

**Task Sharing to Improve Access of Long Acting Reversible Methods**  
**POLICY STATEMENT – BALOCHISTAN**

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## 1. Introductory Note on Task Sharing

The contraceptive prevalence rate in Pakistan is quite low relative to other countries in South Asia at 35 percent in 2012-13 compared to India at 51 percent and Bangladesh at 61 percent in 2012 and has remained static over the last decade. Around twenty percent of all women expressed to have an unmet need for contraception. For women who have access to contraceptive services, the available method mix is dominated by tubal ligation (38 percent), condom use (31 percent), injections and intrauterine devices (IUDs) (11 percent each), and oral contraceptive pills (10 percent). To date, implants have not received due importance as an effective method to improve birth spacing nor has it been made readily available in Pakistan. In contrast, the IUD has been available in Population Welfare facilities, but the proportion of women dropping out after initial use has been quite high (ever-use 9.4 percent and current use – 2.3 percent) reflecting a need to improve quality of service and counseling for the IUD. Limited availability and access to LARCs directly impacts the objective of increasing contraceptive prevalence. Challenges to implementing LARCs include a lack of trained professionals to administer methods, limited awareness among providers and potential users, and policies that limit the types of cadres who can provide these services.

Currently, two methods, IUDs and implants are categorized as LARC. The first method is available through mid-level service providers in Health and Population Welfare facilities, while implants are offered at secondary and tertiary care public sector facilities and select non-governmental organization clinics. Implant availability is limited due to a protocol restricting administration of implants to doctors only, while IUDs are provided by LHVs, FWWs and women doctors. The implant protocol was designed for earlier versions of implants called Norplant, which had six rods and required highly skilled persons for insertion. This strict protocol made access limited to facilities with doctors, as the central warehouse (CWH) dispenses only to authorized cadres and facilities. With new and improved technology, single rod implants can be inserted more easily with well-designed trocars, which improve the simplicity of insertion. With these improvements, ease of the service delivery has improved and best practices across the world have demonstrated mid-level providers are able to provide implants with competence and confidence.

## 2. The Context of Sindh

The province of Balochistan, spreads over 347,190 square kilometers, is the largest province of Pakistan (with 43.6% territorial area), with Quetta as its capital. The Population Census 2017 has recorded a population size of 12,344,408 much higher than any projection and growing at 3.37 percent inter-censal rate. It is home to only 5.94% of the country's total population. In 1998, the population of Balochistan was 6,565,885, which increased by 51.5% between 1981 and 1998 and 78.4% between 1971 and 1981. The Population of Balochistan has doubled in just 18 years (since 1998). According to Population Census 1998 Balochistan population growth rate was 2.47%, thereby doubling the population of Balochistan in 28 years. But the recent growth rate implies that Balochistan population will now double in 20.77 years.

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<sup>1</sup> <http://data.un.org/Data.aspx?d=SOWC&f=inID%3A34>

The Balochistan population grew from 4.2 million (1981 Census) to around 6.6 million (1998 Census) and Census 2017 gives a population of 12.3 million. This rapid change reflects the need to focus on the population variable as dominant factor affecting and influencing socio-economic development goals and processes in the province. A dynamic and comprehensive provincial population policy should advance the cause of population welfare towards the common vision of a prosperous, healthy, educated, and enlightened society.

According to Census 2017, 72.4 percent of Balochistan population resides in rural areas. While as per the 1998 census report, 73.1 percent of the population resided in mostly scattered rural areas. The urban areas of Balochistan including Quetta and other cities swelled from 1.768 million in 1998 to 3.401 million in 2017 (almost doubled in 19 years). The urban growth rate (3.49) has been extraordinary, and also reflects highest sex-ratio across all provinces (111.6). Urban areas of Balochistan have more male population probably for work related. The projected population for Balochistan is approximately 19 million for 2030, which includes large number of births and in-migration in Balochistan annually. This has immediate implications and long term consequences for the socio-economic progress of the province. High population growth not only adds pressures on housing, sanitation, education and drinking water at family level but is also recognized as an important influencing factor in maternal and child health. Besides increasing household level poverty and being a major cause of declining economic growth, rapid population growth further aggravates high dependency on working adults. The rapid population change emphasizes the need to focus on population as a dominant factor affecting and influencing socio-economic development goal and welfare of the people.

High population growth rate of Balochistan has evolved a very young population, with a median age of approximately 22 years (estimated). About 35% of the population is estimated to be under age 15, which reflects a high age dependency ratio (68%). In 2017, the youth population (age 15-29) is estimated to be 3 million, comprising 30% of the total population, and is estimated to rise to 3.24 million by the year 2020. The young population will continue to increase to 5 million by 2030. The proportion of women of reproductive age (WRA) (age 15-49) was 21.3% in 1998 and has risen to an estimated 25% in 2017 (2.56 million WRA). The continuous flow of new entrants into the reproductive cycle contributes towards a high population momentum. Even with the declining population growth rate, the number and proportion of married WRA will be constantly replenished by the large number of surviving female babies being born annually, thus maintaining a high gross reproduction rate. The number of WRA will increase to 3 million by 2025. High growth rates of this segment of the population in the past will continue to reproduce children.

Balochistan faces the highest incidence of preventable deaths among mothers, infants, and young children. The maternal mortality ratio (MMR) was estimated to be the highest in Balochistan (785/100,000 live births), and maternal deaths account for 35% of mortality among WRA (PDHS 2006-07). In 2012, the MMR was estimated at 996/100,000 live births (Sathar, Wazir and Sadiq 2014<sup>2</sup>); the infant mortality ratio (IMR) was 97/1,000 live births; and the under-five mortality ratio was 111/1,000 live births

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<sup>2</sup> Sathar Z.A., Wazir, M.A., and Sadiq, M. 2014. Prioritizing family planning for achieving provincial maternal child health and development goals. Islamabad: Population Council.

(PDHS 2012-13). Unfortunately, this situation appears to be worsening, as maternal and child health indicators in the province are deteriorating and call for urgent and sustained action. Though recognized worldwide that family planning helps promote maternal and child health indicators, these have yet to be operationalized in the Balochistan health policy framework.

The high population growth rate and poor maternal and child health indicators of Balochistan highlight the important role of voluntary FP as an integral component of the health and development sectors. The 18<sup>th</sup> devolution process was undertaken in 2010-11 to strengthen ownership and make provinces master of their social sectors. It provides tremendous opportunity to the province to revisit the subject of contraception, and fully manage the population welfare program within the provincial development framework. It would thereby enable to support, monitor, review progress, observe the effects of the process, and improve synergy to advance the overall objective of sustainable development in Balochistan.

Balochistan has not made significant progress in the implementation of the population welfare program in the past decades. The CPR is 19.5%, the lowest compared to other provinces, with highest total fertility rate of 4.3, MMR of 785, IMR of 97 and neonatal mortality ratio of 63. Demand for children and large families have been persistently high in Balochistan. This high demand is rooted in tribal social values and other indicators including poverty and illiteracy. The fertility in Balochistan declined noticeably from 1990-2013, falling from 5.8 (1990-91) to 4.28 (in 2012-13). Improvements in female education, job opportunities, living standards and communication has helped in bringing a decline in wanted total fertility rate from 5.7 to 3.4 births. The desire to stop child bearing among Balochistan married women is seriously delayed to the sixth living child (around 60%), indicative of strong tribal values and women adhering to them.

Over the years, family planning services and activities has contributed to increase CPR from as low as 2% in 1990-91 to 19.5% in 2012-13. The overall increase from 14.4% in 2006-07 to 19.5% in 2012-13 indicates around 1% annual increase, which is quite slow. Similarly, the modern methods CPR among married women increased from 13 % to 16% over the same period. The overall increase has been quite slow over the past two decades. The use of contraception for limiting births remained slightly higher (11%) in 2012-13 than for birth spacing (9%). The use of contraception remained very low among younger women. The knowledge of contraception to space pregnancies appears to be quite low and women use contraception to limit births once they have attained their desired family size. The trend in method mix reveals that tubal ligation has maintained its status among married women (4%) while use of condoms and intrauterine contraceptive devices (IUCD) have shown a significant increase over the years, but oral pills declined precipitously. Overall, the contraceptive method mix has remained unchanged, showing preference for tubal ligation, condoms and traditional methods that have had limited effect on fertility levels. Low usage of implants, IUCDs, injectables and oral pills are prominent weaknesses noted in surveys. Improving the impact of contraception with adoption of long acting methods is necessary to achieve fertility objectives.

Unmet need for contraception in Balochistan was 31.2%, with 21% in need of spacing and 10.3 % in need of birth limiting as reported by PDHS 2012-13. Unmet need has increased from 11 percent since 1990-91. Persistence of high latent demand over a decade reflects low attention to address the group needs. Poor

access to FP services characterized by few skilled providers and inadequate commodities supply that has given women little or no choice of methods of FP undermine the women's ability to freely decide on the number and spacing of their children, and this contributed to high levels of unmet need. High unmet need also contributes to unplanned and unintended pregnancies, causing actual fertility to be much higher than wanted fertility. Poor access to contraceptive methods is an obvious reason, especially when LHWs and BHUs are unable to give these services to women in remote areas, resulting in much higher risk of maternal death. Unmet need for contraception is higher among women coming from the poorest socio-economic segments of the population. Interestingly, unmet need is high for all groups of education, especially for pregnancy spacing. Access FP emerges as a major cause for unmet need in Balochistan.

In contrast, implants have high efficacy as reported by several scientific journals and documents<sup>3</sup> but were not popular in Pakistan, in general. Implants have been available in Pakistan (in various forms) for over a decade. In contrast to IUCD, awareness regarding implants in Balochistan remained low (33 percent) and its current use remained negligible (0.03%) as recorded by the Pakistan Demographic and Health Survey (PDHS) 2012–2013. The need to improve quality of services to ensure continuity of use especially of long acting methods is noted. In contrast, awareness regarding implants was low and its use was also negligible as reported by PDHS 2012-13, reflecting serious problems in promoting choice of methods, as well as availability in their supplies. Prior to 2015, only trained doctors based at Reproductive Health Service (RHS) Centres of Population Welfare Department as well as some Dept of Health providers administered implants on a limited scale. There exists a large unmet need for long acting contraception that implants and IUCDs can fill.

A number of reasons are identified as barriers to implants poor performance: only doctors are trained at FHCs of PWD to serve implants who would fulfill requirements of strict infection prevention procedures; implants are issued to trained doctors only and not included in the monthly consumption report of the districts; no demand for implants is generated or no women are counseled regarding implants and as such knowledge remains very low; implants are not procured by the Departments in significant numbers due to high cost and as such logistics system does not reflect its distribution process and supplies / usages; etc.

What makes these two methods attractive is that an implant can be used for up to five years and an IUCD for up to ten years, and can be removed at any time. These methods are thus ideal both for women who want to space or delay pregnancy and for those who no longer wish to conceive again. Long acting methods are the most effective means for FP due to convenience, as these require only a single contact with a health care provider (with a follow-up) every few years and no other actions on the part of the user.

To promote implants a number of measures are needed to benefit from such modern methods:

- Improve knowledge of Implants and create demand by building counseling skills & outreach

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<sup>3</sup> Family Planning: A Global Handbook for Provider 2015. Updated. USAID. WHO. And Centre for Communication Program, JH Bloomberg School of Public Health.

- Make implants accessible – Train service providers and make implants an essential part of the referral system
- Make implants available – procure implants regularly as part of contraceptive items and remove policy barriers for smooth requisitioning by all trained staff
- Strengthen supervision and monitoring quality of services of implants

### 3. Addressing missed opportunities and improve contraceptive method mix

Analysis of PDHS data 2012-13 show that a large segment of women fall in the category of ‘missed opportunities’ for postpartum FP especially those who deliver at public health facilities and are not encouraged or provided FP services immediately after their delivery. Imparting necessary skills and competencies to doctors and paramedics to address missed opportunities has resulted in an increase in new clients and improved method mix. Moreover, best practices and global experience of international NGOs demonstrate that the skills required for procedures related to implants and IUDs have been simplified to the point where trained mid-level providers can easily perform them. The World Health Organization’s “Task sharing: global recommendations and guidelines”<sup>4</sup> recommends that task sharing as a valuable strategy in improving access to a broader method mix. Task sharing contributed to meeting a high demand for all family planning methods, LARCs in particular.<sup>5</sup> Organizational experience exists in many countries including Ethiopia, where the Ministry of Health under the Integrated Family Health Program (IFHP), trained frontline health extension workers (HEWs) to insert implants at the health post level. Health providers were also trained to insert and remove the full range of LARC methods (implants and IUDs) contributing to the increased use of implants in Ethiopia from 0.2 percent in 2005 to 3.4 percent in 2011.<sup>6</sup> More recently, Nigeria successfully trained Community Health Workers to insert and remove implants.

### 4. Task Sharing in Family Planning

Recent history of several African nations showed shortages of qualified medical personnel, especially in rural areas led countries face strains in meeting the demands for health services<sup>7</sup>. Continued “brain drain” of trained medical professionals aggravated this situation. The concept of “task shifting,” emerged and described it is as a process of delegation or shifting of some tasks to less-specialized health workers (WHO 2007); while “task sharing,” refers to a partnership in which different levels of providers do similar work, rather than having less-credentialed providers take overall provision of a service.

Task sharing occurs in two main forms: sharing within a health facility and sharing across different types of supply outlets. In the first type, responsibilities are delegated to lower-level providers within a facility.

<sup>4</sup> WHO. Task shifting: rational redistribution of tasks among health workforce teams: global recommendations and guidelines. 2008.

<sup>5</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>6</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>7</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.

In family planning, the combination of high demand for certain methods and overworked providers may lend itself to this type of task sharing, to reduce the time that physicians and other high-level providers spend on routine tasks. The second type of task sharing—between different types of supply outlets or mechanisms—community health workers (CHWs) or other providers perform some of the same tasks that clinic-based physicians and nurses provide, but at more remote locations. This type of task sharing brings services closer to women who would otherwise have to travel long distances. CHWs make home visits, travel time is eliminated for clients, and uptake and continued contraceptive use is facilitated in favor of task sharing in family planning, assessing the strength. Task sharing gains include:

1. Frees up time for higher-level health personnel without sacrificing quality (within clinics)
2. CHWs increase access to and use of health services in rural areas
3. CHWs, Pharmacists, and drug-shop operators provide some products and services with the same level of quality that clinics offer
4. Reduces the cost of health service provision

Taking advantage of vast rural areas Ethiopia addressed its chronically shortage of health staff and facilities by an innovation and trained a cadre of CHWs to insert contraceptive implants. To ensure women's access to at least one long-term method, the government opted to take this bold step. Workers were trained to assure quality family planning services requiring provision of both a product and information about that product. Given the shortage of health personnel in rural settings, however, task sharing remains a necessity in the future.

Similarly, Nigeria tested out shifting provision of contraceptive implants to lower cadre providers such as community health extension workers (CHEWs) to address the growing reproductive health needs. The training for CHEWs was organized using modules focused on insertion and removal of implants and infection prevention using the competency based approach. Participants acquired implant insertion and removal skills under supervision. After achieving competency of implant insertion and removal on the arm models, CHEWs started to insert implants under supervision on actual clients in selected facilities. Trainers visited CHEWs at health facilities to observe services being providing in accordance with approved standards, and the trainers would provide remedial training as needed. These visits provided workers the opportunity to strengthen their skills on implant insertion. Commodity Security and Logistics Support, Demand Creation Activities and Strengthening Referrals System were important components of initiative<sup>8</sup>.

The Nigeria initiative revealed the following key lessons learned from the pilot intervention:

1. CHEWs can provide quality contraceptive implant services with adequate support including continual supportive supervision and regular refresher training. Continual supervision is necessary to ensure high-quality services are provided.
2. The 2-week training duration was adequate to ensure competently trained CHEWs.

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<sup>8</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. Implant insertions with 5 clients under observation were sufficient to achieve competency and confidence.

In addition to effective training component, learnings also show that Programs should make efforts to:

- a. Ensure availability of implants and other supplies: Policies to ensure availability of implants and other materials (including infection prevention and other supplies) necessary for implant insertion.
- b. Create demand: Demand for implant services in communities should be created prior to introducing the services, and community mobilization work should be ongoing. Misconceptions and fears about family planning and implants overall are common and should be addressed at the community level.
- c. Develop and disseminate targeted messages to community members using information materials in a local language: Key messages for community mobilization activities need to be developed and disseminated to promote implant uptake.

## **5. Balochistan Population Policy 2015**

According to Balochistan Population Policy 2015, government envisages ‘A prosperous, healthy, educated, and knowledge-based society for Balochistan where every pregnancy is planned, every child is nurtured and cared for that enjoy quality of life’. With the aim to attain replacement level fertility by 2040, the government seeks to achieve population stabilization and sustainable human development in the province. The policy also aims to achieve CPR level of 30% by 2025. The Population Policy attaches special priority to enhancing access to family planning information and services by all stakeholders and envisions to reposition family planning as maternal and child health perspective to facilitate Health sector take active role promoting family planning. The Balochistan population policy recognizes that birth interval through voluntary FP is pivotal for improving maternal health and child survival, and to strike a balance between population increase and economic growth. To achieve this object, the PWD will be in the primary actor to provide high quality FP services at affordable costs to all segments of society. The approved Population Policy is a driving force that will guide and strengthen the approach and system for voluntary use of contraception. The underlying framework encompasses HTSP by providing a strong health perspective to contraception and effectively linking it with maternal and child health indicators.

The Balochistan Population Policy envisioned achieving ‘replacement level fertility i.e. 2.1 births per woman by 2040’ for which ‘achieving universal access to safe and quality reproductive health/family planning services by 2020’ is imperative. To achieve this and to align with the FP2020 goals, the pledge makes it important to ensure all stakeholders play their due roles and provide necessary choices to clients regarding family planning. The Policy emphasizes an active pursuit of birth spacing strategy to achieve long-term fertility goals. It envisions close collaboration with the private sector and civil society in its implementation, and in such a way that conforms to the national development priorities and commitments. Pakistan’s commitment to the FP2020 goals at the London Summit in 2012 is endorsed by Balochistan and has accordingly set a target to achieve CPR of 32% by 2022. The substance of the policy is based on voluntary character of the pursuit, equity and fairness in the provision of services, and the right to information with choice of methods to manage fertility preferences. This policy emphasizes an active pursuit of the birth spacing approach. In pursuit of its long-term fertility goals, the policy envisions

improvements in the contraceptive method mix to increase access to long-acting reversible contraceptives (LARCs).

The draft Health Sector Strategy document prepared in 2015-16 was structured on the WHO's six pillars of management. The draft Health Strategy lacks to relate achievement of maternal health indicators with birth spacing or FP, and thereby overlooked the commonly-cited gains evidenced in recent research. This weakness is quite evident from various strategies outlined in the document. Incorporation of FP commodities in the essential package of health services is an urgent need, as it will help to integrate FP services in MNCH and achieve the economies of scale in procurement of FP commodities for all programs.

The draft Costed Implementation Plan for Balochistan 2017 outlines Strategy 1 for 'Enhance coverage and improve access to contraceptive services by focusing on supply and demand side interventions for easy availability, with assured quality of services, by enforcing the established protocols and standards and ensuring adherence by all stakeholders; and by creating space and linkages for public-private partnership to reach the most vulnerable segments of the population, including those living in remote areas', identifies a number of important activities including expansion of services network, hiring of additional staff, health workers to receive training in family planning to carry out some of the tasks, and adopting task sharing/shifting approach, etc. Task sharing / shifting will be adopted to enhance access to all methods, including new methods/range of methods across all clients especially in remote and rural areas. Under the strategy, LHVs/FWWs will be trained to carry out some of the tasks that are being looked after by medical doctors at the public facilities. Furthermore, LHWs will be trained to administer first contraceptive injection to married women of reproductive age (MWRA); which at present they can only administer second injections onwards. Activities include 'building skills of LHVs at DHQ/THQ and RHC levels and imparting skill and competencies to LHVs in IUCD and implant insertion) in selected facilities DHQ, THQ, RHCs, and BHUs (under PPHI) and FTOs posted at MSUs.

The CIP Balochistan envisions two methods (IUCDs, and implants) to be made available on a vast scale to improve method mix for lasting impact on fertility rate. The CIP forecast for implants to improve its contribution from 0.03 percent (2017) to 0.9 percent (2022), and IUCD from 2.5 percent to 4.4 percent in the same period. The Plan estimates that IUCD users will rise from 43 thousand (2017) to around 85 thousand by 2022, while implant users are expected to rise from around 550 to over 17 thousand. This increase of around 16,500 implant clients by 2022 needs a dynamic action plan to engage various key stakeholders and all available service providers as doctors alone will not be able to meet the huge task. Improved contraceptive method mix using all FP interventions is expected to have tremendous impact in Balochistan on averting maternal and child deaths, reducing in unintended pregnancies, and of course induced abortions. Achieving policy and CIP guided objectives are gigantic tasks and seek concerted efforts by all stakeholders.

## **6. Task Shifting/Sharing Policy Goal**

The goal of the task shifting and sharing policy is to meet the universal coverage of FP services and the health needs of the population through the mobilization of available human resources to ensure

accessibility, equity, and effectiveness in the delivery of essential health care services / needed FP services.

The overall goal of the task-shifting and sharing policy is to reduce the maternal and newborn morbidity and mortality in accordance with the set SDG targets for Pakistan.

### **a. Task Shifting Policy Objectives**

- Provide a framework for empowering a range of health care workers to rapidly expand access to FP as an essential health care service
- Promote competency and expertise of trained mid-level cadres to meet the population FP /health needs
- To promote efficiency and effectiveness in the utilization of financial and nonfinancial resources in scaling-up access to essential health care services delivery

The task shifting policy will promote rational redistribution of tasks among existing health workforce cadres. It allows moving specific tasks, where appropriate, from highly qualified staff to health workers with shorter competency based training and fewer qualifications in order to make more efficient use of the available workers and to improve access to services for the people<sup>9</sup>.

## **7. Success Stories of Task Sharing**

First, Department of Population Welfare, Government of Sindh in collaboration with Pathfinder undertook an initiative to pilot test training of Family Welfare Workers in implant insertion in Badin district in 2017. The initiative had three-stages: first stage established and strengthened training program at district level including finalization of training material, the second stage focused on actual training at Multi-purpose Centre and building implementation plan at the district level, and the third stage prepared community based workers to promote demand and facility-based IEC campaign regarding the methods to ensure smooth service delivery remaining within the existing system. With necessary demand created by LHWs and effective referral to facilities, all 38 FWWs, 25 LHWs and 3 WMOs were trained initially on dummy arm model and then on clients from the community. On average four live cases were undertaken by each trainee for implant insertion. The pilot demonstrated that FWWs and LHWs when given opportunity and an enabling environment can competently perform such tasks. Women Medical Officers were trained to enhance their supervisory role at the district level. The activity was also closely supported by demand creation activities by LHWs of their respective areas. The pilot provided a sustainable replicable model for scale-up purpose as it utilized Departments resources for training and supervision, and strengthening District Technical Committee to oversee the progress.

Second, provision of Depo injection by Lady Health Worker in Sindh is also a successful pilot carried out by SUKH initiative with close collaboration of the LHW Programme. The pilot was undertaken during Jan 2016 to Feb 2017 in Karachi. LHW were tasked to provide second and onward doses of injectable contraceptive. The first-dose pilot included various phases: capacity development of LHWs to independently provide the first dose of Injectable contraceptive; formulation of checklist by using the

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<sup>9</sup> WHO: Task Shifting-Global Recommendations and Guidelines. 2008. Available at: <http://www.who.int/healthsystems/TTR-TaskShifting.pdf>

Medical Eligibility Criteria wheel to help LHWs understand non-eligible clients for DMPA dose, and finally briefing LHWs on the checklist. Once clients' eligibility for DMPA dose was ascertained by FWW, the LHW provided the dose in FWWs presence and following the instructions on the checklist. The first dose of Injections was administered since March 2017. The uptake of first dose of injection in the targeted community doubled (from 1271 to 2028) in six months. Service data from March to July 2018 reported 1137 additional injection users, which shows an increase of four-folds over the baseline. Task shifting model mainly attributed enhancement in access to modern contraceptive in the community. The initiative has overall improved the method mix by 2 % towards injectable. The pilot reflects the capability of LHWs to provide the first dose of injectables provided effective supervision is essential in place. The model is scalable and replicable in other provinces. The model can easily institutionalize as the implementation was undertaken by the LHW Programme, Sindh with the support of SUKH Initiative.

Large number of married women go to health facilities in rural areas to get MCH and RH services. Doctors are posted/stationed in such facilities but are not always present to serve women clients while LHWs are there to serve them. Keeping in view the FP/RH requirements of these women esp their need for LARCs, task sharing has evolved as an important concept / model to enhance access to such needed services. Furthermore, the task shifting/sharing is among the strategies for accelerating the progress towards achievements of the reproductive health SDGs 4 and 5.

Trained workers who are providing FP services, including community based workers (LHWs), who receive wages and other incentives, and can be held accountable for the assigned tasks are defined to be the relevant parties in Task Shifting.

Key development partners have been actively pursuing training of various cadres in variety of modern family planning techniques. To-date Jhpiego, a major partner, has trained a total 6195 personnel of different cadres. These include trainings to MOs, LHWs, LHWs, FWC and others in management cadres carried out under various projects like: MCHIP (1986), Packard (1750), HANIF (998), GIZ (210), SUKH (137) and till date MCSP (1114). Prominent training included IUCD insertion to more than 200 female staff working under PPHI, 608 male and female staff trained in implant insertion in 2015. These training were undertaken by Population Welfare Department with MCHIP support. Furthermore, 403 PPHI staff was trained under UNFPA support in implant insertion by PWD during 2016-18. PPHI has performed remarkably well fully converting these training into provision of long acting modern methods. PPHI inserted 30,432 thousand IUCDs during 2014-18 and around 118.2 thousand implants (Jadelle) in the same period. Though very few removals were reported yet repeat clients need to be served for continuity of protection at facility level. A large majority of these insertions were made in out-reach camps and close clients follow-up yet needed to be supported.

## **8. Policy statements on adopting task shifting**

Statement 1:

Government of Sindh in collaboration with relevant stakeholders and partners will be implementing Task Shifting initiative where access to priority FP services, are constrained by ill staffed or equipped facilities

to meet FP needs. Task shifting is considered as an interim measure, and will be implemented alongside other efforts to increase the numbers of skilled workers.

Statement 2:

Task shifting approach, will be supported by an endorsed framework to ensure harmonization and provide stability for the priority FP services that are provided throughout the public and private sectors.

Statement 3:

Task shifting implementation will be evidence-based and informed through regular updating of facility profiles at the district level. Regular review of performance will help improve progress.

Statement 4: Creating an enabling regulatory environment for Implementation of task shifting policy

Task shifting will ensure a thorough assessment and consider using existing health / workers regulatory mechanisms and approaches (laws and proclamations, rules and regulations, policies and guidelines) where possible, or undertake revisions as necessary, to enable cadres of workers to practice according to an extended scope of practice, based on the proposed shifting or sharing of tasks among existing cadres of health workers. The code of ethics of the responsibility that are shifted will apply to the personnel having the new tasks.

Statement 5: Creating an enabling regulatory environment for Implementation of task shifting policy

A strategy will be adopted to produce revisions to the regulatory framework (laws and proclamations, rules and regulations, policies and guidelines) where necessary. If needed (after a period of 3 year implementation of this task shifting policy), a long-term reform will be pursued to support task shifting on a sustainable basis within a comprehensive endorsed regulatory framework. This may include changes in pre-service training material and curriculum on family planning techniques and counseling.

Statement 6: Ensuring quality of care

As part of task shifting policy implementation, province will adapt human resources for FP quality assurance mechanisms to support the task shifting or task sharing approach. These will include processes and activities that define, monitor and improve the quality of services provided by all cadres of staff and workers. In view of in-service training under Task Shifting framework, training schedule will be flexible but all competencies will be fully covered.

Statement 7: Ensuring quality of care

The roles and the associated competency levels required will be defined both for existing cadres that are extending their scope of practice, and for those cadres that are being newly created or assigned additional / new tasks under the task shifting policy approach.

Statement 8: Ensuring quality of care

A systematic approach to harmonized, standardized and competency based training that is needs-driven and accredited will be adopted so that all workers are equipped with the appropriate competencies to undertake the tasks they are to perform.

Statement 9: Ensuring quality of care

Training programmes and continuing educational programmes for workers will be tied to certification, registration by relevant regulatory agencies like Pakistan Nursing Council (PNC).

Statement 10: Ensuring quality of care

Supportive supervision and clinical mentoring will be regularly provided to all workers within the system and functions of field workers. It will be ensured that Individuals or Staff who are tasked with providing supportive supervision or clinical mentoring to workers to whom tasks are being shifted will themselves be competent and have appropriate supervisory skills.

Statement 11:

An efficient referral system will be ensured that supports the decentralization of service delivery in the context of a task shifting approach. Workers will be informed about the referral systems and trained to use it.

Statement 12:

Paramedics (FWWs and LHVs) can safely and effectively undertake specific clinical tasks for which they are trained in the context of service delivery according to the task shifting approach. Paramedics will be trained in implant insertion while medical doctors will support and undertake implant removals also.

Statement 13:

LHVs and midwives can safely and effectively undertake a range of clinical tasks in the context of service delivery according to a task shifting approach.

Statement 14:

Government will prepare a long term plan and dedicate necessary funds to procure implants for provision at all identified facilities with trained staff. Furthermore, registration of implants with Drug Regulatory Authority of Pakistan (DRAP) will be the responsibility of the provincial government.

Statement 15:

Under Task Shifting, distribution mechanism will cover all certified and trained cadres and staff (LHVs, FWWs and CMWs) to have direct access to warehouse to requisite implants along with supplies needed in its provision.

Statement 16:

Task Shifting approach is firmly based on demand creation support by community based workers and local NGOs. Referral mechanism will link community workers with nearest facilities for services.

Introduction to task sharing, the work on quality family planning service delivery and leveraging resources will be the immediate outcome. Trainees for implant services may include female medical officers, MOs, LHVs, FWWs and CMWs. Even though the mandate of family planning lies with FWWs posted at Family Welfare Centres, yet the large network of LHVs at BHUs and RHCs can easily meet the tremendous opportunity to promote LARCs.

Task Shifting / Sharing framework aims to improve access and availability of implants and IUDs through health care providers including paramedics at all public sector facilities. The purpose is to address missed opportunities and improve method mix toward LARCs. The focus is to institutionalize training in implants and IUDs for paramedics (including FWWs and LHVs) as well as. No new infrastructure or posts will be created to implement Task Shifting / sharing framework.

## **9. Strategies for task shifting Initiative**

A three-prong strategy is well tested for increasing access to skilled provision of LARC using task sharing.

- Promote LARCs especially implants through all available cadres at the facilities (primary and secondary levels) including male and female doctors, FWWs, and LHVs.
- Institutionalize training in LARCs at the district level for regular follow-up training process.
- Establish effective demand creation for LARCs through community based workers and at facilities.

### **a) Formation of Technical Working Group**

A Provincial Technical Working Group (PTWG) will be established, which will include technical experts and representatives of concerned Departments to follow-up on the recommended actions of the technical meeting and advise on the implementation. The PTWG will review and finalize curriculum for various cadres and ensure that identified facilities provide implants and IUDs — that is, they have trained competent staff with counseling skills, adequate number of clients, space, supplies, and infection prevention material. To ensure application and utility of the trainings are not limited to the immediate post-training period, the Departments will work to:

- 1) Provide the trained staff with necessary kits and commodities so they can serve immediately.
- 2) Schedule regular mentoring/supervision visits to facilities to oversee and improve quality service provision. Once the staff has gained competence, supportive supervision will be less frequent.

### **b) Training in Long Acting Reversible Methods (LARCs)**

The skills training will be competency-based trainings, including practicums on models, followed by clinical practicum - a supervised service delivery to clients. Skills and competencies of RHSC existing staff and trainers will be improved to act as Master Trainer and to engage trainers from other RHSCs (if necessary). PWD will strengthen the Training Centre at the district level and prepare two master Trainers on implants (insertion and removal) and postpartum family planning. A training plan will be developed for training of all trainees to be undertaken continuously for several weeks by set of trainers to ensure all cadres receive necessary training in one or both methods. Training centres will be improved and necessary support will be provided to make it an effective training center.

The training will be a combination of classroom sessions and hands on clinical skills training, grounded in infection prevention. The caseload for the trainings will be generated by LHWs from their catchment areas using their individual/ community counseling sessions. The Population Welfare Department recognizes that FWWs have a lower skill mix than LHVs. Therefore, due attention will be paid to their skills and understanding in human anatomy specific to arm and skin as it relates to implant insertion. Therefore, direct training approach to create an appropriate mentorship and training structure to build

their capacity. However, PWD will train both the cadres (FWWs and LHVs) in insertion and WMOs in insertion and removal of implants. Refresher training especially IUD will be organized for LHVs and WMOs as they have received previously orientation and some training in IUD insertion but may not have practiced over the year. The implant removal training will be initially on models, while select doctors, at the district hospital will be trained in phases after six months to achieve the necessary caseload.

Building Competencies and skills: Existing material and resources for training and supporting capacity building efforts will be used. PTWG will prepare and finalize module / curriculum for LHVs and FWWs on implant training using training material. Furthermore, IEC material for service centers; local curriculum (if needed), specifically implant and IUD, specially counseling cards, one pager pamphlets/ brochures, protocols for facilities will be developed.

Development of Training Plan for the district: Departments will work with DTC of the selected district to analyze the HR situation. Map out available service providers and tag LHWs and FWAs for social mobilization tasks.

- Preparation of service providers lists to be trained in implants. WMOs, LHVs, FWWs, etc.

- Identification of district(s) to initiate training (DoH and PWD)

- Development of Training Plan and Training Methodology. Six-day classroom training implants

### **c) Demand creation:**

Departments will work closely to engage and train LHWs, and FWAs and men social mobilizers to share information regarding LARCs at the community level. The community based workers will refer cases to facilities even during the training sessions so that women who need implants or IUDs are served with their method of choice. Departments support method choice for clients by providing all necessary information regarding all contraceptive methods – how to use, benefits, side effects, contraindications, etc. Departments will complement this effort by expanding provision of LARC focusing on implants through training and demand generation in the community, particularly with young mothers and youth. The availability of LARCs will be ensured and clients will continue to freely choose their method of choice. Spearheaded by the LHWs, and FWAs in the district, the demand generation and referral strategy will result in improved tracking of referrals from the community. Job aids and necessary IEC material will be updated and disseminated among community workers, facility workers for display at the facilities.

Departments will strengthen referral mechanism (LHW's, and FWA's and Mobilizers) to facilities. Departments will undertake printing of training modules and IEC material, referral slips and referral protocols.

### **d) Coordination and Supervision:**

The District Technical Committee (DTC) headed by DHO of District Health Office, is district level coordinating body for both Departments. DTC members contribute to the development process as an effective body and efficiently respond to field issues. DTC will prepare lists of all providers to be trained in LARCs. DTC and Deputy Director Technical (PWD) will prepare the training plan in close coordination with the Trainer and Facility in-charge. In the process of providing technical guidance, members of the DTC will be oriented in technical supervision, analysis, review, and monitor reports to ensure timely supervision is undertaken and necessary measures for demand generation are in place. They will also ensure that

dedicated staff is maintained for quality assurance monitoring. DTC will assure smooth supplies of implants and IUDs to all trained health care providers of both departments. PWD will especially focus on building the capacity of the DTC to regularly review, monitor, and maintain minimum stock levels for rapid decision making.

For effective implementation, continued technical supervision, based on competency-based checklists, plays a critical role. Departments will improve available technical supervisory protocols to help promote quality services of implants and IUDs. All Trainers will act as technical supervisor in addition to Deputy Director Technical of the PWD at the district level. PWD will provide technical support at the district level to strengthen facility monitoring.

### **e) Monitoring:**

Monitoring for quality of family planning services will be carried out by a dedicated supervisory team, constituted by the Chair of the District Technical Committee (DTC). DTC members will monitor trainees using the Competency Check List and steps for field supervision. PWD will help develop tools and recordkeeping registers as well as train staff on recording client status (new, old or switched), complications, and detailed requests for removal. The team members will make regular visits to the facilities to assess providers on clinical competencies and conduct random client exit interviews. Analysis of these monitoring reports and service records (including clients' demographics) will be undertaken by the District Demographer. PWD will build expertise of District Demographer in analysis to be presented and reviewed on monthly basis by DTC. In addition, PWD will continue to provide supportive supervision and technical assistance to the supervisory tasks.

### **f) Sustainability of the Initiative:**

The Departments will work to ensure that the model is institutionalized and scaled-up in all districts and especially ensuring regular district level review meetings and monitoring by the DTC and provincial office. Active involvement of provincial Directorate in quarterly meetings and close oversight of DTC will help ensure learning is passed on to the senior officers of the Directorate who will monitor the performance of the district.