

# **TASK SHIFTING AND TASK SHARING POLICY FOR MATERNAL AND NEWBORN HEALTH CARE IN NIGERIA**



Federal Ministry of Health

4/1/2013

## CONTENTS

---

Acronyms .....	2
Acknowledgements .....	3
Members of the TSWG .....	<b>Error! Bookmark not defined.</b>
Task Shifting and Sharing Policy for Emergency Obstetric and Newborn Care Services in Nigeria.	4
1. Background .....	4
1.1. Burden of maternal and newborn mortality in Nigeria.....	4
1.2. Skilled birth attendance and maternal mortality .....	5
2. Human resources for health in Nigeria.....	8
3. Task shifting policy for nigeria .....	11
3.1 What is Task Shifting? .....	11
3.2. Justification for a task-shifting and task-sharing policy in Nigeria.....	11
3.3. revised Obstetric and Newborn Signal Functions.....	13
4. Task shifting recommendations for maternal and newborn health in nigeria	14
4.1 Objectives of the task shifting policy .....	14
4.2 List of maternal and newborn health care tasks for different cadres of skilled birth attendants.....	14
4. Implications for implementation .....	18

## ACRONYMS

---

<b>ACCESS</b>	Access to Clinical and Community Maternal, Neonatal and Women's Health Services
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>ANC</b>	Antenatal Clinic
<b>ART</b>	Antiretroviral Therapy
<b>BPCR</b>	Birth Planning and Complication Readiness
<b>CDD</b>	Community Directed Distributor
<b>CHEWs</b>	Community Health Extension Workers
<b>CHO</b>	Community Health Officer
<b>CHPRBN</b>	Community Health Practitioners' Registration Board Of Nigeria
<b>CIDA</b>	Canadian International Development Agency
<b>CME</b>	Continuing Medical Education
<b>CPD</b>	Continuing Professional Development
<b>CPR</b>	Contraceptive Prevalence Rate
<b>CTC</b>	Core Technical Committee
<b>FMOH</b>	Federal Ministry of Health
<b>FP</b>	Family Planning
<b>HCW</b>	Health Care Worker
<b>HIV</b>	Human Immunodeficiency Virus
<b>IMNCH</b>	Integrated Maternal, Newborn and Child Health
<b>IPTp</b>	Intermittent Preventive Treatment In Pregnancy
<b>IUCD</b>	Intrauterine Contraceptive Device
<b>LGA</b>	Local Government Area
<b>LHW</b>	Lay Health Worker
<b>MCHIP</b>	Maternal and Child Health Integrated Program
<b>MDG</b>	Millennium Development Goal
<b>MIP</b>	Malaria In Pregnancy
<b>MMR</b>	Maternal Mortality Ratio
<b>MOH</b>	Ministry of Health
<b>MSS</b>	Midwifery Service Scheme
<b>MVA</b>	Manual Vacuum Aspiration
<b>NCH</b>	National Council Of Health
<b>NDHS</b>	Nigeria Demographic and Health Survey
<b>NMCN</b>	Nursing and Midwifery Council Of Nigeria
<b>NMR</b>	Neonatal Mortality Rate
<b>NPHCDA</b>	National Primary Health Care Development Agency
<b>PATHS 2</b>	Partnership For Transforming Health Systems
<b>PHC</b>	Primary Health Care
<b>SBA</b>	Skilled Birth Attendant
<b>STIs</b>	Sexually Transmitted Infections
<b>TBA</b>	Traditional Birth Attendant
<b>TSWG</b>	Task Shifting Working Group
<b>VCT</b>	Voluntary Counseling And Testing
<b>WHO</b>	World Health Organization

## ACKNOWLEDGEMENTS

---

The Task Shifting and Sharing Technical Working Group wishes to thank all those who in one way or the other supported the development of this policy document which is aimed at increasing access of the most vulnerable in our communities to quality maternal and newborn care in an effort to significantly reduce the unacceptably high mortality ratios and to achieve set MDG targets for the country. The TSWG is particularly grateful to the Honorable Minister of Health, Prof. Onyebuchi Chukwu for his support and guidance and to Dr. Wapada Balami, Head of the Family Health Department and the Head of Planning Research and Statistics Department for their support. We also acknowledge all the members of the Core Technical Committee (CTC) of the IMNCH Secretariat and the TSWG members listed below who reviewed the document. The TSWG is also very grateful to the MacArthur Foundation that is funding this project.

## PARTICIPANTS AT TASK SHIFTING STAKEHOLDERS MEETINGS

---

1. Dr. Wapada Balami, Head, Family Health Department (FHD), FMOH
2. Dr. (Mrs) Bose Adeniran, Deputy Director, FHD
3. Mrs. B. Osuntogun, FHD
4. Dr. Chris Egah, FHD
5. Dr. Tony Udoh, HRH Unit, Planning, Research and Statistics Department, FMOH
6. Alheri G Yusuf, Nursing and Midwifery Council of Nigeria
7. Mr. Shiono A. Bennibor, Registrar, Community Health Practitioners Registration Board of Nigeria
8. Dr. Mohammed Abdullahi, Director, NPHCDA
9. Dr. Ugo Okoli, NPHCDA and SURE-P Project
10. Mrs. Mmeme G. Adiari, Community Health Practitioners Registration Board of Nigeria
11. Dr. Peter Johnson, Director of Global Learning, Jhpiego Baltimore, USA
12. Prof. E.O. Otolorin, Country Director, Jhpiego Nigeria
13. Dr. Oniyire Adetiloye, HIV/AIDS Program Director, Jhpiego Nigeria
14. Mr. Bright Orji, Jhpiego Nigeria
15. Dr. Fred Achem, President of SOGON
16. Dr. Olusegun Adeoye, Executive Secretary, SOGON
17. Dr. Habib Sadauki, Deputy Chief of Party, TSHIP.
18. Dr. Jaiyola Oyetunji, Preservice Education Advisor, TSHIP Project, Bauchi.
19. Dr. Halima Mukaddas, Preservice Education Advisor, TSHIP Project, Bauchi.
20. Dr. Shittu Abdu-Aguye, Population Council, Abuja
21. Dr (Mrs) Abimbola Williams, Save the children, Abuja
22. Dr. Kole Shettima, Country Director, MacArthur Foundation, Abuja

## TASK SHIFTING AND SHARING POLICY FOR EMERGENCY OBSTETRIC AND NEWBORN CARE SERVICES IN NIGERIA

---

### 1. BACKGROUND

---

#### 1.1. BURDEN OF MATERNAL AND NEWBORN MORTALITY IN NIGERIA

---

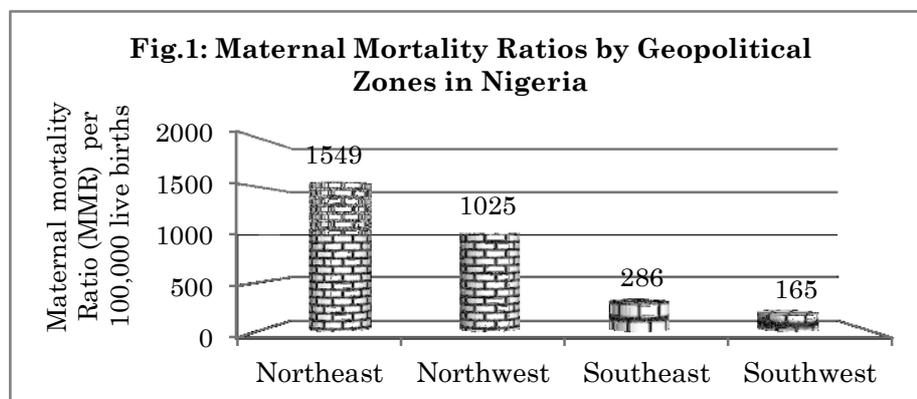
Nigeria's health and development indicators have been generally unsatisfactory, especially in the Northern states of the country. Even though Nigeria contributes only 2.4% to the world's population of 7 billion, it contributes over 14% to the global maternal mortality burden which is approximately 358,000 maternal deaths per annum<sup>1</sup>. In total numbers, the burden of maternal deaths in Nigeria which is put at 40,000 deaths annually is only second to India in its contribution to the global burden.

According to the 2008 National Demographic and Health Surveys, the national **maternal mortality ratio (MMR) is estimated at 545 per 100,000 live births**<sup>2</sup>. However, the data generated in the 2008 DHS was inadequate to allow for the determination of State/Regional maternal mortality ratios for the purposes of regional comparison. Hospital data in Nigeria have shown MMRs ranging from 270<sup>3</sup> to 2420<sup>4</sup> per 100,000 live births. Furthermore, **for every woman or girl who dies, another 20-30 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 Fig.1 above). It can be seen that for every single woman who dies in Southwest Nigeria as a result of pregnancy and childbirth, 6-10 women die in the Northern States. Among the reasons given for this disparity is a lack of skilled attendance at birth in these regions, primarily due to a preference for home births conducted mostly by unskilled birth attendants (e.g. self, family members or TBAs). Other reasons for the disparity include ignorance/illiteracy, poverty, a cultural/traditional reluctance to use modern contraceptives partly due to a

- 
1. WHO. Trends in Maternal Mortality: 1990-2008. Estimates developed by WHO, UNICEF, UNFPA and The World Bank, *WHO 2010*, ISBN 978 92 4 150026 5
  2. National Population Commission [Nigeria] and ICF Macro. 2009. *Nigeria Demographic and Health Survey 2008*. National Population Commission and ICF Macro: Calverton, Maryland.
  3. Okaro JM; Umezulike AC; Onah HE; Chukwuali LI; Ezugwu OF; Nweke PC. Maternal mortality at the University of Nigeria Teaching Hospital, Enugu, before and after Kenya. *Afr J Reprod Health* 2001 Aug; 5(2): 90-7.
  4. Adamu YM; Salihu HM; Sathiakumar N; Alexander GR. Maternal mortality in Northern Nigeria: a population-based study. *Eur J Obstet. Gynecol. Reprod. Biol.* 2003 Aug 15; 109(2): 153-9 (ISSN: 0301-2115)

preference for large families, and the non-availability of contraceptives for those who wish to use them.



With respect to **newborn mortality**, the 2008 NDHS revealed that the neonatal mortality rate (NMR) for Nigeria was estimated at 40 per 1,000 live births. This translates to about 241,000 newborn deaths out of the 5.9 million babies born in Nigeria annually. In addition, approximately 30 stillbirths occur per 1000 live births, leading to a total of 163,400 stillbirths annually. The under-5 child mortality fell from 199 in 1990 to 157 deaths per 1000 in 2008. 29% of under-5 child mortality is due to newborn mortality. This trend has not changed significantly over the last couple of decades. Therefore, if Nigeria is to reduce its under-5 mortality, it must tackle the problem of newborn mortality.

## 1.2. SKILLED BIRTH ATTENDANCE AND MATERNAL MORTALITY

Dogba M and Fournier P (2009) in a systematic review of human resources and the quality of emergency obstetric care in developing countries concluded that staff shortages are a major obstacle to providing good quality EmONC and that women are often dissatisfied with the care they receive during childbirth<sup>5</sup>.

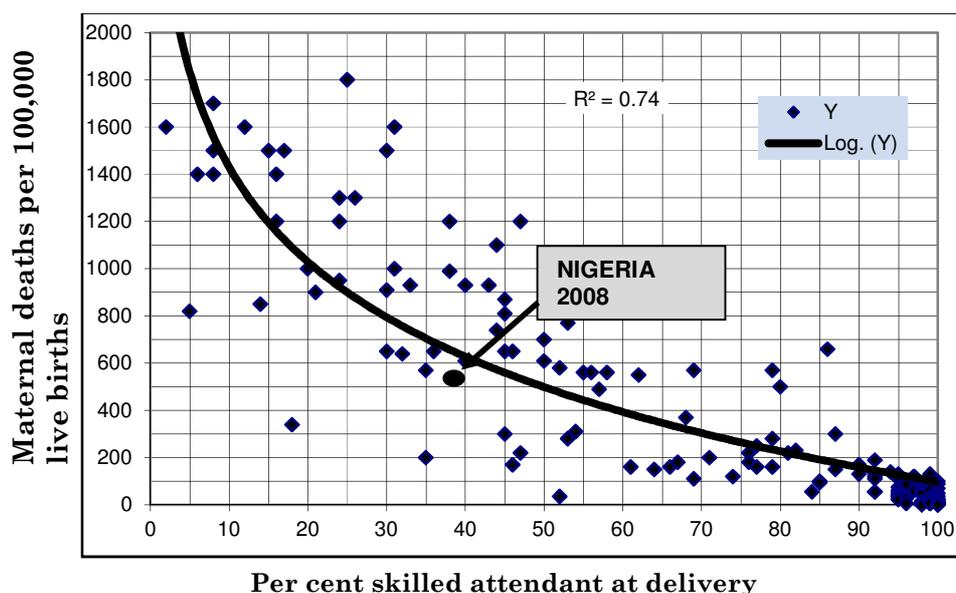
The WHO has defined a skilled birth attendant as “an accredited health professional such as a doctor, midwife, nurse **who has been trained to proficiency** in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management 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 Fig.2).

<sup>5</sup> 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 2009, 7:7 doi: 10.1186/1478-4491-7-7

In the figure, each diamond dot represents a country. It can be seen that there is an inverse relationship between maternal mortality ratios and proportion of births delivered by skilled attendants. The higher the proportion of women delivered by skilled birth attendants, the lower the maternal mortality ratio for that country.

The bigger black dot represents Nigeria where only 39% of women are delivered by skilled birth attendants while 545 maternal deaths occur per 100,000 live births (2008 NDHS). Therefore, in order for Nigeria to achieve the target set for the Millennium Development Goal (MDG) #5 which deals with *improving maternal health* by reducing MMRs by three-quarters from the 1990 figure, Nigeria will need to increase the proportion of women delivered by skilled birth attendants to about 85%. At this level, Nigeria's maternal mortality ratio will have to 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<sup>6</sup>, which will be 25 years after the current MDG target date.

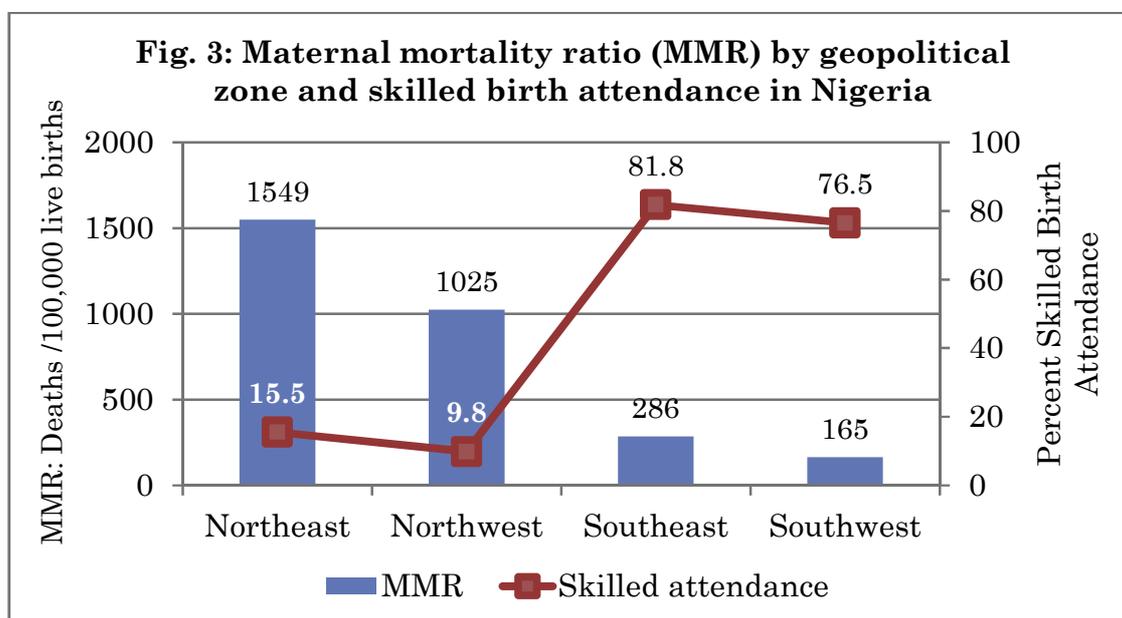
**Fig. 2: Correlation between skilled birth attendance rate and maternal mortality ratio**



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 a skilled attendant in 2008 compared to 38.9% nationally (NPC and ICF Macro 2009). As shown in Fig. 3 below, the Southwest and Southeast regions with high skilled birth attendance rates have much

<sup>6</sup> Source: [www.thelancet.com](http://www.thelancet.com) Vol 378 September 24, 2011

lower maternal mortality ratios than the Northeast and Northwest regions with low skilled birth attendance.



*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 such as tetanus immunization, prevention of malaria in pregnancy, prevention of mother-to-child transmission of HIV, detection and management of hypertensive disorders of pregnancy, detection and prompt treatment of sexually transmitted infections such as syphilis, nutritional supplementation with iron and folic acid, deworming where hookworms are endemic and birth planning and complication readiness education etc.

Despite the abundant evidence that **healthy timing of pregnancy and child birth through the use of family planning saves lives of mothers and newborns**, the total contraceptive prevalence rate (CPR) in the Northwest of Nigeria is 2.8%, with only 2.5% of married women using a modern method of family planning (FP). The corresponding figures for all of Nigeria are: 14.6% and 9.7% for all methods and modern methods respectively. What this really means is that 98% of women of reproductive age in Northern Nigeria do not use contraceptives. While majority may be ignorant of the benefits of family planning, at least 20% of them who are aware and willing to use contraceptives have no access to them. This is what is referred to as the *unmet need* for FP.

Educational levels of females in Nigeria are low, with only about 64% having at least some primary school education (only 25.8% in the Northwest Zone). 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. The resultant effect is that the region has the highest number of children per woman (total fertility rate) in the country, 7.3 compared to the national average of 5.7 children per woman.

## 2. HUMAN RESOURCES FOR HEALTH IN NIGERIA

---

Even though a National Policy on 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) and funded by the MacArthur Foundation found that there was neither a clear definition of a Skilled Birth Attendant (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 for an SBA in Nigeria. The recommended definition, modified from the World Health Organization (WHO) definition, says:

*“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 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. These cadres are also sometimes referred to as Senior CHEWs. The CHEWs curriculum currently covers 90 hours of mostly didactic lectures. The goal of the reproductive health 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 the anatomy and physiology of the male and female reproductive system
- Understand the concept of reproductive health and rights, including family planning
- Understand the process of pregnancy
- Understand the management of labor according to acceptable standards
- Understand the care of the mother and child during the puerperium
- Understand population dynamics and the benefits of family planning
- Understand abortion and its possible complications
- Understand the concept of infertility
- Understand menopause and andropause
- Understand the concept of female genital mutilation (FGM)

- Know the 'at risk' pregnant woman for prompt referral

This curriculum does not make enough provisions for developing the skills of CHEWs as skilled birth attendants. CHEWs have not been generally welcome in delivery rooms where needed 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 such certificated CHEWs find themselves alone in remotely located PHCs where the communities have great expectations, they begin to experiment with some of the life-saving 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 et al, professional competence can be achieved by using a more skilled-based training approach, supported by regular clinical supervision.

In Nigeria, the health care worker (HCW) to population density (20 doctors, nurses and midwives per 10,000 population) is a little below the WHO recommendations of 23 per 10,000<sup>7</sup>. 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 South-Western part of the country with the majority living in the commercial city of Lagos. Table 1 below shows a health care worker to population density in the country.

**Table 1: Status of skilled birth attendants in Nigeria compared to WHO recommendations**

Cadre	Number	WHO recommended HCW/Population density per 10,000	Actual HCW/Population density in Nigeria (per 10,000 population)
<b>Doctors</b>	58,325	5.5	4 per 10,000 <sup>8</sup> Ranging from 0.11 in Adamawa State to 4.48 per 10,000 in Kwara State
<b>Nurses and Midwives</b>	137,198	17	16 <sup>6</sup> per 10,000 Range not available.
<b>Community health practitioners</b>	117,568	NA	20 <sup>9</sup> per 10,000 Range not available

<sup>7</sup> WHO: Global Atlas of the Health Workforce, August 2010.

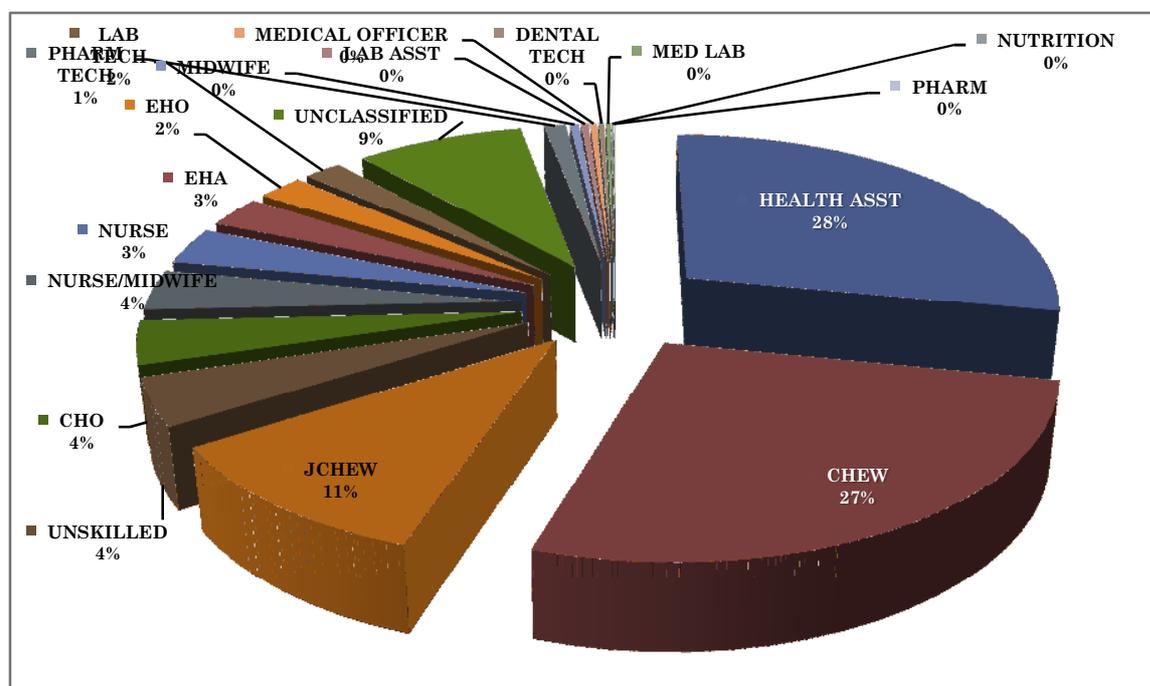
<sup>8</sup> WHO, World Health Statistics 2012

<sup>9</sup> Federal Ministry of Health, 2006

It can be seen that Nigeria has approximately 20 CHEWs per 10,000 population which is a largely untapped resource for emergency obstetric and newborn care. It is also noteworthy that the States with the lowest density of skilled birth attendants have the highest maternal mortality ratios in the country, thereby necessitating the need to empower the CHEWs to provide the much needed maternity services which 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 community health practitioners (CHWs) working in the PHCs as against only 5604 skilled birth attendants (doctors, nurses and midwives). Fig. 4 below shows the distribution of human resources at the PHCs. 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 antenatal care, indicating serious gaps in their level of skills.

**Figure 1: Distribution of health care workers in Primary Health Care Centres (Source: NPHCDA)**



*N.B Nurse-midwives are health care workers with double qualifications as a registered nurse and a registered midwife.*

### 3. TASK SHIFTING POLICY FOR NIGERIA

---

#### 3.1 WHAT IS TASK SHIFTING?

---

The World Health Organization 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”<sup>10</sup>. 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”**<sup>11</sup>.

Task shifting has been used in a number of countries to address the human resource shortages that militate the provision of critical services like HIV testing and treatment with antiretroviral drugs or community distribution of injectable contraceptives. In Malawi and Uganda, the basic care package for people living with HIV/AIDS has been designed to be delivered by non-specialist doctors or by nurses supported by community health workers and people living with HIV/AIDS<sup>12</sup>.

Already, the National Guidelines for the integration of Reproductive Health and HIV programs published by the FMOH in 2008 recommends that community health workers (CHEWs, CHOs) can be trained to provide certain services at PHCs including advocacy, mobilization and awareness creation on HIV/AIDS, health education about HIV/AIDS, HIV counseling and testing using RDTs, universal precautions for infection control and referral of HIV positive clients to secondary facilities<sup>13</sup>. This is the first formal documentation of task shifting related to HIV/AIDS care in Nigeria.

#### 3.2. JUSTIFICATION FOR A TASK-SHIFTING AND TASK-SHARING POLICY IN NIGERIA

---

The shortage of skilled birth attendants in Nigeria is accentuated by a maldistribution of available cadres skewed in favor of urban locations in the Southern states of the country. Other factors responsible for this shortage include a freeze on employment in the public service of some States, poor working environment leading to external and internal brain drain to other professions. At the local government area LGA level, there

---

<sup>10</sup> WHO: Task Shifting-Global recommendations and guidelines, 2008

<http://www.who.int/healthsystems/TTR-TaskShifting.pdf>

<sup>11</sup> World Health Organization (WHO). Working together for health: the World Health Report 2006. Geneva, Switzerland: World Health Organization, 2006. Available: [http://www.who.int/whr/2006/whr06\\_en.pdf](http://www.who.int/whr/2006/whr06_en.pdf)

<sup>12</sup> Samb B, Celletti F, Holloway J, Van Damme W, Lawson L, De Cock K, Dybul M. 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, 2007.

<sup>13</sup> FMOH, 2008. National Guidelines for the integration of reproductive health and HIV programs in Nigeria

appears to be a preference for hiring CHEWs rather than nurse/midwives because of their lower remuneration package even though these CHEWs have not been trained to competency to provide 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 and basic emergency obstetric and newborn care services should be available 24 hours a day and 7 days a week in such centers if Nigeria's high maternal and newborn mortality rates are to be significantly reduced. Regrettably very few skilled birth attendants (doctors, nurse and midwives) can be found at this level of health care delivery. Rather, most PHCs are staffed by CHEWs who have not been trained to proficiency in basic emergency obstetric and newborn care, partly because there has been no clear policy on their role in the fight against maternal and newborn mortality. As can be seen in Fig. 4 above, community health workers (CHOs, CHEWs and JCHEWs) constitute 42% of all human resources at the PHC level with nurses, midwives or doctors (recognized as SBAs) constituting only 7%. To address this problem of shortage of skilled birth attendants 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 health care workers (especially CHEWs) on how they can best contribute to the reduction of maternal and newborn mortality in Nigeria.

A few programs in-country have demonstrated the fact that CHEWs can be trained to proficiency to provide routine and basic emergency obstetric and newborn care services and family planning at PHCs. Examples of such projects include the ACCESS and MCHIP projects implemented in Zamfara, Kano and Katsina States, the on-going 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 etc. Some of these projects have demonstrated that CHEWs, when trained to competency, can provide focused antenatal care, normal delivery care, prevention and initiation of treatment for postpartum haemorrhage, initiation of treatment and referral for eclampsia, manual vacuum aspiration for incomplete miscarriage and health promotion for safe motherhood and healthy timing and spacing of pregnancies.

For example, in the ACCESS/MCHIP projects, trained CHEWs working in 23 PHCs provided delivery services to 651 women in FY08 rising to 1177 in FY09, 1285 in FY10 and 2144 in FY11<sup>14</sup>. Also, a recent study in Nigeria followed 1421 women who used misoprostol during home births, either self-administered or administered by a lay health worker (LHW) such as a traditional birth attendant. Postpartum interviews confirmed that 1394 women (98%) took three tablets as directed and 1248 (88%) used the correct

---

<sup>14</sup> ACCESS/MCHIP project database 2011.

timing and suggested route of administration (oral)<sup>15</sup>. Also in a Malaria in Pregnancy (MIP) program in Akwa Ibom state, the use of Community Directed Distributors (CDDs) increased access to two doses of IPTp (intermittent preventive treatment of malaria in pregnancy using sulphadoxine-pyrimethamine) from 27.7% to 76.7% in the catchment intervention areas compared to an increase from 32.1% to 50.0% in the communities around the control clinics ( $p=0.0001$ ). These are examples of successful task shifting projects in the country.

### 3.3. 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 health care workers are trained to proficiency in the prevention, detection and/or treatment of complications arising in pregnancy, labour/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 below lists proposed obstetric and newborn signal functions that will enable frontline health care workers to fulfill maternity care expectations. Therefore, it is critical that in the absence of physicians and nurse/midwives, who have been trained to proficiency to provide these services, CHEWs can be trained to share the tasks for routine care and basic emergency obstetric and newborn care as outlined in Table 2 below.

**Table 2: Proposed maternal and newborn signal functions modified from Gabrysch S et al.<sup>16</sup>**

Maternal care	Newborn care
<b>A. Routine care for all mothers and newborns</b>	
Monitoring and management of labour using the partograph	Thermal protection
Infection prevention measures (hand-washing, use of gloves)	Immediate (within 1 hour of birth) and exclusive breastfeeding
Active management of the third stage of labour (AMTSL)	Infection prevention including hygienic cord care and application of chlorhexidine to prevent umbilical cord sepsis
<b>B. Basic emergency care (for mothers and babies with complications)</b>	

<sup>15</sup> 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

<sup>16</sup> 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

<b>Maternal care</b>	<b>Newborn care</b>
Parenteral administration of magnesium sulfate for severe pre-eclampsia and eclampsia	Antibiotics for preterm or prolonged premature rupture of membranes (PROM) to prevent infection
Assisted vaginal delivery (e.g. vacuum extraction)	Corticosteroids in preterm labour
Parenteral antibiotics for maternal infection	Resuscitation of non-breathing baby (using bag and mask)
Parenteral administration of oxytocic drugs for haemorrhage	Kangaroo Mother Care (KMC) 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
Use of antiretroviral drugs for PMTCT if mother is HIV-positive	Use of antiretroviral drugs for HIV-exposed babies
<b>C. Comprehensive emergency care (functions in addition to Basic)</b>	
Surgery (e.g. Caesarean section, laparotomy for ectopic pregnancy) including provision of anesthesia	Intravenous fluids
Blood transfusion	Safe administration of oxygen

#### 4. TASK SHIFTING RECOMMENDATIONS FOR MATERNAL AND NEWBORN HEALTH IN NIGERIA

##### 4.1 OBJECTIVES OF THE TASK SHIFTING POLICY

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

1. To increase access of pregnant women in hard to reach areas to skilled attendance at birth
2. To clearly outline the MNH related tasks that can be performed by different cadres of frontline health care workers attending to pregnant women and their babies at PHCs.
3. To provide a legal framework for empowering community health workers (CHOs and CHEWs) to provide quality maternal and newborn care services, especially at PHCs

##### 4.2 LIST OF MATERNAL AND NEWBORN HEALTH CARE TASKS FOR DIFFERENT CADRES OF SKILLED BIRTH ATTENDANTS

The tasks listed in Table 2 above are just the critical tasks needed for quality maternal and newborn care. However, a more comprehensive list of tasks can be viewed in Tables 3, 4 and 5 below. These recommended tasks have been developed for the three available cadres of health care workers, namely CHEWs, Nurse/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 maternal and newborn care and basic EmONC services including referral for comprehensive EmONC services when needed. In any case, the reality on 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 in order to hide the information. Hence, the formal approval of this policy recommendation will provide the legal framework for the review of CHEWs preservice and in-service training curricula and adaptation of appropriate training materials and methods.

**Table 3: Task Shifting/Sharing Policy Recommendation for Frontline Health Care Workers**

Task	CHEWS	Nurses/ Midwives	Medical officers
<b>Overarching Tasks</b>			
Communicate effectively cross-culturally in order 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 and case audits	√	√	√
<b>Antenatal Care Tasks</b>			
Takes a detailed history by asking relevant questions	√	√	√
Assesses needs of women and her family	√	√	√
Gives appropriate advice and guidance	√	√	√
Calculates the expected date of delivery	√	√	√
Performs screening tests including VCT for HIV.	√	√	√
Assists pregnant women and their families in Birth Planning and Complication Readiness (BPCR)	√	√	√
Educates a women and her family regarding self-care during pregnancy, childbirth and the postnatal period	√	√	√
Identifies prenatal complications (anemia, pre-eclampsia, eclampsia, bleeding, malaria, other	√	√	√

Task	CHEWS	Nurses/ Midwives	Medical officers
medical complications), performs first-line management, life-saving procedures and ensures effective referral			
Manages severe pregnancy complications (anemia, pre-eclampsia, eclampsia, bleeding, malaria, other medical complications)	NO	✓	✓
Manages fetal mal-presentation	NO	✓	✓
Manages multiple gestation	NO	✓	✓
<b>Labor and Delivery Tasks</b>			
Performs vaginal examination	✓	✓	✓
Identifies onset of labour	✓	✓	✓
Uses partograph to monitor progress of labour, maternal and fetal well-being and take appropriate action, including referral where required	✓	✓	✓
Identifies labour complications ( mal-presentations, prolonged and/or obstructed labour, hypertension, bleeding, and infection), performs first-line management, life-saving procedures and ensures effective referral	✓	✓	✓
Manages labour complications (mal-presentations, prolonged and/or obstructed labour, hypertension, bleeding, and infection)	NO	✓	✓
Provides supportive care	✓	✓	✓
Facilitates support by companion of choice	✓	✓	✓
Promotes infection prevention	✓	✓	✓
Provides pain relief	✓	✓	✓
Performs episiotomy	✓	✓	✓
Manages normal vaginal delivery	✓	✓	✓
Performs vacuum extraction delivery	✓	✓	✓
Performs outlet forceps delivery	NO	NO	✓
Performs cesarean	NO	NO	✓
Provides anesthesia during Cesarean	NO	NO	✓
<b>Immediate Post-Natal Tasks</b>			
Performs active management of the third stage of labor	✓	✓	✓
Administers uterotonic (Oxytocin or misoprostol)	✓	✓	✓
Performs manual removal of retained placenta with active bleeding	✓	✓	✓
Refers woman with retained placenta and no active bleeding	✓	✓	✓ (if in doubt of

Task	CHEWS	Nurses/ Midwives	Medical officers
			skills)
Performs Bi-manual compression of uterus in case of uncontrolled hemorrhage	✓	✓	✓
Applies an anti-shock garment in case of uncontrolled hemorrhage	✓	✓	✓
Starts and maintain administration of IV fluids	✓	✓	✓
Repairs episiotomy	✓	✓	✓
Repairs a simple vaginal laceration	✓	✓	✓
Repairs a complex vaginal laceration	NO	✓	✓
Repairs a cervical laceration	NO	✓	✓
Provides blood transfusion	NO	✓	✓
Identifies preeclampsia/eclampsia, performs first line management and ensures effective referral	✓	✓	✓
Manages preeclampsia and eclampsia	✓	✓	✓
<b>Immediate Newborn Care Tasks</b>			
Provides essential newborn care (warm, dry, wrapping, cord care)	✓	✓	✓
Promotes initiation of breastfeeding	✓	✓	✓
Identifies newborn complications (asphyxia, low birth weight, anomaly), performs first-line management, life-saving procedures and ensures effective referral	✓	✓	✓ (if in doubt of skills)
Manages newborn complications	NO	NO	✓
Provides early infant male circumcision	NO	✓	✓
<b>Post-Natal Care Tasks</b>			
Provides information and counseling on self-care, nutrition, safer sex, breastfeeding, family planning, healthy lifestyle	✓	✓	✓
Assesses maternal wellbeing including maternal nutrition	✓	✓	✓
Supports exclusive breastfeeding	✓	✓	✓
Supports women living with HIV/AIDS including ART	✓	✓	✓
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 preventative measures against malaria	✓	✓	✓
Identifies post-natal complications (puerperal sepsis, cord sepsis, depression, anaemia, mastitis), performs first-line management, life-saving procedures and ensures effective referral	✓	✓	✓

Task	CHEWS	Nurses/ Midwives	Medical officers
Manages mild to moderate anaemia, mild puerperal depression, mastitis and uncomplicated malaria), referring when necessary	✓	✓	✓
Provides contraceptive method or refers as necessary	✓	✓	✓
Performs tubal ligation	NO	NO	✓
Performs vasectomy	NO	NO	✓
Inserts contraceptive implant	✓	✓	✓
Inserts IUCD	✓	✓	✓
<b>Post-Miscarriage Care</b>			
Provides contraceptive method or refers as necessary	✓	✓	✓
Provides emergency contraceptive	✓	✓	✓
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, life-saving procedures and ensures effective referral	✓	✓	✓
Manages complications to miscarriage (bleeding, sepsis)	✓	✓	✓
Performs uterine evacuation (MVA) for incomplete miscarriage	✓	✓	✓
Screens women for STIs/HIV, takes first line measures and ensures effective referral	✓	✓	✓
Treats women with STIs	✓	✓	✓
Supports women living with HIV/AIDS including ART	✓	✓	✓
Manages ectopic pregnancy	NO	NO	✓

## 5. IMPLICATIONS FOR IMPLEMENTATION

1. The approval of this task-shifting policy by the National Council for Health (NCH) will give clear guidelines on the 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.
2. 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.
3. 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 training curriculum review to guide preservice education.
4. All training activities to build the capacity of these health care workers (be it pre-service or in-service) will have to re-emphasize skills development rather than knowledge acquisition. For the training of CHEWs, a *Low Dose High Intensity Training* approach should be adopted. To this end, all preservice 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.
  5. Once the policy is approved, professional regulatory bodies should emphasize capacity building for new skills in their Continuous Professional Development (CPD) programs and tie certification, licensure, registration and career progression to receipt of approved CMEs
  6. The FMOH and State MOH will need to invest in post-training supportive supervision and provision of additional on-the-job training (OJT) to ensure that health care workers maintain their skills.
  7. The referral systems between PHCs and Hospitals will need to be strengthened for mentorship of CHEWs and Nurse/midwives while providing the best available quality service to the clients.
  8. A monitoring and evaluation system will have to be put in place to track service utilization, compliance with set performance standards and patient outcomes in order to provide evidence of the effectiveness of this approach to solve the acute human resource shortages in some parts of the country.
  9. Governments at national and sub-national levels will have to develop a basket of staff retention incentives to ensure that trained frontline health workers do not move out of the health care delivery systems.
  10. The timing of these policy development is very appropriate as the Government of Nigeria is launching the 'Saving One Million Lives' project to be funded under the Subsidy Re-investment Program (SURE-P).
  11. In order to ensure long-term sustainability, stakeholders should advocate to the National Assembly for a speedy passage and Presidential assent of the National Health Bill.