√	√	√	√	√
Provide treatment of acute respiratory infections in children under 5 years using	√ (oral only)	√ (oral only)	√	√	√

Task	CORPs/ VILLAGE HEALTH WORKERS	CHEWs	Nurse	Midwives, Nurse/ Midwives	Medical Officers
antibiotics					
Dispense misoprostol in the community	√	√	√	√	√
Prevents umbilical cord infection using Chlorhexidine gel	√	√	√	√	√

Integrated management of childhood illnesses for under 5 children (IMCI) for under-5 care

TABLE 3: TASK-SHIFTING/SHARING POLICY RECOMMENDATIONS FOR FRONTLINE HEALTH CARE WORKERS INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES

Task	CORPs/ VILLAGE HEALTH WORKERS	CHEWs	Nurse	Midwives, Nurse/ Midwives	Medical Officers
INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESSES FOR UNDER 5 CHILDREN					
Identify and Check for General Danger Signs for Referral ***[not able to drink or breastfeed, vomit everything, had convulsion, lethargic or unconscious, and child convulsing now]***	No	√	√	√	√
Identify, classify and treat for difficult breathing as severe **pneumonia** or very severe disease; pneumonia or no pneumonia	No	√	√	√	√
Identify, classify and treat for **dehydration** as severe; some or no dehydration	No	√	√	√	√
Identify, classify and	No	√	√	√	√

treat for **diarrhoea** as severe persistent diarrhoea or persistent diarrhoea					
Identify, classify and treat for **dysentery**	No	√	√	√	√
Identify, classify and treat for **fever** as very severe febrile disease; malaria or fever: no Malaria	No	√	√	√	√
Identify, classify and treat if measles now or within last 3 months as severe complicated measles; measles with eye or mouth complications or measles	No	√	√	√	√
Identify, classify and treat for ear problem as mastoditis; acute **ear infection**; chronic ear infection or no ear infection	No	√	√	√	√
Check and classify for malnutrition as complicated severe **acute malnutrition**; uncomplicated severe acute malnutrition; moderate acute malnutrition and no acute malnutrition	√	√	√	√	√
Check and classify **Anaemia** as Severe Anaemia; Anaemia and No Anaemia	No	√	√	√	√
COMMUNITY LEVEL SERVICES					
Key household and Community Practices on **Growth Promotion & Development** *[Exclusive Breastfeeding for*	√	√	√	√	√

6months; Appropriate complimentary feeding from 6 months up to 2 years; Adequate micronutrient through diet or supplementation; Growth Monitoring; Promote Mental & Psychosocial development and Birth Registration]					
Key household and Community Practices on **Disease Prevention** *[Proper disposal of faeces, hand washing, etc; Child and Mother Sleep under LLINs; Prevention of HIV & Care of PL/AHA and Prevent Child Abuse /Neglect and take appropriate action]*	√	√	√	√	√
Key household and Community Practices on **Home Management** *[Continue to feed & offer more food & fluids when child is sick; Give child appropriate home treatment for infection and Take appropriate action to prevent & manage child injuries & accidents]*	√	√	√	√	√
Key household and Community Practices on **Care Seeking & Compliance** *[Take Child to complete full course of Immunization before 1st birthday; Recognize when child needs treatment outside home & take to Health Worker; Follow Health Workers Advice about treatment, follow up and Referral; Safe Motherhood; Community Newborn Care and Active Participation of Men in Child Care & Reproductive Health Service]*	√	√	√	√	√

Justification for Task Shifting and Sharing in HIV Care

The first HIV Sentinel Survey in 1991 showed a prevalence of 1.8%. Subsequent sentinel surveys produced prevalence of 3.8% (1993), 4.5% (1996), 5.4% (1999), 5.8% (2001), 5.0% (2003), 4.4% (2005), 4.6% (2008) and 4.1 %(2010). A more comprehensive survey was conducted in 2012, (NARHS plus II 2012) which showed a decline to 3.4% in HIV prevalence, indicating a reversal of the epidemic in the country, compared to the 2007 figure of 3.6%[19].

The initial Government of Nigeria coordinated response to HIV from 2001-2004 focused on immediate access to ART to treat large numbers of terminally ill and dying persons with HIV and AIDS. However, with supplemental funding from the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and the World Bank, the Federal Government's mandate changed focus to scale up HIV services with a goal to increase access to ART. As in most developing countries, Nigeria lacks sufficient skilled health workers to effectively accommodate the influx of patients requiring ART. The centralized ART service delivery models (mostly at tertiary hospitals and few secondary facilities) coupled with traditional role specifications for health worker categories became major challenges to expansion of access to life-saving ART. As many ART sites become overstretched due to high patient volumes, long waiting times and high attrition rates of health professionals that contributed to the severe limitations in access to prevention, treatment, care and support for people living with HIV/AIDS (PLWHA). There were also excessive transportation and other economic burden on patients who lived far from the ART sites.

With increasing number of patients in need of ART, high patient-to-doctor ratios, high default rates among patients already on ART and decrease in patient satisfaction, there were obvious concerns over the quality of HIV care being provided at major treatment centers. These lead to a pressing need to decentralize and devolve ART services to further expand patient access to care. In 2009, the FMOH recommended a systematic approach for ART decentralization. Implementation of decentralized ART service involved shifting HIV management tasks appropriately from physicians to non-physician providers, from nurses to CHEWs and subsequently to trained peer educators, patients and communities. Task shifting and sharing have rapidly increased the number of sites providing ART services and scaled up PMTCT in Nigeria. ART provision at the PHC levels maximizes the benefits of the LGA health systems by ensuring that services are brought closer to patients' homes, By so doing, patients do not have to travel long distances to health care facilities. Therefore in the context of HIV, task shifting and

[19] National AIDS Control Agency: 2012 Nigeria Global AIDS Response Progress Report

sharing allow specialized health workers more time to focus on advanced clinical conditions while non-physician providers attend to the more stable patients. Most of all, it engages the community to take care of their own.

Justification for Task Shifting and Sharing in Malaria Care

Malaria remains an important cause of morbidity and mortality in Nigeria. Nigeria accounted for 32 percent of the global estimate of 655,000 malaria deaths in 2010 (World Health Organization, 2012). Children under age 5 and pregnant women are the groups most vulnerable to illness and death from malaria infection in Nigeria. Advice or treatment was sought from the public sector for 26 percent of children, with government hospitals accounting for 12 percent of this total. Advice or treatment was sought from the private sector for 42 percent of children, primarily from a chemist or patent medicine vendor (34 percent)[20]. For 8 percent of children, advice or treatment was sought from other sources such as shops, traditional practitioners, and markets. Although use of ACT for malaria treatment increased from 2 percent in 2008 to 18 percent in 2013, this figure remains below the national target (which is at least 80 percent by 2010, as specified in the national malaria strategic plan). Therefore there is a need to engage a wider network of health care workers and volunteers in order to scale up low cost effective evidence-based interventions for the elimination of malaria.

The current mission of National Malaria Elimination Program (NMEP) is based on its mission policy to provide equitable, comprehensive, cost effective, efficient and quality malaria control services ensuring transparency, accountability, client satisfaction, community ownership and partnership. To further promote prompt treatment of malaria, diagnostic and treatment services need to be brought as close as possible to the persons needing treatment. This is to be achieved through the community delivery mechanisms; either as stand-alone community based diagnosis and treatment programs or within the context of integrated Community Case Management (iCCM).

The level of iCCM implementation in Nigeria was reported low by the 2012 MPR. An estimate based on the assumption that one CHW will be required to provide iCCM to 500 persons among 65% who reside in rural areas. Using a projected total population of 173 million in 2013, a total 225,561 community-based frontline health workers will be required to adequately reach the rural population. High rate of attrition of trained health workers has been identified as a barrier to success in iCCM implementation which could be mitigated by a concurrent initiative to motivate

[20] Source: 2013 NDHS

volunteers and retain health workers by building locally-acceptable and sustainable incentive programs into the iCCM strategy.

Justification for Task Shifting in Tuberculosis care and prevention

With the declaration of Tuberculosis (TB) as a global emergency in 1993 at the General Assembly, the African Union and Nigeria in 2006 also declared TB an emergency. The FMOH through the National TB programme started the process of task shifting to address the declarations. The diagnosis of TB and prescription of rifampicin based treatment which was hitherto reserved for Medical Officers shifted to other cadres of staff (CHEWs and Nurses). Other tasks shifted include identification of and management of drug reactions, HIV counselling and testing and analysis of data at facility and LGA levels. However, despite these efforts by the FMOH, the results of the TB prevalence survey in 2012 revealed that the disease burden is much higher than previously thought.

Currently, the Nigerian Government aims to provide Nigerians with universal access to high-quality, patient-centered prevention, diagnosis, and treatment services for TB, TB/HIV, and drug-resistant TB by 2018. Addressing low case detection, as seen from the 2012 TB prevalence report, requires a rapid scale-up of diagnostic capacity, and engagement of all health care providers in identifying people with TB. Other areas include partnerships with community-based organizations to provide outreaches and education of key affected populations, and to increase knowledge while reducing stigma among the general population. To achieve this, the programme will focus on addressing low detection of TB cases in adults and children, improving treatment outcomes in some areas, provide adequate capacity for diagnosing and treating drug-resistant TB. Increasing access to laboratory services for Acid-Fast Base (AFB) diagnosis, the cornerstone of TB control, has been a key limiting factor mainly due to few laboratories and inadequate number of personnel.

Areas of focus will be:

- Improve diagnosis of TB in children by empowering Nurses and CHEWs at community level using an algorithm for diagnosis of TB in children.
- Increasing access to AFB microscopy and GeneXpert in the communities by empowering laboratory technicians and assistants to perform AFB microscopy and GeneXpert test.
- Build capacity of CBOs and community volunteers to provide education on TB and HIV in the community.
- Empower CBOs and community volunteers to support patient treatment and carry out defaulter tracing/retrieval.

Policy statement:

The Government of Nigeria shall:

i. Provide access to good quality first line choice of ACT, ART and anti-Tuberculosis medications in line with National Treatment Guidelines at all levels of care.

ii. Institute capacity building mechanisms for all cadres of health workers who will perform task-shifted roles including community oriented persons such as peer educators and patent medicine vendors on skills for effective treatment, counseling and referral (where necessary).

iii. Ensure systems are in place for effective supervision of Malaria, HIV and Tuberculosis case management at community levels.

iv. All healthcare workers who will need to diagnose health conditions addressed in this policy document are trained on the appropriate tasks specified including community volunteers, PHC workers and staff of secondary and tertiary health care facilities

COMPREHENSIVE HIV CARE SETTING

In the context of HIV, task shifting allows the specialized health workers more time to focus on advanced clinical conditions while lower cadre of health workers attend to the more stable patients.

The following tables provide a list of activities (or tasks) that constitute the care, treatment and support for HIV/AIDS. Specific cadres of health care workers according to the national ARV guidelines and relevant regulatory agencies perform these tasks.

Each task in the table is cross-referenced against the main categories of health worker cadres. These are medical doctor (MD); Registered Nurses (RN); Pharmacists; Pharmacy Technician; Pharmacy Assistants; Laboratory Scientist; Laboratory Technicians; Laboratory Assistant; Medical Records Officers (MRO)); Medical Records Assistants (MRA), Community Health Workers (CHW) and Persons Living with HIV (PLHIV) volunteers.

A tick (√) is used to indicate which cadres are able to execute that task in a manner that is both safe and effective, assuming that all health workers have standardized training and appropriate supervision specific to the performance of the individual task. A 'NO' indicates that it is not recommended that the task be performed by the cadre. PLHIV who are working as CHEWs can add value in the delivery of specific services by virtue of their own HIV status provided that they undergo appropriate training and supervision.

TABLE 4: TASK-SHIFTING/SHARING POLICY RECOMMENDATIONS FOR FRONTLINE HEALTH CARE WORKERS ON HIV/AIDS CARE

TABLE 4A: Patient registration

Activity	MRO	MRA	CHEW	PLWHA
Recognize those to be enrolled into HIV care	√	√	√	√
Register new patient in the pre-ART register and assign correct unique number	√	√	√	√
Insert blank copies of PMM forms into folder	√	√	√	√
Fill in the biodata part of the PMM forms	√	√	√	√
Issue patient appointment card and schedule client for appointment to see clinician	√	√	√	√
Sort out folders of those clients on appointment on each clinic day	√	√	√	√
Ensure laboratory results are picked up from laboratory and filed in the correct folder	√	√	√	NO
Identify patients that are available during clinic visit and fill out ART clinic attendance register	√	√	√	√
Compile list of those who missed appointment at the end of clinic and file folders in “missed appointment” section of the shelf	√	√	√	√
Send folders of all those present to ART nurse for triaging	√	√	√	√
Supervision: Supervise MRA in the above activities	√	NO	NO	NO
Supervision: Supervise CHW in the above activities	√	√	NO	NO
Supervision: Supervise PLWHA in the above activities	√	√	√	NO

TABLE 4B: HIV clinical management

Activity	MD	RN	CHEW	PLWHA
Adherence				

Activity	MD	RN	CHEW	PLWHA
Register client and gather additional socio-demographical data	√	√	√	√
Assess client's knowledge of HIV, discuss goals of ART, reasons for combination therapy and importance of medication adherence	√	√	√	√
Identify difficulties and potential barriers to keeping medical appointments, taking and adhering to medications	√	√	√	√
Identify client's need for other services and make appropriate referrals	√	√	√	√
Assess the patient for adverse drug effects and, if necessary, refer client immediately to the consulting physician for further assessment and symptom management	√	√	√	NO
Discuss the client's experience with the medications, identify any difficulties reported by the patient in taking the medications, develop strategies to manage these difficulties and achieve adherence	√	√	√	√
Review prevention and risks of HIV transmission while on ART	√	√	√	NO
Schedule client for adherence counselling visits	√	√	√	√
Supervision: Supervise RN in the above activities	√	NO	NO	NO
Supervision: Supervise CHEW in the above activities	√	√	NO	NO
Supervision: Supervise PLWHA in the above activities	√	√	√	NO
Clinical consultation				

Activity	MD	RN	CHEW	PLWHA
Conduct a routine clerking and physical examination of the client to assess health status and fill items 8 – 37 of the ICE form	√	√	√	NO
Complete a baseline assessment using the ICE form	√	√	NO	NO
Determine the stage of HIV infection using the WHO clinical staging criteria	√	√	NO	NO
Fill in the LOR form and request for other laboratory investigations not on LOR form if necessary	√	√	√	√
Initiate treatment for acute symptoms and any existing treatable conditions	√	√	√	√ (HBC)
Discuss eligibility, counsel client on ART adherence to avoid resistance stressing the importance that 1st line regimen has the best chance for long term success	√	√	NO	NO
Assess client's readiness to commence ART	√	√	NO	NO
Issue prescription for ARV regimen based on the national guideline on the POF and refer to pharmacy	√	√	NO	NO
Follow-up monitoring for clients who have started ART and manage side-effects	√	√	√	√ (HBC)
Substitution of ARV regimen according to national guidelines	√	√	NO	NO
Assessment for treatment failure (clinical and immunological) and discontinuation of current ARV regimen	√	NO	NO	NO
Interruption of therapy and non-adherence	√	NO	NO	NO
Substitution of ARVs in pregnancy if indicated	√	NO	NO	NO

Activity	MD	RN	CHEW	PLWHA
Determine client's special needs and refer for specialized services using the referral forms	√	√	√	√
Supervision: Supervise RN in the above activities	√	NO	NO	NO
Supervision: Supervise CHEW in the above activities	√	√	NO	NO
Supervision: Supervise PLWHA in the above activities	√	√	√	NO

TABLE 4C: ARV dispensing

Activity	Pharm.	Pharm. Tech	Pharm. Asst.	PLWHA
Verify and interpret prescription for authenticity, completeness and identify prescription anomalies	√	√	NO	NO
Prepare prescription items: prescription labels, dispensing containers, etc according to requirements and dispense drugs according to prescription information	√	√	NO	NO
Pre-packaging of prescription items	√	√	√	√
Explain item's use/benefits, onset of action, route, dosage form, administration schedule, actions to be taken in case of missed dose, potential common side effects, procedure for obtaining refill, proper storage and need for 100% adherence (Medication adherence counseling)	√	√	NO	NO
Document quantities of items dispensed and sign POF, document each encounter in PDDW (adult/paediatric)	√	√	NO	NO
Signing of POF	√	NO	NO	NO

At month end, transfer information accurately and completely from PDDW to PMW and generate MSF	√	√	√	√
Supervision: Supervise Pharm. Tech in the above activities	√	NO	NO	NO
Supervision: Supervise Pharm. Assistants in the above activities	√	√	NO	NO
Supervision: Supervise PLWHA in the above activities	√	√	√	NO

TABLE 4D: ART laboratory

Activity	Lab. Scientist	Lab. Tech	Lab. Assistant	PLWHA
Equipment maintenance (daily, weekly, monthly)	√	√	NO	NO
Receive lab. Request/order forms from patients and verify that it is properly filled	√	√	√	√
Preparation of items for sample collection, labelling of the sample containers for sample collection and preparing of patients	√	√	√	√
Collection of samples from patients into appropriate containers and registration in the specimen receipt register	√	√	√	√
Samples separations into different units in the ART laboratory for analysis	√	√	√	√
Sample analysis	√	√	NO	NO

Activity	Lab. Scientist	Lab. Tech	Lab. Assistant	PLWHA
Documentation of results in the appropriate worksheets and general laboratory register	√	√	NO	NO
At month end, preparation of end of month laboratory data, requisition form for HIV test kits and reagents	√	√	√	√
Supervision: Supervise Lab. Technician in the above activities	√	NO	NO	NO
Supervision: Supervise Lab. Assistants in the above activities	√	√	NO	NO
Supervision: Supervise PLWHA in the above activities	√	√	√	NO

TABLE 5: TASK-SHIFTING/SHARING POLICY RECOMMENDATIONS FOR FRONTLINE HEALTH CARE WORKERS ON TB CARE

Task	CORPs/ VILLAGE HEALTH WORKERS	CHEWs	Nurse	Midwives, Nurse/ Midwives	Medical Officers
OVERARCHING TASKS					
Suspect and diagnose TB in children using the algorithm for diagnosis of TB in children.	NO	√	√	√	√
Administer anti-TB drugs to all diagnosed TB patients.	√	√	√	√	√
Collection and analysis of relevant data at facility level and use of data for decision-making	√	√	√	√	√
Perform routine counseling and testing	√	√	√	√	√

Task	CORPs/ VILLAGE HEALTH WORKERS	CHEWs	Nurse	Midwives, Nurse/ Midwives	Medical Officers
for HIV on all TB cases					
Provide education on TB at community level using IEC materials produced by the TB programme.	√	√	√	√	
Manage mild drug site effects and reaction of anti-TB medicines and refer when necessary.	NO	√	√	√	√
Support patient treatment and carry out defaulter tracing/retrieval.	√	√	√	√	√

IMPLICATIONS OF TASK SHIFTING AND TASK SHARING POLICY FOR GOVERNANCE AND COORDINATION

The TSWG is seeking approval for this proposal by the National Council of Health (NCH) in order to give clear guidelines on specific tasks that can be performed by different categories of health care workers charged with the responsibility of providing care to pregnant women and their babies. The approval of specific tasks that can be performed by trained health workers will lay a foundation for needed capacity building of these cadres of staff. The following activities are crucial going forward:

- The FMOH will need to disseminate the approved task-shifting policy framework at national and sub-national levels (in collaboration with State MOHs) to create an enabling environment for policy implementation.
- The Nursing and Midwifery Council of Nigeria (NMCN) as well as the Community Health Practitioners Registration Board of Nigeria (CHPRBN) will need to review their regulations to accommodate these recommendations and to initiate a training curriculum review to guide pre-service education or in-service training.
- All training activities to build the capacity of these HCWs (pre-service or in-service) will have to re-emphasize clinical skills development rather than knowledge acquisition. For the training of CHEWs, a low-dose high-frequency (LDHF) training approach, which introduces critical knowledge and skills in

stepwise manner, should be adopted. To this end, all pre-service training institutions (especially schools/colleges of health technology will have to be equipped with appropriate user-friendly anatomic models and obstetric instruments to guide these trainings. Appropriate time allotment for skills development will also need to be made in the curriculum. Post-training supervision and mentorship should be integrated with the curriculum and budgeted for as part of in-service trainings. In-service trainings need to be standardized and tailored to each cadre of health workers. A step wise in service training of health workers could be considered, with an initial training in parts of the country where the need is most acute.

- Once the policy is approved, professional regulatory bodies should emphasize capacity-building for new skills in their continuous professional development programs and tie certification, licensure, registration and career progression to receipt of approved continuing medical/health education.
- The FMOH and State MOHs will need to also invest in post-training supportive supervision, clinical mentoring, and provision of additional on-the-job training and in availing job aids to ensure that HCWs maintain their skills.
- The referral systems between PHCs and hospitals will need to be strengthened for mentorship of CHEWs, nurses and midwives, while providing the best available quality service to the clients.
- A monitoring and evaluation system will have to be put in place to track service utilization, compliance with set performance standards for critical services and patient outcomes. This system will provide evidence of the effectiveness of this approach to solve the acute human resource shortages in some parts of the country. Maternal death surveillance and response systems, which permit the identification, quantification, determination and notification of causes of maternal deaths for a defined period of time at the facility and community levels should be included.
- Governments at national and sub-national levels will have to develop a basket of staff retention incentives to ensure that trained front-line health workers are retained in the healthcare delivery systems. Consideration should be given to compensation incentives for additional responsibilities where indicated.
- The timing of these policy developments is very appropriate as the Government of Nigeria in the early stages of implementing the “Saving One Million Lives” initiative being funded under the Subsidy Re-investment Program (SURE-P).
- In order to ensure long-term sustainability, stakeholders should advocate to the National Assembly for the speedy passage and Presidential assent of the National Health Bill, which contains a component for capacity-building of frontline workers in the health sector.
- A comprehensive plan should be developed by the Government to implement this policy

- Periodic review of the policy is recommended to ensure the policy continues to respond to the HRH needs of the Nigerian population

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