Background

Many developing countries face shortages of qualified medical personnel, particularly in rural areas. Task-sharing is recognized as a promising strategy for addressing these gaps in the health system. Yet in most countries, including those that have implemented robust task-sharing programs, access to voluntary modern contraception for adolescents and young people remains limited. Furthermore, task-sharing programs have not specifically focused on providing access to long-acting reversible contraceptive methods (LARCs) for this young population.

In order to help the 23 million adolescents that want access to contraception and do not have it, task-sharing programs must embed specific training and support for healthcare providers to provide voluntary access to an expanded contraceptive method mix for adolescents and young people, that includes LARCs.

Key Themes

Task-sharing can effectively maximize the use of health infrastructure and human resources, freeing up time for providers to serve more clients and reducing the cost of health service provision without sacrificing quality. Task-sharing is included in many FP2020 commitments because it can accelerate progress towards the goal of enabling 120 million more women and girls to use contraceptives by 2020.

Task-sharing of LARC provision poses unique challenges and opportunities. Successful task-sharing of LARCs for youth requires more than just training new providers on insertion and removal of the methods. Providers need dedicated time, supplies, supervision, sensitivity to young people’s needs and enough client demand to maintain competency and sustain skills.

Task-sharing reflects the transition and re-distribution of tasks and responsibilities among health worker cadres to improve access and cost-effectiveness. When task-sharing is done well, lower level cadres such as community health workers, community volunteers and pharmacists can take a larger role in the distribution of short-acting methods (e.g. oral contraceptive, injectables and condoms), freeing up higher level cadres (e.g. nurses, midwives, health extension workers) to provide LARC insertion and removals. For instance, community volunteers can be engaged in outreach efforts, providing information and demand generation activities for young people to learn about LARCs, as well as accompany them to facilities for services. Community health workers can provide contraceptive education and group counseling for youth in comfortable settings outside the health facility. Auxiliary nurses or assistants can provide individual counseling for young people on LARCs.

Understanding how and where young people want to access contraception should inform decisions about who to engage in task-sharing. Demand creation activities are necessary to ensure there is sufficient demand to justify task-sharing. Higher demand will also ensure that providers maintain their skills. When considering the potential outcomes of task-sharing, it is necessary for programmers and providers to ask:
**What is the goal of task-sharing?** Is the goal to:

- Meet unmet demand for LARCs among youth who face barriers to access?
- Make LARC services more acceptable to young people by enabling them to receive the services from a provider who is more relatable (e.g., Providers with direct links to communities, such as midwives and community health workers, may be younger, more approachable, speak the same language and understand local norms better than facility-based doctors, midwives or nurses.)
- Generate and meet demand for LARCs among youth whose needs are not well met by other methods?
- Improve cost-effectiveness of the program?

**Recommendations**

**Advocates and policy-makers**

- Advocate for the training of multiple cadres of health service providers to provide LARCs for youth
- Review, update and develop less restrictive policies to support contraceptive provision to youth by a wider variety of health service providers at the community level
- Allocate funding for youth-specific pre-service, in-service and whole site training on the provision and removal of LARCs
- Create/review systems of supervision that consider the unique needs of youth
- Ensure continuity of care includes follow-up and removals of LARC methods and referral systems for wider method choice
- Collect and analyze age and sex disaggregated data including LARCs for youth
- Develop and disseminate messages about cost and time-savings with task-sharing, particularly as they relate to meeting the contraceptive needs of youth

**Researchers**

- Establish rigorous research to inform future revisions to the task-sharing guidelines, focusing on youth-specific needs
- Conduct research on how, where and from whom young people trust and want to access contraception, including LARCs. This may be related to provider age, gender, level of cadre, experience, placement within the health system or community, etc.
- Document and publish task-sharing research and implementation outcomes to share lessons learned for replication and scale-up

**Programmers and service providers**

- Design programs and service delivery models that account for the time, supplies and supervision needed for providers to successfully share youth-friendly LARC provision within a health system
- Look for opportunities for task-sharing among other youth-serving providers (e.g. pediatricians, general practitioners) and locations (immunization services, postnatal care, post abortion care)
- Consider, mitigate and address any increased risks with task-sharing for youth-friendly service delivery
- Address provider attitudes or negative perceptions and norms associated with LARC use among youth
- Train providers on the unique contraceptive needs and challenges related to youth service provision
- Ensure services are delivered through multiple channels within and outside clinic settings