

Exploring the Regulation of Task Sharing for Access to Family Planning Services in Uganda



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Abstract

There is an acute shortage of Human Resources for Health in Uganda. While task sharing in the delivery of reproductive services is one of the strategies to avert this crisis, it takes place in an unregulated environment. The consequent lack of legal protection for health care providers poses a potential barrier to task sharing for both providers and the government. We show in this legal and policy review that the approach is not new in the country and that it has provisions in some policy documents. We further show the legal implications if it is rolled out in an unregulated environment and propose six options to guide regulation. These include enforcing the Health Service Commission Act, utilizing the mandate of the Director General to authorize treatment, amending the regulations of health professional regulatory bodies, developing regulation to support implementation of the acts for health professionals, developing a full act of parliament, and enacting ordinances at the district level.

Abbreviations: HRH: Human Resources for Health; MoH: Ministry of Health; ART: Anti-Retroviral Therapy; EMTCT: Elimination of Mother to Child Transmission; DG: Director General's

Introduction

Task sharing is proposed as one part of a broader strategy to address the acute shortage of Human Resources for Health (HRH) in Uganda [1]. In 2013, the Ministry of Health (MoH) made efforts to adopt and scale this approach in the country, including formation of a National Task Sharing Advisory Committee [2]. This was done with support from Civil Society working on sexual and reproductive health with an aim to increase access to family planning. While the national level efforts have stalled, the legal environment within which it would be adopted is unclear and may lead to health workers undertaking tasks for which they have not been originally trained and accredited. As such, their contributions, which may be as vital as saving lives, may be regarded as actions executed outside the boundaries of the law. This may attract punitive action hence sustaining the health worker crisis. To prevent this possibility and also guide future discussion for scale up, we carried out a legal and policy analysis of task sharing in Uganda and recommend options for an enabling environment.

Methods

In August 2016, we consulted key informants on where to find information on international guidelines, current practices, and regulatory documents on task sharing. We reviewed: 7 documents providing international guidance of task sharing; 9 policy and strategic documents on human resources for health in Uganda; and 8 laws relating to human resources for health. We further searched PubMed for literature on task sharing in Uganda and found two relevant articles.

Findings

International Guidance on Task Sharing and Task Sharing

Most of the documents acknowledge the global crisis in human resources for health. They provide guidance on Task sharing as one of the ways to manage the crisis, although the resolution from

the 2009 World Medical assembly hints that it is also used where there are no human resource shortages [3]. The documents further emphasize integration of Task sharing into the health system and adherence to the right-to-health framework. The CESC General Comment No. 14 elaborates the role that health workers have to play in the fulfilment of the right to health [4]. The First Global Forum on HRH, does not specifically mention Task sharing but implores leaders to resolve the health worker crisis, determine the appropriate health workforce skill mix and institute coordinated policies to sustain that mix, among other recommendations [5]. The documents recommend operationalizing Task sharing within a regulated environment that is safe for the health workers involved. The Joint Health Professionals further emphasize that unemployed and underemployed health workers should be considered before hiring lower-level health workers [6].

The WHO HIV guidance proposes four levels of Task sharing. The first level is non-physician clinicians performing tasks that are usually reserved for doctors and specialized physicians. The second level involves nurses performing tasks usually reserved for non-physician clinicians. The third level involves nursing assistants and community health workers performing tasks usually reserved for nurses. The last level involves patients self-administering medication in the absence of a nursing assistant or a community health worker [7]. The WHO also provides specific guidance on Task sharing to improve access to contraceptive methods [8]. This guidance highlights the use of various non-physician health worker cadres to provide tubal ligation, vasectomy, intrauterine devices (IUD), contraceptive implants and education and counselling.

Task Sharing/ Shifting in Uganda

A case study on the policy and programmatic implications of task sharing in Uganda illustrates how the Ministry of Health has implemented the WHO levels of task shifting [7]. At the first level guidelines have been developed for anti-retroviral therapy (ART) and elimination of mother to child transmission (EMTCT) to guide clinicians at Health Centre IIIs because there are no medical doctors at this level. In another illustration community based psychiatric clinical officers now provide a scope of health services fairly similar to that of psychiatrists. A different study on task sharing surgical methods of contraception and found that clinical officers increased access to bilateral tubal ligation safely and effectively and their service is acceptable to clients [9].

At the second level, nurses, instead of doctors, routinely insert intravenous lines in hospitals; appropriately trained midwives carry out manual vacuum extractions in place of doctors; and nurses who have been trained to provide only nursing services also perform midwifery. At the third level community health workers, rather than nurses, carry out home-based management of fever; and microscopists help with laboratory services in place of laboratory technologists. At the fourth level patients' relatives at the burns unit of Mulago Hospital have been trained to assist in the on-going

care of patients; at the Infectious Diseases Institute people living with HIV sometimes handle registration and follow-up reminders to their peers.

The Policy and Legal Framework on Human Resources for Health in Uganda

Uganda Vision 2040 describes the overall normative policy framework of the government of Uganda. It sets out to transform Uganda into a prosperous country within 30 years and should be implemented across different development plans [10]. While Vision 2040 does not focus on HRH, it provides the framework for development of health sector policies and plans.

All health policy documents and plans acknowledge the constraints in human resources for health. They highlight the importance of the right to health by providing guidance on different aspects of the availability, acceptability, accessibility and quality of human resources for health. Of the nine documents reviewed, seven including the Second National Health Policy [11] and the Human Resources for Health Policy [12], do not mention Task sharing. Of the two that address task sharing, the 2012 National Policy Guidelines and Service Standards for SRHR do not explicitly mention it, but they imply it [13]. They make provision for an adequate number of health workers who are qualified and skilled to provide a full range of quality SRH services through appropriate pre-service training and integrated continuing education. The Family Planning Costed Implementation Plan explicitly mentions task sharing as a priority to increase access to family planning services for underserved populations by the year 2020. It actually spells out annual budgets for task sharing up to 2020 and proposes advocacy initiatives to further the approach [14]. The policy, however, does not describe how the approach will be implemented to achieve the desired outcomes.

While the second National Development Plan does not mention Task sharing, it proposes strategies that support the approach. These include addressing the human resource constraints, strengthening the capacity of human resources, and regulating the health workforce to conform to expected standards of practice [15]. Two of the policy documents that we reviewed-the Uganda Medical and Dental Practitioners Council Code of Professional Ethics and the MoH patients' charter-include guidance that suggests the risk of Task sharing/sharing if it is not within a legal framework. Both call on practitioners to respect human rights and refrain from performing actions that violate human rights [16,17]. The practitioners' code prohibits health practitioners from performing a professional act that they are inadequately qualified or experienced to provide (Article 9g) [16]. The patients' charter also allows patients to reject a service from a health worker if they deem the worker unqualified to provide that service [17]. It is, as well, a violation of a patient's rights if a health worker performs a service above their cadre and does not so inform the patient. Unfortunately, qualification is legally indicated only in terms of what a health

worker is accredited to perform regardless of any experience or training he or she may have performing a task. The FPCIP proposes to relax the accreditation requirements in the future for particular procedures to protect cadres of health workers from litigation. These include those who perform tubal ligations and implants and VHT members who provide injectable contraceptives [14].

The Legal Framework on Task Sharing in Uganda

Almost all these laws criminalize the performance of duties outside those of the accredited profession. The penal code specifically uses the term “false pretence” to refer to a person who represents himself or herself as someone else. This person is subject to criminal liability (Section 304) [18]. The Practitioners Acts further spell out the liability as a fine of between Uganda Shillings 300,000 and Uganda Shillings 3,000,000 and/or imprisonment of between three months and one year [19,20]. The Pharmacy and Drugs Act is the only law that implies the possibility of Task sharing. It permits pharmacists to give medical, veterinary or dental advice or first aid in cases of treatment, or first treatment in cases of simple ailments, if the patient cannot immediately access a professional accredited to treat the ailment (Section 29) [21]. The Occupational Safety and Health Act makes it a duty of an employer to protect his or her workers and the public from dangerous aspects of the employer’s undertaking at his or her own cost (Section 13) [22].

Therefore, the professional bodies that regulate health care professionals in Uganda have the legal mandate to protect them from unwarranted criminal liability, as should government. The Local Government Act gives powers to the local governments to enact bye-laws and ordinances on issues, which could include the delivery of health care through task sharing [23]. It would be important for government to positively exploit these provisions because health workers who perform tasks on behalf of the state in a legal framework that does not protect them from criminal liability suffer a violation of their labour rights. Furthermore, they are exploited and discriminated against when they perform tasks for which no pay or inadequate pay is provided. The WHO guidelines on task sharing, which should guide national frameworks, spell out key considerations for Task sharing that include remuneration to reflect changes in the affected cadre’s scope of work [9,10].

Discussion

Task sharing in Uganda happens in an unregulated environment. The cadres who have embraced the approach have no legal protection to perform duties that they are not originally accredited for and are at risk of criminal liability; secondly, common law commits the health professional to warn the patient of possible serious risks involved in any procedures. In task sharing, unfortunately, the level of expertise of the health professional may not be adequate to meet these requirements under the current legal frameworks. Breaching this duty of care could be interpreted as criminal negligence and violation of ethical codes of practice; thirdly, standardizing the regulations on Task sharing may be complicated by the reg-

ulations that govern professional bodies. For example, if a member of the Allied Health Professionals Council provides services that are regulated by the Nurses and Midwives Council, they cannot be accredited by the latter for those tasks. These laws also forbid regulated professionals from practicing outside the areas regulated by the bodies. The FP CIP recognizes this barrier and proposes to waive the restriction by the year 2020; finally, there is reported resistance from medical professionals’ associations and government officials who do not prioritize community health programmes [24-29].

Albeit this reality, there are existing factors that can facilitate a legal and policy shift to advance uptake of the approach: There is national recognition of the HRH crisis in Uganda and appreciation of Task sharing as one of the ways to address this crisis, considering that it has been adopted to a small extent and reflected in some policies such as the FP CIP. If the legal environment is clarified, the approach can be scaled up; there is resident expertise on task sharing as well as extensive international guidance to inform the development of a national policy. From this analysis, we have identified a few options to support legal reforms that advance task sharing:

- a) **Enforce the Health Service Commission Act:** Section 8(1) c of the act mandates the Commission to review the terms and conditions of service, standing orders, training and qualifications of members of the health service and any other matters connected with their management and welfare and to make recommendations on them to government. The Commission can, therefore, develop regulations to spell out the scope of task sharing and also issue standing orders on the approach. The commission can further amend its health recruitment guidelines to provide for instances where health workers are allowed to perform tasks outside their job specifications. This could be supported with comprehensive clinical guidelines on flexible roles of health professionals.
- b) **Utilize the Director General’s (DG) mandate:** Under the Medical and Dental Practitioners Act, a person authorized by the DG of Health Services may give medical or dental treatment in a government medical institution after appropriate training. However, such a person is not allowed to possess or use any drugs, instruments or appliances other than those authorized by the DG or even to charge or receive any fee or other consideration for the treatment rendered to a person. Under this option the DG may authorize lower-level health professionals to undertake duties of medical and dental practitioners as long as they have what the law describes as appropriate training.
- c) **Amend the regulations of health professional regulatory bodies:** Health professional regulatory bodies have a mandate to regulate the quality of services provided under task sharing because they exercise control over human resources for health. These bodies can, therefore, amend their regulations to protect and regulate their members who may

perform tasks that they are not legally accredited to perform by creating standards for accrediting them. Since these organizations also control the training of professionals, they can elevate standards for training to widen the scope of tasks performed by lower cadres.

d) Develop regulations to support implementation of the health professionals acts: The Allied Health Professionals Act, the Nurses and Midwives Act, the Medical and Dental Practitioners Act and the Pharmacy Act empower the Minister of Health to make regulations to support their implementation. Unlike laws, regulations do not have to go through parliamentary and cabinet approval to be developed and rendered applicable in the legal system. The MoH also has the opportunity, without seeking parliamentary approval, to define the scope of Task sharing. However, considering that many acts prohibit lower cadres from performing tasks reserved for higher cadres, the regulations on task sharing would not hold unless these acts are amended.

e) Develop a comprehensive act of parliament: Task sharing are already practiced in Uganda and should be supported by a comprehensive legal and regulatory framework. Proposed provisions include permitting health workers to perform shifted tasks, permitting regulatory bodies to accredit them, removing criminal liability for performing shifted tasks, creating standards of quality assurance and protecting the rights of providers, which includes remuneration for extra services provided. A comprehensive act can be presented as a private member's bill or a cabinet bill. The challenge with this approach is that the legislative process through which an act of parliament is created is long. Furthermore, if it is introduced as a private member's bill, it would be difficult to find champions in parliament to advance the cause, given that the legal and policy situation surrounding Task sharing is complex and maybe difficult to understand.

f) Enact ordinances at the district level: Under the Local Government Act, district councils have powers to make laws consistent with the Constitution. This includes laws on provision of services such as health care. The laws are introduced by way of a local bill, which the district council forwards to the Attorney General to certify. The bill is then signed by the District Chairperson, gazetted and eventually passed as an ordinance. Every member of the district council or city council has a right to introduce a bill for an ordinance in the council. The impact of such regulations would be limited, as they apply only in the district that passes them.

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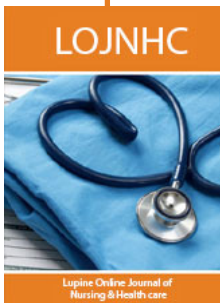
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