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# TASK SHIFTING AND TASK SHARING FOR FAMILY PLANNING IN PAKISTAN: PROGRESS, CHALLENGES AND WAY FORWARD



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# 1

## Introduction

Pakistan with an estimated population of 221 million (in 2020) and growing at a high growth rate (around 2 percent) is acknowledged as the fifth most populous country in the world (UNPD 2019). Since the 1970s Pakistan has persistently committed attainment of replacement level fertility as a long-term goal but lagged in achievements of the stated objectives. Pakistan recently committed at ICPD25 Nairobi Summit in November 2019 to 'achieve universal access to sexual and reproductive health as a part of universal health coverage (UHC)' and raising Contraceptive Prevalence Rate (CPR) to 50% by

2025, and further to 60% by 2030; and thereby lowering the total fertility rate to 2.2 children per woman by 2030. The country pledged to ensure universal access to family planning, reproductive health services, and commodities, besides ensuring access to fulfill human rights requirements. Modern contraceptive prevalence rate (mCPR) of 25 percent (PDHS 2017-18) after more than five decades of programmatic support by public and private sectors reflects serious under-performance, manifested in inequity in contraceptive use and high fertility differentials.

### Pakistan's commitment at ICPD25 Nairobi Summit



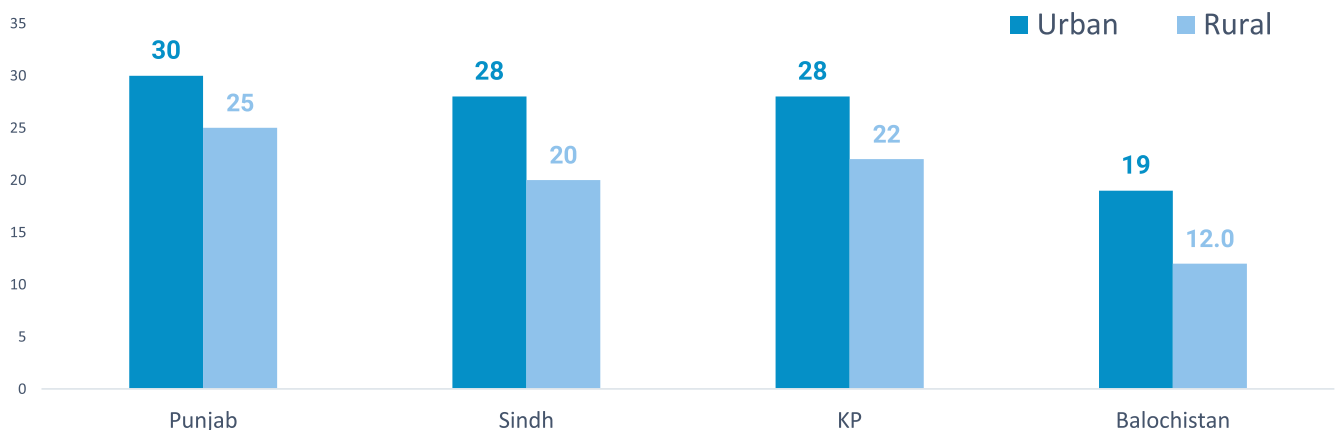
### Access to Family Planning Services



The structural barrier in the service delivery of the department of health and population welfare have constrained access to family planning services in Pakistan and characterized by fewer or lack of skilled providers and inadequate supply or unavailability of desired modern method leaves women with low or no choice of FP methods, that undermines the women's ability to freely decide on the number and spacing of their births. Results of Pakistan DHS 2017-18 revealed that 44 percent of women receive services from public sector facilities. The use of modern contraceptive methods is higher in urban areas across all provinces (see Figure I). The method mix of contraceptives from the same survey also shows the low use of most effective methods for spacing (Injectables

and Implants - 2.5% and 0.4% respectively) and has made a minimal contribution towards birth spacing. Although the desire to space the birth within the next two years is quite high among all segments of the population only 8 percent of women report receiving injectables or implants from public sector outlets. The potential is high for the public sector to promote these two methods and directly address not only the birth spacing needs but also the persistent high unintended pregnancies, which ultimately shortens the wider urban-rural fertility differentials in Pakistan that currently at one child per women. These challenges will require some innovative approaches to address the gaps in service delivery of family planning to achieve the national and international commitments of Pakistan<sup>1</sup>.

Figure I: Urban - Rural Difference in Modern CPR 2017-18 Across Provinces



<sup>1</sup> <https://www.nairobisummiticpd.org/commitment/pakistan-national-commitmentstatement-nairobi-summit-icpd25>.

## 2 Background

International research identifies two key challenges for expanding access to FP services: contraceptive method mix biased towards less effective methods and shortage of skilled service providers. The absence or low use of long-acting contraceptive methods like implants are now recognized as priority interventions to enhance birth spacing and improve choices of methods available to women. To address both aspects, WHO evolved the concept of “task shifting and task sharing,” as a process of delegation or shifting of selected tasks to less-specialized health workers (WHO 2007) based on challenges of serious shortages of qualified personnel, especially in rural areas to meet the demand for health services<sup>2</sup> faced by several African nations during the mid-2000s.

Developing the health system by enhancing the competencies of less-skilled cadres adopts two approaches. First, responsibilities are delegated to lower-level health care providers within a facility to reduce the time that physicians and other high-level healthcare providers spend on routine simple tasks and is referred to as task shifting. The second approach is task-sharing between different types of service outlets or mechanisms—community health workers (CHWs) or other providers perform some of the same tasks that clinic-based physicians and nurses provide, but carry out the same functions at more remote locations. Task sharing enhances access to health services, addresses missed opportunities, and contribute to important gains<sup>3</sup> that include<sup>4</sup>: bringing services closer to women especially when CHWs undertake home visits, eliminating client’s travel time, and facilitating uptake with continued contraceptive use; freeing up time for higher-level health

staff without sacrificing quality (within clinics); and reducing the cost of health and FP service provision.

The experience of several countries across the globe shows many benefits of task shifting and task sharing to providers and users. The approach provides new opportunities to health care providers to advance their professional roles, expand core competencies, and gain economic empowerment (HIP<sup>5</sup>:2019). Task sharing allows a broad range of health providers to meet client needs through integrated service delivery and provide comprehensive client-centered care and ensure reaching marginalized communities. Overall, the impact of such best practices received a boost when service providers across facilities share responsibilities across the system. From the client’s perspective, several direct effects include enhanced availability of a method of choice, easy access to a broader range of method mix<sup>6</sup> at the doorsteps, and better counseling on contraceptive technology and side effects. During the Covid-19 pandemic, the promotion of implants and injectables using task shifting and task sharing approach provides long term protection and reduce the need to visit facilities frequently to replenish contraception commodities. Task sharing contributes to addressing a high demand for all family planning methods, implants in particular<sup>7</sup>. Task shifting and task sharing emerged as an effective approach to enhance equity in access to birth spacing methods especially for the poorer segments of the society and allow women to obtain the desired method from their nearest service delivery point. Ultimately, women get protection against unintended pregnancies and thereby avoid costs associated with such pregnancies and of course induced / unsafe abortion.

Ethiopia was a pioneer to launch task-sharing by training health extension workers in inserting implants and mid-level health care providers were trained to insert and remove the full range of LARC methods (implants and IUDs), that contributed to increased use of implants from 0.2 percent in 2005 to 3.4 percent in 2011<sup>8</sup>. Based on this successful implementation, Nigeria in 2014 introduced the provision of injectables and implants to the tasks of community health workers for their community-based outreach and facility-based services. Commodity security and logistics support demand creative activities with social mobilization and strengthening referrals system were important components of the initiative’s result in the increase of contraceptive prevalence<sup>9</sup>.

<sup>2</sup> Barbara Janowitz, John Stanback, and Brooke Boyer 2012. Commentary on Task Sharing in Family Planning; *Studies in Family Planning*: Volume 43 Number 1 March 2012.

<sup>3</sup> Gish O, Hill KR, Elliot K: Health, manpower and the medical auxiliary. Intermediate Technology Group Ltd: London; 1971.

<sup>4</sup> Task-shifting alone cannot respond to the needs of poor communities, especially if other issues are not addressed at the same time: inadequate facilities, lack of or faulty equipment, lack of transport for field work and for patient evacuation, unreliable electrical power supply, inadequate refrigeration facilities, lack of accommodation for staff, and inadequate continuing education efforts, among others.

<sup>5</sup> High Impact Practices: 2019. Task Sharing Family Planning Services to Increase Health Workforce Efficiency and Expand Access: A Strategic Planning Guide.

<sup>6</sup> WHO. Task shifting: rational redistribution of tasks among health workforce teams: global recommendations and guidelines. 2008.

<sup>7</sup> Asnake, M., Henry, E.G., Tilahun, Y., and Oliveras, E. (2016) Addressing Unmet Need for Long Acting Family Planning in Ethiopia: Uptake of Implanon and Characteristics of Users. *International Journal of Gynecology and Obstetrics*.

<sup>8</sup> Central Statistical Agency [Ethiopia] and ICF International. 2012. Ethiopia Demographic and Health Survey 2011. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ICF International.

<sup>9</sup> Charyeva Z, Oguntunde O, Orobato N, Otolorin E, Inuwa F, Alalade O, et al. Task shifting provision of contraceptive implants to community health extension workers: results of operations research in northern Nigeria. *Global Health: Science and Practice*. 2015; 3(3):382-394.



### 3

## Rationale of Task Shifting and Task Sharing for Pakistan

Department of Health and Population Welfare at the national and provincial levels fully recognized the importance of birth spacing strategy to achieve long-term fertility goals through universal access to safe and quality reproductive health/ family planning services. The recommended duration between two pregnancies is 36 months, which in Pakistan's case remained around 28 months for several years (PDHS 2017-18).

Unfortunately, the contraceptive method mix in Pakistan over three decades is not effective for the birth spacing of 36 months. Among other, two contraceptive methods

(injectable and Implant) are effective means of the birth spacing due to convenience, as these require only a single contact with a health care provider (with only a follow-up) every few months or years and no other actions on the part of the user. Injectable has been part of the family planning programs in Pakistan for several decades while implants were introduced over a decade ago. Given the high demand for birth spacing and the shortage of skilled personnel in the provision of FP services in rural settings, reaching out to clients using task sharing and task shifting emerges as a necessity to be actively pursued and sustained to improve the method mix.

## 4

# Task Shifting and Task Sharing Initiatives in Pakistan

For improving method mix and increasing birth spacing, Pakistan has taken series of measures to lay the foundation of initiatives that include: advocacy; policy formulation; capacity building; demand creation; and institutional and system strengthening. UNFPA pioneered the work to establish a task shifting and task sharing approach in collaboration with relevant government departments and development partners in all four provinces.

### To introduce and establish Task Shifting and Task Sharing on firm footing, steps taken included:

- i. Introductory advocacy seminars held with secretaries along with senior technical staff from the De-partment of Health and Population Welfare;
- ii. Policy formulation was critical to share direction, and strategies needed to outline linkages with the program and evolve collaboration between the departments to identify cadres and staff in each prov-ince by engaging technical staff of both departments. Task sharing review committee was formed to support and guide the work. Policy drafts were shared with the secretaries of the Department of Health and Population Welfare for their feedback, endorsement, and adoption;
- iii. The initiative, being pilot, capacity building of identified cadres (and related training institutions) were supported through developing training materials, continuously improving training methodology, pre-paring master trainers, and undertaking training of service providers including paramedics. Master trainers and supervisors were trained in implant removals.
- iv. Awareness creation and community education are vital elements to empower women and families to make an informed choice. Community-level workers (LHWs and FWAs) were trained initially to create awareness in communities close to pilot training sites.
- v. Building ownership of task sharing is critical for the sustainability of the initiative.

To ensure institutionalization and sustainability of task sharing and task shifting in Pakistan, we need to strengthen planning, finance, monitoring, supervision, procurement, logistics, and operations research. Development of Plan of Action for each province followed. Advocacy and policy formulation drew lessons and best practices from similar countries but local survey results were used to evolve the rationale and local evidence of what works in Pakistan was based to elaborate linkage of task sharing strategy with overall population policy goals of enhancing access, improving method mix and addressing an unmet need. Furthermore, to provide evidence-based guidance to senior managers, a pilot was undertaken to test competence building in implant insertion among trainees (female doctors and paramedics). The findings revealed that paramedics were not only keen learners but were equally good in building their competencies in implant insertion.

Task shifting and task sharing were readily recognized more so by the department of health as an approach for

the programmatic initiative by the senior management in all provinces to enhance access to services to address urgent needs of birth spacing and provision of wider contraceptive choices for women. The initial focus was implants insertion and removal only, while users' field reviews reflected the need for including IUCD and injectables. In pursuit of enhancing access to family planning services, task shifting and task sharing ventured into two new initiatives with different cadres: (i) provision of IUCD during the post-pregnancy period in hospitals and maternity clinics; and (ii) provision of the first dose of injectables by Lady Health Workers. The later initiative focused on training LHWs with the first dose of DMPA<sup>10</sup> (injectable contraceptive) and skill-building in the use of WHO's Medical Eligibility Criteria to help LHWs screen and select appropriate clients for the first dose. The pilot initiative improved the method mix by 2 percent towards injectable in the target communities in Karachi. The model is scalable and replicable and can be easily institutionalized as the implementation was undertaken by the LHW Programme, Sindh.





<sup>10</sup><https://www.nairobisummiticpd.org/commitment/pakistan-national-commitmentstatement-nairobi-summit-icpd25>).

# 5

## Positive Vibes and Challenges Faced by the Provinces

All provinces across Pakistan have endorsed task shifting and task sharing approach both in terms of Policy endorsement and programmatic initiatives. Policy statements housed in the Population Welfare Departments are a joint reflection of two departments (including Health) for enhancing access implants to widen the method choice and address birth spacing goal. KP and Balochistan notified the task sharing policy in 2018 and 2019, respectively. The formal inclusion of the approach in the costed implementation plan of Sindh in 2016 provided a solid and sustainable direction to comprehensively promote implants and widen method choice. The preparation of PC-I entitled 'Accelerated Action Plan for Task Shifting and Sharing (2018-2020)' by PWD – KP reflected the seriousness of the Department to adopt the approach across all districts of the province.

In programmatic terms, several measures highlight the direction adopted by provinces to initiate implementation and scaling up across districts. Sindh initiated the capacity building process in 2015 and to-date PPHI trained 880 service providers in implants (65% of whom are paramedics while doctors are trained in removals) in 17 districts. The scope of Task Sharing was broadened in Sindh with the inclusion of Family Welfare Workers, and Lady Health Visitors while Medical doctors were trained and engaged in technical supervision of service delivery in three districts (Badin, Hyderabad, and Thatta). The total number of trained staff is around 109 doctors and 342 paramedics. LHWs training in 1st dose of injectable contraceptive is actively being pursued by a development partner in Sindh<sup>11</sup>. In Punjab, the Department of Health took lead to train 175 doctors across 30 districts, and 378 paramedics in implant insertion from three districts (Faisalabad, Sheikhpura, and Jhang). Three additional districts (Kasur, Mianwali, and Chiniot) are currently preparing Master Trainers to provide competency-based skills to LHWs and Nurses in implant insertion. In KP, Population Welfare Department has taken the lead and has prepared 48 doctors as trainers across 22 districts and 118 paramedics in the Mardan district only. Furthermore, district Mansehra is focused to promote implants through LHWs and Nurses at BHUs and RHCs. Department of Health has trained around 500 LHWs in providing the first dose of DMPA to women in rural areas. In Balochistan, trained staff in implant technology (183 doctors and 487 paramedics) are spread over 28 districts but concentrated in three districts (Quetta, Lasbella, and Jaffarabad). These staffs are mostly from the Dept of Health and require refresher training as they ran short of supplies to fulfill the

Province	Districts Covered	Doctors Trained	Paramedics Trained
 SINDH	17	109	342
 PUNJAB	30	175	378
 KHYBER PAKHTUNKHWA	22	48	118
 BALOCHISTAN	28	183	487

training requirement of at least 5-6 live cases during training due to shortage of provision of implants. Furthermore, 250 LHWs from the Quetta district have also been trained in the first dose of injectable contraception and another 700 are in pipeline for training in other districts.

At the national level, 346 thousand implants (Jadelle and Implanon) were dispensed from 2015 to 2019 of which 84 percent was dispensed in Sindh alone. A large majority of these implants were dispensed in out-reach camps, where the client's follow-up still needed support. Demand creation efforts in Sindh are drawn from community support meetings and LHW's campaign at the community level. The performance of the other three provinces summed to 55 thousand implants in four years. Implants being a new method added in the procurement list, the procurement process faced barriers in terms of financing new items and purchasing a relatively expensive item over condoms, oral pills, and injectables. Department of Health in Punjab, KP, and Balochistan allocated funds to procure implants but could not materialize procurement due to low quantity assessment and lack of bids. These shortages also negatively impacted the full availability of human resources with the capacity to deliver services as trainees did not have the necessary supplies to meet standard requirements. Furthermore, other issues that emerged as a barrier to the process included: a shortage of master trainers at the district level, inadequate provision of government finance for enhancing coverage, and inadequate establishment of a supervisory system to oversee training and service delivery.

<sup>11</sup> Public Sector Service Delivery Project under DAFFPAK.

## 6 Promising Practices and Equity in Service Delivery

Following elements are essential to evolve best practices in task shifting and task sharing approach which not only improves method choice to women in remote areas by promoting equity in service delivery but also empowers women by ensuring birth spacing and availing best of economic and social opportunities for their welfare:

- i. **Political will** is critical to ensure (a) persistence and continuity of family planning efforts and (b) bringing the two Departments (Health and Population) together to collaborate in achieving overall goals of task sharing. This is essential for mutual support and joint resources for capacity building, demand creation, supervision, mapping, referral system, record keeping, and procurements. It would remain difficult to reach and attend to the needs of post-partum women without effective and permanent collaboration between the two departments whether it is at functional or structural levels.
- ii. **Sustainability** guided by Long term plan supported by Sustainability is guided by long term plan supported by finance and budget. Formulation of a long-term plan

for scaling up, capacity building, actual implementation, procurements, etc. lays the foundation for requirements of funds and financing all operational matters. Partnership development with local organizations for social mobilization and demand creation allows the public sector to focus on the delivery of quality services, ensuring supplies and regulation.

- iii. **Strengthening systems** for monitoring, supplies, and quality of services. Regular progress review is necessary for defining responsibilities and procedures to sustaining progress.

These elements are vital for building ownership and ensuring task shifting and sharing is an integral part of routine program implementation which is government-financed. Currently, only one province (Sindh) is showing significant commitment towards the approach with financing, capacity building, and procurements. Close working relationships and integration between the department of health and population welfare in Sindh province is another best practice that other provinces should replicate.

## 7 Limitations and Challenges

Task Shifting and Task Sharing approaches have tremendous value to boost performance and meeting lower fertility goals. The Strategy papers are endorsed by the provinces, but not fully taken up in terms of management, creating an enabling environment, developing systems and organization, and linking it with a Plan of Action. Several challenges continue to inhibit full institutionalization:

- 1 Task sharing and task shifting capacity building remain dependent on donor support and technical assistance of partners. No single training institute is designated to house task-sharing capacity-building efforts and carry it forward in the future.
- 2 Procurement of implants emerged as a serious issue between PWD and DoH leading to a shortage of training and service provision in three provinces. Inadequate supply of implants for training made training inefficient and staff not fully trained as per standard. Only one or two implants were provided for live cases as against 5-6 required number. Inadequate supplies of injectable contraceptives have also constrained the smooth provision of services to women in rural areas.
- 3 Population Welfare, Punjab management considers FWWs and FTOs inappropriate for task-sharing approach as against evidence shared locally and from international experience. Unwillingness to get their FWWs and FTOs trained in implants. No uniformity in terms of which cadre should be included in task sharing and task shifting.
- 4 Lack of active coordination between the Department of Health and Population to jointly pursue task-sharing goals and operational matters. In Punjab, the Department of Health is yet to fully embrace task sharing and task shifting at a larger scale.
- 5 Sustainability remains a challenge as pre-service training is yet not adopted to incorporate implant training regularly. Though task-sharing does not need new institutions or cadres and is thus a cost-effective means to achieve short term goals, it does require additional financial and material support to sustain activities for a longer period. These may cover procurement, supervisory costs, refresher training, and holding regular reviews, and undertaking operations research.
- 6 A non-perusal of field-based evidence to improve operationalization

# 8

## Way Forward to fully benefit from the approach

Pakistan has committed at the ICPD25 conference in Nairobi to achieve a contraceptive prevalence rate of 50 percent and to lower fertility to 2.8 births by 2025. This is possible provided full attention is given to task shifting and task sharing to increase family planning coverage, improve quality of care by providing wider contraceptive choices for women through empowering a range of health care workers to rapidly expand access to FP as an

essential health care service. To improve the contraceptive method mix, all provinces uniformly implement Task Shifting and task sharing to upfront meet birth spacing needs through implants and injectable contraceptives and urgently address inequity in access. Following critical measures are recommended for smooth and uniform implementation of the approach.



### 1. Advocacy

Advocacy is a priority area to not only ensure policymakers fully understand the task sharing and task shifting approach but also what important benefits are being missed as a result of not fully adopting it or delaying it. Political commitment is needed for continuity and scale-up implementation to meet the desired goals.



### 2. Institutionalization

Ensure institutionalization of capacity building, procurement of commodities in sufficient quantities, and timely supplies to facilities and authorized field staff. Global evidence supports decentralized planning, budgeting, and implementation, as one budget and centralized procurement with rapid distribution and provision of commodities and necessary supplies to ensure smooth implementation. For sustainable capacity building, pre-service training institutions need to incorporate modules and prepare a plan to oversee future training. Training materials, once tested by experts (competency building or counseling skills), should be made available to all stakeholders for uniform application. Capacity building plan should adopt priority districts as identified in the Plan of Action for each province.



### 3. Quality assurance and evidence generation

Quality assurance and field supervision, monitoring, and regular holding of review meetings are necessary processes in the execution phase. Promote sharing of best practices and success stories from within Pakistan to overcome resistance to innovation and adoption of cost-effective measures. Conduct regular operations research for timely corrective actions and improvements.



### 4. Awareness creation and community education:

Demand generation for implants and promotion of rights-based birth spacing needs a priority in communication activities especially through the community-level interface by the Lady Health Workers and others.

#### ACKNOWLEDGMENTS

This policy brief was prepared by Dr. Tauseef Ahmed with technical and financial support from United Nations Population Fund (UNFPA) Pakistan. Special Thanks to Dr. Yilma Melkamu, Dr. Jamil Ahmed, Dr. Naila, Dr. Rafique, and for Dr. Asif Wazir for technical inputs.