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Policy Brief

IMPLEMENTATION OF TASK SHARING GUIDELINES FOR LONG-ACTING AND PERMANENT METHODS[1]

In the context of family planning (FP), *task sharing* is the systematic redistribution of FP counseling and method provision to expand the range of health workers who can deliver these services. Task sharing can bolster numerous high-impact practices (High-Impact Practices in Family Planning, 2019) and address the shortage of skilled health providers, particularly in low- and middle-income countries (LMICs), through a more rational distribution of tasks and responsibilities. This practice has been proven to increase access to FP and reproductive health services as well as to support cost effectiveness (World Health Organization [WHO], 2017). THE WHO has developed two guidance documents on task sharing and task shifting (see text box) for evidence-based optimization of maternal and newborn health, FP, and contraceptive use.[2]

According to the WHO, *task shifting* is the complete delegation of tasks to less specialized health workers. *Task sharing* refers to expanding the range of health workers who can appropriately deliver services by capacitating additional cadres to take on identified tasks, such as counseling and provision of contraceptive methods. The latter is the preferred approach. Hence, there is more reference to task sharing as opposed to task shifting in this document, although the terms are sometimes used interchangeably.

[1] This brief is basesd upon a longer report: Implementation of the World Health Organization's Task Sharing Guidelines for Long-Acting Reversible Contraceptives and Permanent Methods across MOMENTUM Safe Surgery in Family Planning and Obstetrics Countries: Desk Review.

[2] In 2012, the WHO released *Optimizing Health Worker Roles to Improve Access to Key Maternal and Newborn Health Interventions through Task Shifting*, including guidance on the use of various cadres of health worker to provide FP. WHO released a second, complementary document in 2017, *Task Sharing to Improve Access to Family Planning/Contraception*, which includes a summary of recommendations for FP and contraception services specifically and provides further clarity on the similarities and differences between task sharing and task shifting.

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Several LMICs, particularly in Sub-Saharan Africa (SSA), made commitments at various global and regional fora (e.g., FP2020) to increase access to a wide range of FP methods, including long-acting reversible contraceptives (LARCs) and permanent methods (PMs), through task sharing. LARC provision by healthcare providers other than medical doctors and physicians is generally accepted globally. Prior reviews indicate that national guidelines in most LMICs, particularly those in SSA, allow nurses, midwives, associate clinicians, clinical officers, health technicians, health officers, advanced clinical associates, advanced clinical officers, and assistant medical officers to provide LARCs. Some LMICs, such as Nigeria, have gone further, developing policies that allow trained lay workers (e.g., community health extension workers [CHEWs]) to provide implant and intrauterine device (IUD) information and services in health facilities and at community levels. Unlike LARCs, most countries in SSA limit the provision of PMs to doctors and specialists, even in settings where such services could potentially be performed by other cadres of healthcare providers.

The WHO recommendations for task sharing present categories of healthcare providers and supply guidance on what different cadres within the health system are authorized to do in relation to the provision of contraceptive information and services, as well as the contexts in which they are allowed to offer contraceptive services. Table 1 presents the WHO's recommendations about FP services that can be performed by varying cadres of health workers effectively and safely.

Table 1: WHO Guideline Recommendations for Task Sharing of Contraception (2017)

FP Methods and Services Typically Offered by Cadre of Service Provider

National policies and service delivery guidelines dictate which cadres of providers can offer specific FP services. The chart below shows the FP methods that are typically offered by these cadres of providers based on recommendations from WHO.

Contraceptive Service	Lay Health Workers (e.g., CHWs)	Pharmacy Workers	Pharmacist	Auxiliary Nurse	Auxiliary Nurse Midwife	Nurse	Midwives	Associate/ Advanced Associate Clinicians	Non-specialist doctors	Specialist doctors
• Informed choice counselling • Combined oral contraceptives (COCs) • Progesterone-only oral contraceptives (POPs) • Emergency contraceptive pills (ECPs) • Standard Days Method and TwoDay Method • Lactational amenorrhea method (LAM) • Condoms (male & female), barrier methods, spermicides	✓*	✓*	✓*	✓*	✓*	✓*	✓*	✓*	✓*	✓*
• Injectable contraceptives (DMPA, NET-EN or CICs)	✓	✓	✓	✓	✓	✓*	✓*	✓*	✓*	✓*
• Implant insertion and removal	R✓	✗	✗	✓	✓	✓	✓	✓*	✓*	✓*
• Intrauterine device (IUD)	✗	✗	✗	R✓	✓	✓	✓	✓*	✓*	✓*
• Vasectomy (male sterilization)	✗*	✗*	✗*	R✓	R✓	R✓	R✓	✓*	✓*	✓*
• Tubal ligation (female sterilization)	✗*	✗*	✗*	✗*	✗*	R✓	R✓	✓*	✓*	✓*

✗* Considered outside of the typical scope of practice; evidence not assessed.	✗ Recommended against	R✓ Recommended in the context of rigorous research	✓ Recommended in specific circumstances	✓ Recommended	✓* Considered within typical scope of practice, evidence not assessed.

All of the recommendations above assume that the assigned health workers will receive task specific training prior to implementation. The implementation of these recommendations also requires functioning mechanisms for monitoring, supervision, and referral.

The recommendations are applicable in both high- and low- resource settings. They provide a range of types of health workers who can perform the task safely and effectively. The options are intended to be inclusive, and do not imply either a preference for or an exclusion of any particular type of provider. The choice of specific health worker for a specific task will depend upon the needs and conditions of the local context.

CONTEXT

MOMENTUM Safe Surgery in Family Planning and Obstetrics is a five-year project funded by the United States Agency for International Development. The project supports countries to strengthen safe surgery within FP and maternal health programs by promoting evidence-based approaches. These include well-

structured and supervised task sharing as a strategy for increasing access to LARCs and PMs as part of full, free, and informed method choice.

The project conducted a desk review of national health systems documents (policies and guidelines, regulatory frameworks, healthcare provider scopes of practice, and related training resources) and identified global evidence, including published and grey literature on task sharing, to determine the extent to which its implementation countries[3] had adopted and operationalized the WHO task sharing recommendations to increase access to high-quality FP information and services. Of 41 sourced documents, 32 were eligible for the review based on date of publication (2012 to 2021) and a focus on LARCs and PMs. In addition to identifying the extent to which countries have codified the WHO recommendations within guidance documents, the review also identified key challenges, barriers, and opportunities for effective implementation of task sharing guidelines, where they exist. Findings from this review are being widely disseminated at global, regional, and country levels. The project is also using these findings to inform the design of country-specific technical assistance and capacity strengthening to support task sharing of voluntary LARC and PM provision. This brief synthesizes key findings and recommendations to enable donors, policymakers, advocacy groups, and program implementers to address existing policy and human resources barriers to implementation and to leverage opportunities to expand this practice.

FINDINGS

National policies, guidelines, and protocols for FP, maternal, and sexual and reproductive health should be readily accessible to all stakeholders. However, accessing the policy documents, scopes of work for different categories of healthcare providers, and LARC and PM training resources from several implementation countries for this review was at times challenging. The review revealed that the cadres of health workers responsible for the provision of LARC and PM information and services were consistent with the 11 categories of healthcare workers[4] listed in the WHO guidance documents, although their names, definitions, types of education and training, and roles and responsibilities varied significantly from country to country. Additionally, while all focal countries are adopting LARC and PM task sharing, the nature of the tasks shared varies. Signifcantly, the Democratic Republic of Congo (DRC), India, Nigeria, and Senegal either do not have or have phased out categories of healthcare workers such as clinical associates, clinical officers, health officers, or medical assistants. In addition, some cadres outside of those recommended by the WHO were providing LARC and PM services (see Implant Information and Services section for details). India is the only country from the review with indemnity coverage for all trained providers providing FP, including all catgories of nurses and midwives. In addition, providers in India are compensated for the increased responsibilities.

Nigeria is the only country with a standalone national task shifting and task sharing policy for essential healthcare services (FMOH, 2014). The other countries included in the review have embedded FP and reproductive health task sharing guidance in documents from their respective ministries (MOHFW, 2013, 2014a, 2014b, 2018; MSAS-DSME, 2020; MSAS, 2019; Rwanda Biomedical Center and MOH, 2020). National guidelines and training resources accessed from India, Mali, Nigeria, Rwanda, and Senegal included outdated infection prevention content at the time of this review. The information that follows captures how LARC and PM services are task shared among different cadres within project implementation countries and how task sharing is codified within national guidance documents.

[3] At the time of the desk review (June to November 2021), project implementation countries included Democratic Republic of Congo, India, Mali, Mozambique, Nigeria, Rwanda, and Senegal.

[4] Doctors of complementary medicine are not featured in Table 1 but are included in the 2017 WHO guidance. India is the only review country where this cadre is part of the formal health system and allowed to provide FP, including LARC services.

Implant Information and Services

Implants are offered in six of the review countries; they were not available in the public sector in India at the time of the review,[5] and information was unavailable at the time of the review for Mozambique. Where implants are offered, national documents state that insertion and removal services should be provided in healthcare facilities and not at the community level. Rwanda is an exception, in that a range of methods (including implant insertion and removal services), can be provided by the relevant cadre of health worker outside of health facilities, including in public places, such as schools during outreach events. In addition, only Rwanda's national FP guidelines permit pharmacists to insert and remove implants. However, this is contradicted by Rwanda's 2021 N*ational Reference Manual for Continuous Training in Family Planning*, which is currently under ministerial review. The project was unable to retrieve any locally generated evidence or publication in support of this practice from Rwanda or other LMICs. Furthermore, the WHO guidelines do not recommend that pharmacists or pharmacy workers perform implant or IUD services.

In Nigeria, the Federal Ministry of Health national task sharing policy states that CHEWs (who are categorized as lay workers) can deliver IUD and implant insertion and removal in healthcare facilities. It further states that CHEWs and other health professionals (such as medical doctors, nurses, and midwives) are permitted to provide information about, insert, and remove implants at different times in relation to pregnancy (interval, postpartum, and postabortion). It is notable that the CHEW cadre in Nigeria undergoes three to four years of training, which is longer than the typical period for training lay workers. The cadre is also regulated by a national entity and work mostly at health facilities. Table 2 shows which cadres are allowed to provide implant information and services in the project implementation countries where the method, and information about the method, was available.

Table 2: Cadre Allowed to Provide Implant Information and Services, by Country

Type of Information and Service, by Level	**DRC** (0.7%, DHS, 2013-14)*	**Mali** (6.7%, DHS, 2018)	**Nigeria** (3.4%, DHS, 2018	**Rwanda** (26.6%, DHS, 2019-20)	**Senegal** (9.7%, DHS, 2019)
Implant insertion and removal information and services at facility level	Specialist, medical officer, nurse, midwife, auxiliary nurse, auxiliary midwife	Specialist, medical doctor, midwife, nurse, obstetric nurse, matrone	Specialist, medical officer, nurse, midwife, nurse midwife, CHEW, community health officer (CHO)	Specialist medical officer, clinical officer, nurse, midwife, associate nurse, pharmacist	Specialist doctor, generalist doctor, *soins* obstétricaux *d'urgence* (generalist doctor competent in emergency obstetrics [SOU]), midwife, nurse, assistant nurse
Implant information at community level	*Information unavailable at time of review*	Relais, matrone, agent de santé communautaire	Junior CHEW, CHEW, CHO, community-owned resource person (CORP)	CHW	Agent de santé communautaire, acteur communautaire, relais, matrone

*% of currently married women aged 15 to 49 years who are implant users as recorded in the Demographic and Health Survey (DHS)

[5] At the time of review, implants were only offered in the private sector and the assessment did not include review of private sector guidance documents. Hormonal implants are currently being piloted through the public sector in India, reflecting a shifting landscape.

IUD Information and Services

All seven desk review countries include copper IUDs in their range of FP methods. Hormonal IUDs are included in policy documents in select countries (DRC, Mali, Nigeria, Rwanda, and Senegal); however, content and guidance on use of hormonal IUDs varies significantly. All seven focal countries reviewed provide guidance on the lowest level of facility permitted to provide IUD services, stating that IUD insertion and removal procedures should be performed in designated health facilities at a specified level within the healthcare system. Consistent with WHO recommendations, none of the guidance documents authorize provision of copper IUD services at the community level. Table 3 shows which cadres can provide copper IUD information and services at the facility level for five implementation countries. Official policy documents from DRC and Mozambique did not state which cadres were allowed to provide FP services or procedures.

Table 3: Cadre Allowed to Provide IUD Information and Services, by Country

Type of Information and Service, by Level	**India±** (2.7%, DHS, 2019-21)*	**Mali** (1.0%, DHS, 2018)	**Nigeria** (0.8%, DHS, 2018)	**Rwanda** (2.1%, DHS, 2019-20)	**Senegal** (1.9%, DHS, 2019)
Interval IUD information and services at facility level	Specialist, medical officer, Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homeopathy (AYUSH) practitioner, nurse, auxiliary nurse midwife, Lady Health Visitor (LHV)	Specialist, medical officer, matrone, medical assistant, auxiliary nurse midwife, wise wife (midwife), obstetric nurse, state certified nurse	Specialist, medical officer, nurse, midwife, nurse midwife, CHEW, CHO	Specialist, medical officer, clinical officer, nurse, midwife	Specialist, generalist doctor, SOU, midwife, nurse, assistant nurse
Interval IUD information at community level	Accredited Social Health Activist (ASHA), auxiliary nurse midwife	Relais, matrone, agent de santé communautaire	CHO, CHEW, junior CHEW, CORP	CHW	*Information unavailable at time of review*
Postpartum IUD services at facility level	Specialist medical officer, skilled birth attendant, LHV, trained AYUSH practitioner, nurse, auxiliary nurse midwife†	Specialist, medical officer, nurse, obstetric nurse, midwife	Specialist, medical officer, midwife, nurse, nurse midwife, CHEW, CHO	Specialist, medical officer, clinical officer, nurse, midwife	OB/GYN, SOU, doctor trained in FP, senior health technician, midwife, nurse
Postabortion (first trimester) IUD services at facility level	Specialist, doctor, nurse, auxiliary nurse midwife	*Information unavailable at time of assessment*	Specialist, medical officer, nurse, nurse midwife, midwife, CHEW, CHO	*Information unavailable at time of assessment*	*Information unavailable at time of assessment*
Postabortion (second trimester) IUD services at facility level	Specialist, doctor	*Information unavailable at time of assessment*	Specialist, medical officer, nurse, nurse midwife, midwife, CHEW, CHO	*Information unavailable at time of assessment*	*Information unavailable at time of assessment*

*% of currently married women aged 15 to 49 years who are IUD users as recorded in the DHS

± FP services (including IUD) can only be offered by providers empaneled by the relevant bodies at district and national levels

† Provided by those empaneled or enrolled by state and/or district indemnity subcommittees

Female Sterilization Information and Services

India is the only country included in the review where laparoscopic tubal occlusion is the preferred approach for female sterilization[6] as an interval procedure, and where it can be provided by specialist OB/GYNs, doctors with postgraduate diplomas in obstetrics and gynecology, specialists in other surgical fields, and trained medical officers. All providers offering FP in India must be empaneled and registered at state and/or district levels. Minilaparotomy for female sterilization is the preferred approach in all other review countries. India, Nigeria, and Senegal have no policy recommendation on task sharing female sterilization to other cadres, such as associate clinicians or their equivalent. Furthermore, national guidance documents state that minilaparotomy can only be performed by medical doctors or specialist doctors. Rwanda is one of the three countries that has a clinical officer cadre, but they are not allowed to provide minilaparotomy (or vasectomy). Mali and Mozambique are the only review countries where midlevel providers, medical assistants and *tecnicos de cirurgia*[7] respectively, are permitted to provide minilaparotomy. Table 4 shows the cadres that can provide female sterilization information and services at the facility level for six countries; information was unavailable for the DRC at the time of the review.

Table 4: Cadre Allowed to Provide Female Sterilization Information and Services, by Country

Type of Information and Service	**India** (36.3%, DHS, 2019-21)*	**Mali** (0.4%, DHS, 2018)	**Mozambique** (0.2%, DHS, 2011)	**Nigeria** (0.2%, DHS, 2018)	**Rwanda** (2.0%, DHS, 2019-20)	**Senegal** (0.7%, DHS, 2019)
Female sterilization information and pre-op counseling	ASHA, auxiliary nurse midwife, LHV, counselor,** nurse, midwife, medical doctor, specialist OB/GYN, other surgical specialist	Agent de santé communautaire, relais, auxiliary nurse midwife, obstetric nurse, matrone, nurse, medical assistant, doctor, specialist OB/GYN	*Information unavailable at time of review*	Village health worker, CORP, CHEW, nurse, nurse midwife, midwife, medical doctor, specialist	All cadres, including CHWs	Actor de santé communautaire, assistant nurse, nurse, midwife, generalist doctor, emergency obstetric care doctor, OB/GYN, surgeon
Interval and postpartum mini-laparotomy	Specialist OB/GYN, other surgical specialist, doctor with OB/GYN post-graduate diploma, trained medical doctor with bachelor of medicine, bachelor of surgery	Specialist, medical doctor, medical assistant	Specialist, medical doctor, tecnico de cirurgia†	Specialist, medical officer	Medical doctor, specialist	Specialist obstetrician and surgeon, SOU
Post-caesarean	Specialist OB/GYN, doctor with OB/GYN post-	Specialist, medical officer	Specialist medical officer,	*Information unavailable*		Specialist medical officer, SOU

[6] The recommended surgical approaches for tubal occlusion and tubal ligation include minilaparotomy, laparoscopic tubal occlusion, and trans cesarean and intra cesarean after delivery of the baby (and removal of the placenta) by cesarean section.

[7] *Tecnicos de cirurgia* are surgically trained assistant medical officers and assitant medical practitioners, a cadre introduced in Mozambique in 1984. As frontline healthcare workers, this cadre is trained to offer clinical and management services in rural areas.

tubal occlusion	graduate diploma, trained medical officer		tecnico de cirurgia	*at time of review*		

*% of currently married women aged 15 to 49 years who are female sterilization users as recorded in the DHS
** India has an additional cadre who are professional counselors
† Information sourced from publication on task sharing, not from Ministry policy documents

Additional barriers to services exist, such as a mandatory spousal consent requirement in Rwanda before provision of female sterilization (MOH, 2015) as well as requirements related to marital status, client age, spousal consent, and number of living children before a client can receive female sterlization in India (MOHFW, 2014a). While not directly related to task sharing, these factors impose additional and unnecessary barriers to FP access, and infringe on clients' rights, including the right to confidentiality.

Male Sterilization Information and Services

The WHO recommends that vasectomies be provided by associate clinicians (or their equivalent), and doctors, including specialist doctors such as surgeons and urologists. Mali and Mozambique are the only review countries where trained midlevel providers (medical assistants and tecnico de cirurgia) are allowed to perform vasectomy in line with the WHO's recommendations for task sharing male sterilization (MSAS, 2019; Cumbi et al., 2007). In the other five countries, vasectomy can only be provided by trained nonspecialist doctors and specialists in other surgical fields, such as OB/GYNs. National documents in Senegal state that only medical doctors trained in emergency obstetric care and specialists can perform vasectomies; general doctors are not permitted to perform this procedure. Table 5 provides an overview of the cadres that can offer vasectomy information and services at the facility level for six of the reviewed countries. Information across all types and levels was unavailable at the time of review for DRC.

Table 5: Cadre Allowed to Provide Male Sterilization Information and Services, by Country

Type of Information and Service	**India** (0.2%, DHS, 2019-21)*	**Mali** (not reported, DHS, 2018)	**Mozambique** (not reported, DHS, 2011)	**Nigeria** (not reported, DHS, 2018)	**Rwanda** (0.2%, DHS, 2019-20)	**Senegal** (0.1%, DHS, 2019)
Vasectomy information and counseling	All trained providers, including ASHAs and auxiliary nurse midwives	Specialist, medical officer, medical assistant, nurse, obstetric nurse, midwife	All FP providers†	All FP providers†	All FP providers (e.g., clinical officers, nurses, midwives, matrones)	All FP providers (e.g., nurses, obstetric nurses, midwives, matrones)
Vasectomy at facility level	Specialist OB/GYN, doctor with OB/GYN post-graduate diploma, trained medical doctor**	Specialist, medical doctor, medical assistant	*Information unavailable at time of review*	Specialist, medical officer	Medical officer/ general practitioner, medical specialist OB/GYN	Specialist (obstetrician and surgeon), SOU

*% of currently married women aged 15–49 years who are male sterilization users as recorded in the DHS
** All providers trained to conduct NSV and must be empaneled
†The specifics on types of cadres were not explicitly stated in the documents accessed for review

KEY RECOMMENDATIONS

As an overarching recommendation, the authors suggest that ministries of health ensure increased availability of all national policies, protocols, and standards for FP and reproductive health as well as guidelines and scopes of practice for the different cadres involved in FP provision. This could be in the form of printed copies and electronic versions on relevant Ministry of Health web-based platforms, which are readily accessible and can be downloaded by FP service providers, program implementers, program managers, trainers, researchers, etc.

Several essential components of the greater ecosystem are also needed to realize the full potential of task sharing to increase access to FP services. These include development and implementation of national policies and guidelines; expanded task sharing scopes of work that include ensuring an enabling environment to provide high-quality services (for example, availability of supplies and commodities, infrastructure, job aids, and monitoring and supervision); and mechanisms for fairly compensating healthcare workers for services provided. Ensuring that the cadre is fairly compensated for the additional work and appropriately covered from liability are distinct challenges when countries adopt task sharing, and two areas highlighted in the WHO task sharing guidance documents. Explicitly offering indemnity coverage to all trained FP providers is an issue for further analysis. There is similarly a need for increased frequency of supportive supervision, particularly for programs that had introduced provision of LARCs by lay health workers.

National FP programs should consider implementing strategies to address the development of competency of cadres authorized to provide methods that do not have substantial demand such as IUD and vasectomy. Finally, provision of high-quality, voluntary FP services can be safely and effectively offered by trained health providers across cadres as an integral part of postabortion and postpartum care, according to the WHO. These service delivery time periods and contacts serve as entry points for integration of FP information and services, and merit thoughtful consideration. Our desk review revealed limited inclusion of FP information and service provision by nurses and midwives in the peripartum period in the few documents available, necessitating advocacy for elaboration and/or inclusion of the roles of nurses and midwives in FP (including LARCs and PMs provision in particular), given that FP is one of the key strategies for prevention of maternal, newborn, and child morbidities and mortalities. Table 6 provides additional country-specific recommendations emerging from this review.

Table 6: Summary of Key Recommendations by Country

Country	Recommendations
DRC	• Advocate for, and as appropriate, support review and updating of relevant national guidance documents, including relevant training resources.
India	• Advocate for, and as appropriate, support review of reference manuals for IUD and sterilization service provision to ensure they are current, including evidence-based infection prevention and control practices. • Support in-depth analyses of the indemnity cover for FP providers to document its effectiveness and to determine its replicability in other countries. • Advocate for relevant entities within the Federal Ministry of Health to address inconsistencies across guidance documents and/or training resources on LARCs and PMs. • Advocate for the elimination of key barriers to accessing any FP method (e.g., requirements related to minimum age, number of children, and spousal consent).
Mali	• Advocate for and engage with the Ministère de la Santé et des Affaires Sociales to address inconsistencies across different guidance documents on LARC and PM services.

	• Advocate for, and as appropriate, support review and updating of national guidance documents and training resources to include current evidence-based infection prevention and control practices.
Mozambique	• Advocate for, and as appropriate, support review and updating of relevant national guidance documents, including relevant training resources. • Include performance standards for female and male sterilization in the national standards for measuring performance of sexual and reproductive health services.
Nigeria	• Advocate for updating the LARC training package for CHEWS to incorporate current infection prevention and control evidence on decontamination of medical devices for reuse as well as recently revised insertion techniques for Nexplanon®.
Rwanda	• Advocate for policy change to allow trained clinical officers to offer sterilization services. • Conduct an in-depth review to determine the role of pharmacists in LARC provision. • Support relevant entities and institutions within the Ministry of Health to address inconsistencies across different national guidance documents on LARC and PM services. • Support the adoption of evidence-based infection prevention and control practices for decontamination of medical devices for reuse. • Advocate for the elimination of medical barriers to accessing female sterilization (e.g., barriers related to consent from either a spouse or local administration).
Senegal	• Advocate for relevant entities within the Ministère de la Santé et de l'Action Sociale to address inconsistencies across different guidance documents on LARC and PM services; this includes, for instance, ensuring that guidance on the role of the senior health technician cadre in provision of LARCs at different timings (postpartum and postabortion) is consistent across different national policy documents. • Advocate for the adoption of policies allowing trained nonspecialist medical doctors to provide vasectomy services, as this falls within their scope of practice. • Advocate for, and as appropriate, support review and updating of national guidance documents and training resources to include current evidence-based infection prevention and control practices.

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