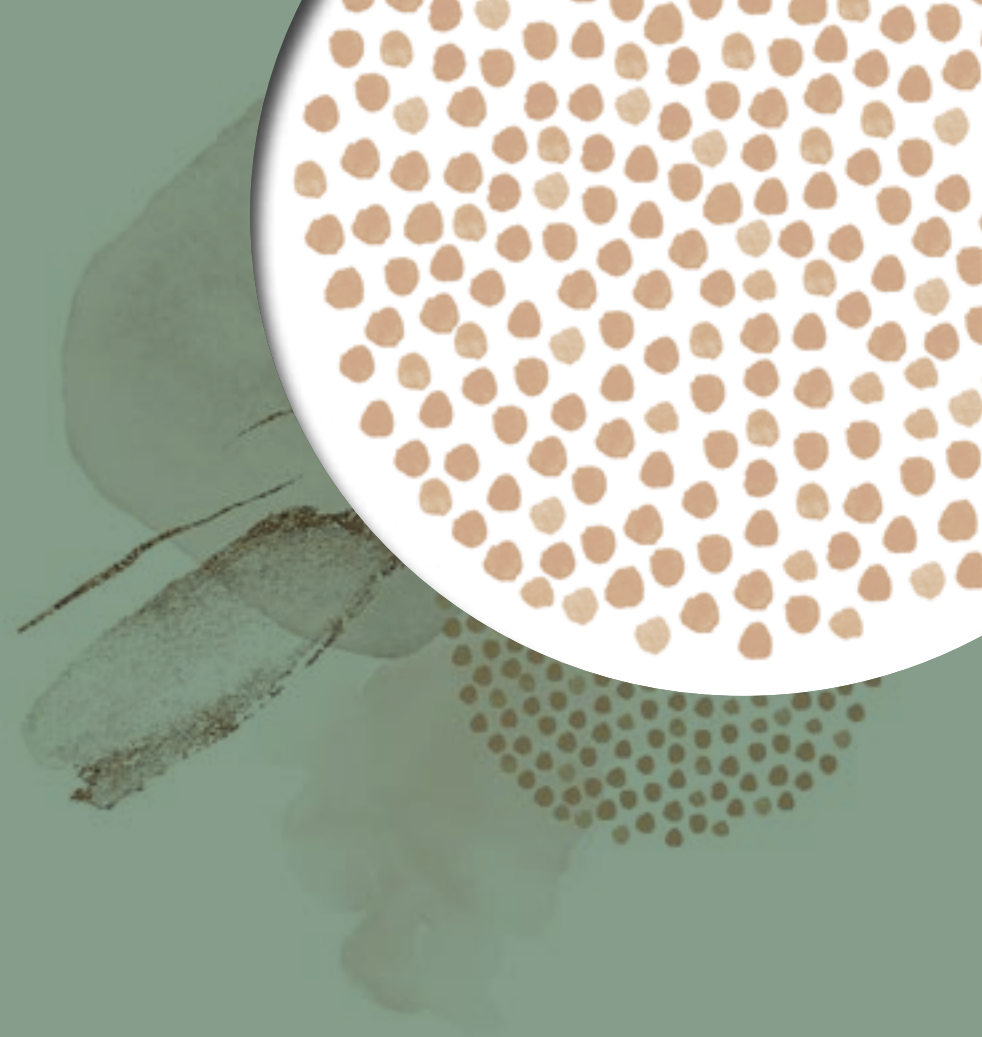

Guidance on **planning, implementing** and **scaling up** task sharing for contraceptive services

World Health Organization

human reproduction programme hrp
research for impact
UNDP · UNFPA · UNICEF · WHO · WORLD BANK

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Acronyms

AAR: Action after review

AIU: Adding It Up

ANM: Auxiliary nurse midwife

CHEW: Community health extension worker

CHV: Community health volunteers

CHW: Community health worker

CYP: Couple-years of protection

DMPA: Depot medroxyprogesterone acetate

DMPA-IM: Intramuscular depot medroxyprogesterone acetate

DMPA-SC: Subcutaneous depot medroxyprogesterone acetate

EC: Emergency contraception

FP: Family planning

FPET: Family Planning Estimation Tool

HMIS: Health management information system

IUD: Intrauterine device

LAM: Lactational amenorrhea method

LARC: Long-acting reversible contraception

LMICs: Low- and middle-income countries

mCPR: Modern contraceptive prevalence rate

MEL: Monitoring, evaluation, and learning

NGO: Non-governmental organization

OCP: Oral contraceptive pills

SMART: Specific, measurable, achievable, relevant, and time-bound

SOP: Standard operating procedure

SRH: Sexual and reproductive health

SSBC: Social and behaviour change communication

STI: Sexually transmitted infection

TBA: Traditional birth attendant

ToC: Theory of change

UHC: Universal health coverage

USAID: United States Agency for International Development

WHO: World Health Organization

Executive summary

Task sharing is a strategy to address the high demand for health care and the shortage of skilled providers within the health system. Task sharing aims to achieve rational and optimal distribution of responsibilities among health teams. Specific tasks are shared, where appropriate, with less specialized health workers to make more efficient use of the available personnel.

Task sharing for contraceptive services can help address high levels of unmet need for contraception, particularly given health worker shortages. Since different contraceptive methods require different levels of technical competency for safe provision, the World Health Organization (WHO) has developed evidence-based recommendations on which health worker cadres can safely provide which methods. This includes the provision of certain contraceptive methods by clients themselves, community health workers (CHWs), pharmacists and pharmacy workers, auxiliary nurses, nurses, midwives and associate/advanced associate clinicians.

A large body of evidence demonstrates that task sharing for contraceptive services is safe and effective. Over fifty peer-reviewed studies were consulted to inform the development of this guidance, including studies on the safety and efficacy of task sharing, as well as programme implementation strategies.

While there is a strong body of evidence on the safety and effectiveness of task sharing for family planning, these policies and practices have not been widely scaled up in many countries. There are also inconsistencies in guidance and regulation within and between countries. Given these challenges, this document provides evidence-based guidance on planning, implementing and scaling up task sharing for contraception. The guidance is intended for use by policy-makers and programme managers in ministries of health or other implementing bodies, such as health facilities or non-governmental organizations (NGOs). Four actionable strategies are outlined to support the implementation and scaling up of task sharing for contraception:

1. **Advocacy and stakeholder engagement:** This includes how to understand WHO guidance, advocate for task sharing, engage key stakeholders and create a mechanism that can provide guidance and stewardship.

2. **Landscape analysis and planning:** This is an overview of how to use available data to craft an evidence-driven plan to implement and scale up task sharing.

3. **Task sharing implementation:** This section includes how to determine roles and responsibilities, update policies, design and roll out training, implement demand generation (where needed) and other relevant programmatic requirements.

4. **Monitoring and quality assurance at scale:** This section provides an overview on how to ensure continuous engagement of stakeholders as well as assure quality and other relevant requirements, and develop and implement monitoring activities.

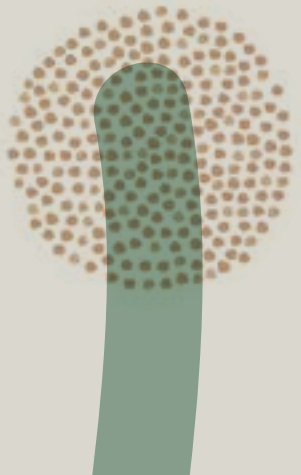
Lastly, the guidance document outlines key research gaps in task sharing for contraceptive services and discusses pertinent research questions and considerations on study design.

This guidance document is also accompanied by annexes containing several tools to support task sharing, including a PowerPoint presentation for advocacy; a project logical framework; a budget template; a cadre mapping table; and task sharing case studies from Kenya, Malawi, Nigeria, Pakistan and Senegal.

This WHO guidance is comprised of four sections:

- **Section 1:** Defines and describes the rationale for task sharing for contraceptive services as well as WHO's current recommendations on which health providers can safely offer different contraceptive methods.
- **Section 2:** Summarizes the status of task sharing for contraceptive services as well as the available evidence on task sharing.
- **Section 3:** Outlines recommended strategies for planning, implementing and scaling up task sharing for contraceptive services, including considerations and activity steps.
- **Section 4:** Contains the annexes which provide useful tools and templates.

Section one



Setting the scene

1.1 Definition of task sharing

Task sharing is a strategy to address high levels of demand for health care given the shortage of skilled providers within the health system. Task sharing aims to achieve the rational and optimal distribution of responsibilities among health teams. Specific tasks are shared, where appropriate, with less specialized health workers to make more efficient use of the available personnel.

Task sharing is widely recognized as a promising strategy for addressing the shortage of highly skilled health care workers *(1)*. By creating a more rational distribution of tasks and responsibilities among different health worker cadres, task sharing can improve access, equity and cost-effectiveness.

1.2 Rationale

Despite the growing body of strong evidence on the safety and effectiveness of task sharing for contraceptive services, these policies and practices have not been widely scaled up in many countries. There are also inconsistencies in guidance and regulation across countries regarding task sharing and contraceptive programmes. Given these challenges, this evidence-based guidance has been developed to help plan, implement and scale up task sharing within contraceptive programmes. This guidance document is intended for programme and policy managers in ministries of health and/or in other implementing bodies (such as NGOs).

Expanding access to contraceptive services

Among the 1.9 billion women of reproductive age (15–49 years) worldwide in 2021, 164 million were not currently using a modern contraceptive despite an expressed desire to prevent a future pregnancy *(2)*. This unmet need for family planning is greatest in sub-Saharan Africa and South Asia and is often skewed towards rural areas, among those with less education and among adolescents *(3,4)*. A critical barrier to accessing high-quality contraceptives in low- and middle-income countries (LMICs) is a shortage of trained health care providers. WHO advises a workforce density of 44.5 doctors, nurses and midwives per 10 000 people. However, there is an estimated global needs-based shortage of over 17 million health professionals, with the greatest shortages in rural areas, which are frequently those with a high unmet need for contraception *(5)*.

Contribution of task sharing to universal health coverage (UHC)

WHO and the international community have set critical goals for achieving UHC. This means that everyone should have access to the full range of quality health services when and where they need them, without financial hardship *(6)*. Task sharing for contraceptive services contributes to UHC by expanding coverage to underserved populations. By delegating specific tasks away from doctors and nurses to a broader range of health care providers, such as CHWs, midwives, and other non-specialist health workers, task sharing expands the reach, affordability and availability of family planning services. This approach allows more people, especially those in remote or marginalized communities, to access a wide range of contraceptive methods *(7)*. Task sharing also contributes to the demedicalization of health services by enabling community-based services where women may feel more comfortable and less stigmatized.

Supporting human rights through task sharing in programme implementation

A rights-based approach to family planning emphasizes the fundamental rights of individuals to make informed choices about their reproductive health without coercion or discrimination *(8)*. This approach prioritizes access to comprehensive information and services for contraception, ensuring that individuals can exercise their right to decide the number and spacing of their children, without discrimination based on race, national or ethnic origin, colour, religion, sex, age, or mental or physical disability. A rights-based approach also advocates for the protection of more vulnerable populations, ensuring that their needs are met and their voices heard *(9)*. A wider range of contraceptive methods provided by a wider group of health workers through task sharing can help to ensure that all individuals, particularly more vulnerable ones, have information about, and access to, the full range of contraceptive methods.

1.3 WHO recommendations

WHO recognizes that many different cadres, other than just physicians, can safely provide a range of contraceptive methods (Table 1). Numerous studies have demonstrated the safety and effectiveness of task sharing for contraceptive services. WHO's evidence-based recommendations advocate for the provision of a range of contraceptive methods by cadres such as CHWs, pharmacists and auxiliary nurses. See Box 1 for full WHO recommendations.

BOX 1

WHO recommendations for task sharing for contraception

Table 1 contains WHO recommendations for which cadres can safely provide which methods of contraception. The table is based on key WHO guidelines, including the guideline *Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting (1)*, an updated brief on task sharing to improve access to family planning/contraception *(10)*, the 2022 revision of WHO guidelines on self-care interventions for health and well-being *(11)*, WHO abortion care guidelines *(12)* and evidence from a recent systematic review *(13)*.

Consolidated table (2025)

Table 1 is based on a previous version of WHO's task sharing for contraception recommendations, originally published in 2017 *(10)*. Compared to the 2017 version of recommendations, Table 1 now includes subcutaneous Depot Medroxyprogesterone Acetate (DMPA-SC) as a contraceptive method and self-user as a cadre category. A systematic review, published in 2023, included studies assessing the safety of self-administration of DMPA-SC (compared to DMPA administration by trained health providers). The authors found that self-injection of DMPA-SC improved contraceptive continuation, with no increase in unintended pregnancy and no difference in side effects compared to provider-administered DMPA (both DMPA-SC and the intramuscular version, DMPA-IM) *(13)*. These findings are now in-line with other previously published WHO recommendations on self-care for contraception and other health interventions, which recommended DMPA-SC self-injection *(11)*. The recommendation for self-use of DMPA-IM aligns with WHO's recent recommendation in the abortion care guidelines, which states that DMPA-IM may be self-administered in specific circumstances (detailed below) *(12)*.

Assumptions and considerations

It is important to note that all the recommendations in Table 1 assume that the assigned health worker cadres will receive task-specific training prior to implementation. Additionally, the implementation of these recommendations requires functioning mechanisms for monitoring, supervision and referral.

The recommendations are applicable in both high- and low-resource settings. They describe a range of health workers who can perform the tasks safely and effectively. The options are intended to be inclusive and do not imply either a preference for or the exclusion of any particular provider. The choice of a specific health worker for a specific task will depend upon the needs and conditions of the local context. National policies and service delivery guidelines dictate which provider cadres can offer which specific family planning services.

Finally, it is also important to note that in these recommendations, pharmacists and pharmacy workers include those professionals who have received formal training and accreditation in line with WHO definitions (Annex 5). The table of recommendations is based on the cadres providing the contraceptive method or service rather than the type of facility or pharmacy/drug shop.

Table 1. Recommendations for task sharing in contraceptive services

Contraceptive service[1]	Self-user	Lay health workers	Pharmacy workers	Pharmacist	Auxiliary nurse	Auxiliary nurse/mid-wife	Nurse	Midwife	Associate/ advanced associate clinicians	Non-specialist doctors	Specialist doctors
Products and methods recommended by WHO for over-the-counter access for self-use, including: » male and female condoms » oral contraceptive pills » emergency contraceptive pills » DMPA-SC (with prescription) » fertility awareness-based methods » lactational amenorrhoea	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Injectable contraceptives (DMPA-IM, norethisterone enanthate (NET-EN) or combined injectable contraception (CICs)	✓[2]	✓[3]	✓[4]	✓	✓	✓	✓	✓	✓	✓	✓
Implant insertion and removal	✗	R	✗	✗	✓[5]	✓[6]	✓	✓	✓	✓	✓
Intrauterine device (IUD)	✗	✗	✗	✗	R	✓	✓	✓	✓	✓	✓
Vasectomy (male sterilization)	✗	✗	✗	✗	R	R	R	R	✓	✓	✓
Tubal ligation (female sterilization)	✗	✗	✗	✗	✗	✗	R	R	✓	✓	✓

Key:

✗	✗	R	✓	✓	✓
Considered outside of the typical scope of practice; evidence not assessed.	Recommended against	Recommended in the context of rigorous research	Recommended in specific circumstances	Recommended[7]	Considered within the typical scope of practice, evidence not assessed.

BOX 1

BOX 1

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[1] Note that before using any of these services or methods, comprehensive counselling should be delivered as a key component of the contraceptive service. Comprehensive counselling on the full range of contraceptive services should enable women and couples to make informed decisions about their reproductive choices, free from coercion, discrimination or misinformation.

[2] Women may self-inject DMPA-IM in specific circumstances, where prefilled syringes are available and 1) they have been trained in the technique of self-injection, 2) they have been trained in and provided with mechanisms for the safe and secure storage and disposal of sharps, and 3) they are able to procure injectable contraceptives on a regular basis without needing to repeatedly visit a health care facility *(12)*.

[3] Lay health workers may provide initiation and maintenance of injectable contraception if there is targeted monitoring and evaluation, as laid-out in the report *Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting (1)*.

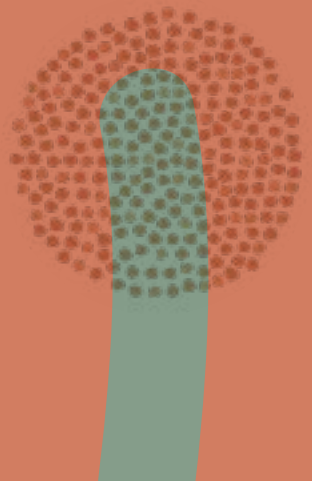
[4] Administering injections is within the typical scope of practice for trained pharmacy workers and thus they would need minimal additional training. This practice could be under the direct supervision of pharmacists. This is detailed in the summary brief *Task sharing to improve access to family planning/contraception* (10).

[5] Auxiliary nurses may provide implant insertion and removal with targeted monitoring and evaluation, as laid out in the report Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting *(1)*.

[6] Auxiliary nurse/midwives may provide implant insertion and removal with targeted monitoring and evaluation, as laid out in the report Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting *(1)*.

[7] Note that the specific circumstances are outlined in more detail in the WHO task sharing recommendations summarised in the guidance document *Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting (1)* as well as the summary brief *Task sharing to improve access to family planning/contraception (10)*.

Section two



Overview of evidence on task sharing for contraceptive services

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2.1 WHO regional survey of task sharing for contraceptive services

To assess the status of contraceptive services and the feasibility of further strengthening task sharing, WHO carried out a survey in member states of three regional offices (Africa, Eastern Mediterranean and South-East Asia) in 2023 (*Ali et al. Task sharing in Family Planning: Findings from 2023 WHO Survey of 64 Member States of Africa, Eastern Mediterranean, and South-East Asia Regions (European Journal of Reproductive Health and Contraception (Accepted, in press, 2025)*). The survey examined the cadres that are allowed to provide contraceptive information, counselling and methods (such as lay health workers, nurses, midwives and doctors). Contraceptive methods assessed included pills, condoms, injectables, implants, IUDs and sterilization procedures. Findings are based on responses from government officials who were asked to report on contraceptive provision by various health care worker cadres in their country.

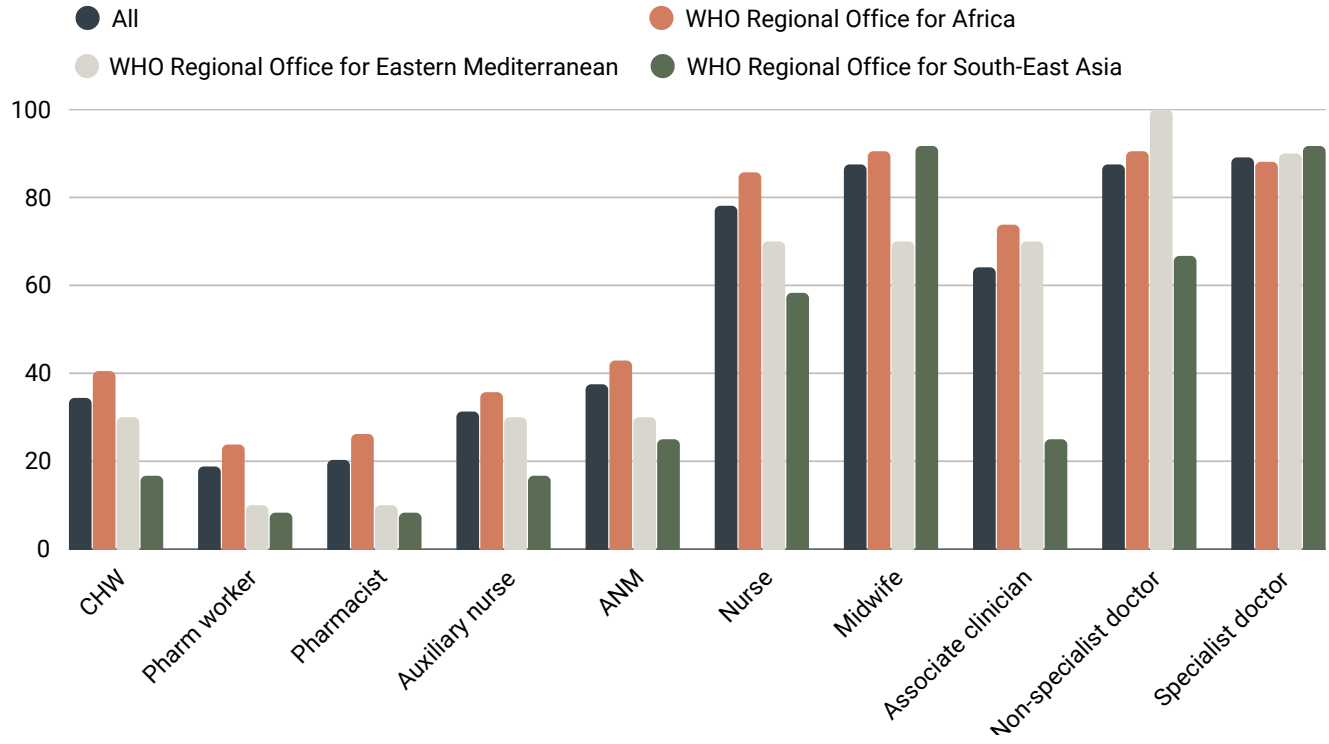
The survey found that task sharing implementation varies by method and does not uniformly conform to WHO recommendations by contraceptive method. Key findings include the following:

- Specialist and non-specialist doctors were the most widely reported providers of contraceptive counselling in all regions. Nurses and midwives also played significant roles, while pharmacy workers, pharmacists and lay health workers were less frequently reported as contraceptive counsellors, despite WHO recommendations for their involvement in counselling.
- Various cadres were allowed to distribute condoms, especially in the South-East Asia region where midwives, nurses and doctors were the most commonly reported providers.
- Oral contraceptives and emergency contraceptive pills were most frequently provided by doctors (both specialist and non-specialist), midwives and nurses in most countries within the African, Eastern Mediterranean and South-East Asian regions, but lay health workers and pharmacy staff were more involved in the African region than in the other two regions.
- Injectables (like DMPA) had limited task sharing, with relatively few countries reporting the provision of injectables by auxiliary nurses, pharmacists or pharmacy workers, despite WHO guidelines on task sharing. See Figure 1 for a detailed breakdown of DMPA provision by region and provider cadre.

» WHO guidelines recommend that implant insertion and removal be carried out by nurses, midwives and associate/advanced clinicians as well as non-specialist and specialist doctors; however, these procedures were commonly reported as being performed by specialist doctors and non-specialist doctors. The provision of implants by midwives and nurses was notably higher in the African region compared to the Eastern Mediterranean or South-East Asian regions.

» Sterilization procedures (tubal ligation) were mainly carried out by doctors (both specialist and non-specialist), with some countries also involving associate or advanced clinicians.

Figure 1. Percentage of countries reporting provision of injectable contraceptives, by service provider cadre (n=64 countries)



Note: CHW=community health worker; ANM=auxiliary nurse-midwife

There are stark regional variations in task sharing, with more task sharing strategies reported in the African region than in the Eastern Mediterranean or South-East Asian regions:

» More countries in the African region reported more task sharing, with lay health workers and less specialized cadres of health workers providing services like condoms and counselling.

» The Eastern Mediterranean region had the least widespread task sharing, especially in the provision of contraceptive methods, and specialist doctors were more dominant in providing services.

» The South-East Asian region has a higher modern contraceptive prevalence rate (mCPR) than the other two, but task sharing in the region is still limited, particularly in the provision of injectable contraceptives and implants.

2.2 Evidence on task sharing for contraceptive services

A narrative review was undertaken to collect and synthesize evidence on safety, uptake, acceptability, cost-effectiveness and programme implementation. A complete description of the review methodology can be found in Annex 8. Fifty-five peer-reviewed papers published over the past three decades were identified, reviewed and synthesized.

2.2.1 Safety

Three systematic reviews on the safety of task sharing for contraceptive services were identified *(13,14,15)*. All systematic reviews highlight that task sharing for contraceptives is safe and effective, but additional studies are needed to strengthen the evidence base.

WHO's initial 2012 task sharing guidance for contraceptive services was informed by a review of six randomized controlled trials (published in 2015). In this review, two studies assessed IUD insertion by nurses compared to doctors, two assessed IUD insertion by auxiliary nurse-midwives compared to doctors, one assessed tubal ligation by midwives compared to doctors and one assessed vasectomies performed by medical students compared to doctors. In general, little or no difference was found in safety and efficacy outcomes between cadres *(14)*.

A 2023 review identified six studies published since the 2015 report and again concluded that task sharing was generally effective and safe *(13)*. Five studies in this review compared DMPA-SC self-administration with DMPA administration by trained providers and found improved contraceptive continuation, with no increase in unintended pregnancy and no difference in side effects. The sixth study found tubal ligation provision by associate clinicians was equally safe when compared to advanced physicians *(16)*.

The most recent evidence comes with important nuances. A trial from Nigeria found that community health extension workers (a cadre of auxiliary nurses) successfully provided implants in rural settings, but attention to provider selection, training, supervision and follow-up were recommended to ensure provision quality *(17)*. A trial in Pakistan found challenges in the provision of DMPA by lay health workers in urban areas, who were unable to screen as well as family welfare workers *(18)*. Lady health workers in the study's rural areas, however, showed no difference in screening and displayed a better DMPA injection technique than the family welfare workers *(18)*.

2.2.2 Uptake

Task sharing expands access to family planning service delivery and, therefore, increases contraceptive uptake. A four-country rapid assessment conducted in 2021 found an increase in the use of family planning after the implementation of task sharing projects; injectable contraceptive use increased more than threefold within six months of a nationwide task sharing strategy around injectables in Burkina Faso; the contraceptive prevalence rate doubled with declines in unmet need for contraception in Ethiopia; and the uptake of long-acting reversible contraception (LARC) methods increased in Ghana and Nigeria *(19)*.

BOX 2

CHWs as an increasing cadre of focus for task sharing

CHWs are a cadre of health workers (sometimes referred to as lay health workers) who receive training in delivering specific health interventions (such as contraceptive counselling or DMPA-SC distribution) but who have received no formal educational certificate or degree *(1)*.

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CHWs and contraceptive use

CHWs have been shown to increase contraceptive use in places that lack universal access to clinic-based services. A review of community-based programmes in sub-Saharan Africa found that six of seven experimental studies demonstrated a significant increase in contraceptive use or reduction in fertility rates *(20)*. A 2005 evaluation in Pakistan illustrated that women served by lady health workers (a CHW cadre) had one and a half times the odds of using a modern reversible method of contraception than women in communities not served by the programme, even after controlling for various household and individual characteristics *(21)*.

CHWs and key factors for success

A qualitative evidence synthesis of 53 CHW programmes for maternal and child health found that success was tied to programme acceptability, appropriateness and credibility as well as to health system constraints *(22)*. Clients may appreciate CHW skills and the similarities they see between themselves and the CHWs, but this may be counter-balanced by concerns about confidentiality when receiving home visits.

Considerations for programme implementation

Work still needs to be done around these programmes and methods to reach the most vulnerable community members, such as adolescents. A study from Uganda highlighted that most young people preferred to access contraception through hospitals and other distribution points in the formal sector, citing fear of privacy violations from village health teams as the main reason for not accessing their free services *(23)*. Also, clients may perceive CHWs as irrelevant or insufficient if they only engage in health promotion activities (and do not distribute commodities or provide services) *(22)*.

2.2.3 Acceptability

Studies assessing client acceptability of task sharing generally report high levels of satisfaction. A task sharing study from northern Nigeria noted that over 95% of surveyed clients reported being satisfied with implants provided by community health extension workers *(24)*. A study from Ethiopia found that 98.2% of tubal ligation clients (who received the task shared procedure from a health officer) would recommend the procedure, as performed by the health officer, to a friend *(25)*. In some contexts, however, concerns about the acceptability of task sharing have surfaced. In the United Kingdom, a relatively new health provider cadre known as a physician associate is under review by the British Medical Association, which cites concerns that they are being asked to do tasks they are not trained for and that there is confusion among patients over their qualifications *(26)*.

2.2.4 Cost-effectiveness

Analysis from The Guttmacher Institute's most recent Adding It Up (AIU) model estimates that implementing WHO recommendations for task sharing for contraceptive services would reduce contraceptive service delivery costs by 28% – or an estimated $1.6 billion cost difference – across 128 LMICs. See Box 3 for the full case study.

BOX 3

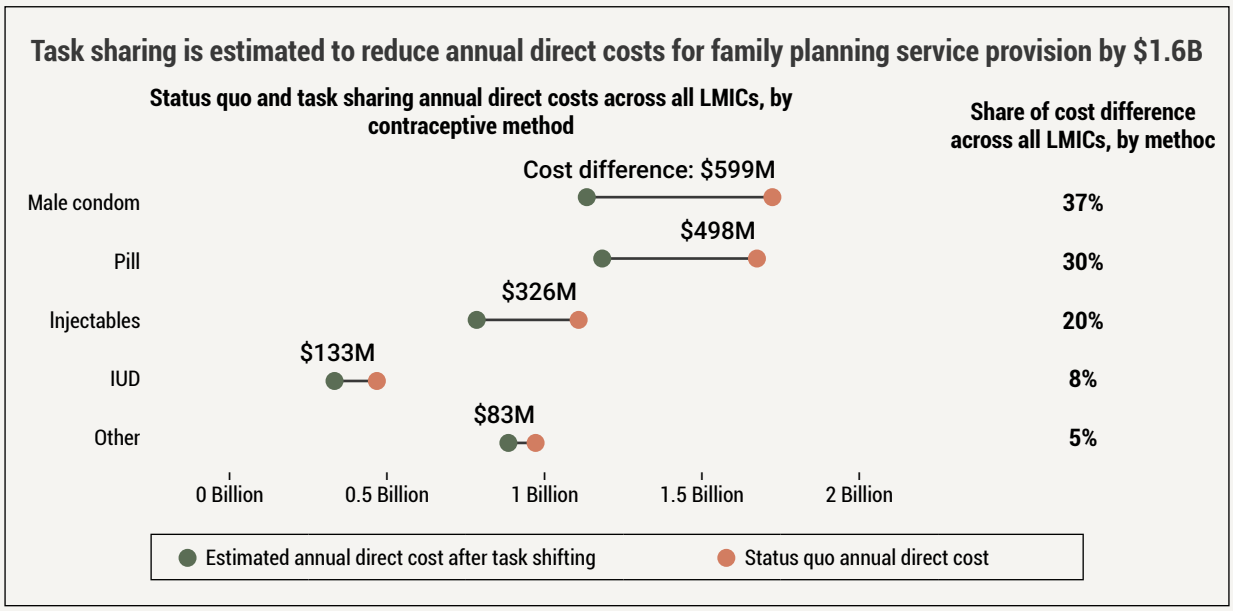
Modelling cost savings from task sharing using the AIU model

A forthcoming analysis, using The Guttmacher Institute's AIU model, estimates that significant cost savings can be achieved by implementing WHO task sharing recommendations[8] (see Table 1) for contraceptive services. Key savings include the following:

1. Fully implementing WHO recommendations would reduce service delivery costs by 28% – or an estimated $1.6 billion – across 128 LMICs. Excluding the task sharing of condom provision, $1 billion in cost savings is still estimated.
2. Task sharing is estimated to bring the highest cost difference and savings for male condoms, contraceptive pills, injectables and IUD provision across all LMICs, adding up to 95% of the overall $1.6 billion cost difference.
3. The largest share of the estimated savings comes from reduced costs in service delivery for male condom provision – nearly $600 million or 37% of the total LMIC cost savings. At nearly $500 million, the second largest share of cost savings is from task sharing contraceptive pill provision, followed by $326 million (20% share) from injectable provision and $133 million (8% share) from task sharing IUD provision.

The AIU model estimates the cost of direct service delivery of contraceptive services, using personnel, commodities, drugs and supplies data. The model accounts for personnel time not only to administer a specific contraceptive method but also to provide quality rights-based service delivery through informed choice counselling as well as counselling for sexually transmitted infections (STIs), including HIV and gender-based violence screening.

Figure 2. Estimated differences in direct costs of annual family planning service provision with task sharing in all LMICs, categorized by contraceptive method.



Additional methodology and results from the AIU model are available from *Adesina A, Sully E, Quinn H, and Ali M. The cost-savings associated with implementing task-sharing in family planning service delivery: model-based estimates for low- and middle-income countries. The Guttmacher Institute, 2024.* A peer-reviewed publication is expected in 2025.

[8] Modelling is done using two scenarios for each specific method type: the first representing the status quo and the second reflecting the implementation of WHO's task sharing recommendations (Table 1). Cadres are based on WHO recommendations, and for this modelling exercise, community health workers are assumed to have received training in-line with auxiliary nurses, rather than lay health workers.

2.2.5 Programme implementation

Recent reports from diverse country contexts have underscored the role of different policy processes for successful task sharing, including the importance of leadership and/or support from ministries of health; the formation of policy advisory committees and/or technical working groups to help lead or help draft policies; the presence of policies, regulations or laws on task sharing; the presence of community health strategies and programmes; ongoing dialogues and discussions on task sharing; in-country communication strategies, including advocacy; and financial commitments (budget lines) for impact sustainability (19,27–29). Box 4 discusses the literature around commonly cited challenges in task sharing implementation.

BOX 4

Challenges to implementation and ways to address them

Reports have documented common challenges to task sharing implementation across different country contexts, namely the difficulties in retention of less-specialized cadres due to financial constraints (insufficient incentives); inadequate documentation of successful processes to support internal learning and external lesson sharing; and difficulties capturing data on service provision by different cadres *(19)*. A recent paper on CHW programmes also highlights financial challenges, with programmes facing inadequate financing, lack of supplies and commodities, low compensation of CHWs and inadequate supervision *(30)*. To address these implementation challenges and ensure the quality and sustainability of task sharing activities, studies highlight a range of strategies, including the following:

1. **Scaling up training and periodic retraining or refresher training** will ensure cadres can maintain and enhance skills. Studies show providers also need sustained experience with new methods to prevent deskilling. For example, a study in Madagascar found higher performance scores among trained CHWs were correlated with more years of education, more weekly volunteer hours worked and refresher training *(31)*.

2. **Mentoring and supportive supervision**, including regular quality assurance checks, will provide newly trained cadres with the opportunity to improve their skills, especially with clinically more complicated services like implants.

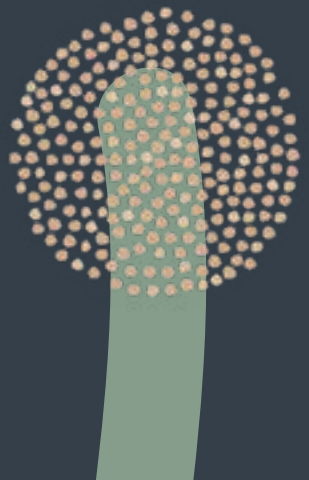
3. **Improved use and dissemination of data and evidence** will help better inform task sharing activities *(17,31–34)*.

4. **Demand generation** is also critical. A recent report on implant task sharing by auxiliary nurses in Nigeria noted that substantial demand-generation activities were needed for research and quality provision (because quality improved with insertion experience) *(17)*. Another study from Nigeria noted a lack of demand for services as a major barrier to task sharing service provision *(24)*.

2.2.6 Evidence summary

The evidence strongly supports task sharing as a viable and effective strategy for expanding access to contraceptive services, particularly in resource-constrained settings. By leveraging the skills of a broader range of health workers, task sharing addresses critical gaps in service delivery, improves contraceptive uptake and offers a cost-effective solution to the global need for accessible reproductive health care. However, careful implementation requires appropriate demand-generation activities, ongoing support to providers, monitoring, communication and quality assurance activities as well as appropriate remuneration.

Section three



Effective strategies for implementing and scaling up task sharing in contraception programmes

3.1 Overview

This section describes strategies for the successful implementation of task sharing for contraceptive programmes. Useful tools to support implementation have been provided in the annexes, including an example PowerPoint presentation, a theory of change, a logical framework, a budget template, a cadre mapping table, documentation for a standard operating procedure (SOP) and an action after review (AAR) template. Additionally, the annexes contain detailed country case studies on task sharing.

These strategies can support countries at different stages of task sharing, ranging from those just planning or piloting a programme to those who have implemented but need to scale-up their programme to those already scaled-up and need to strengthen monitoring, quality assurance or research programmes. The strategies are informed by the narrative review of the evidence (Section 2), implementation frameworks or guidance on task sharing *(35–37)* and recommendations from a WHO-convened task sharing expert group.

Each strategy section provides an overview of considerations and actions to take. The need and relevance for actions under each strategy will depend on the specific country context. The strategies are detailed in Table 2, with an explanation of where to focus depending on the circumstance.

Table 2. Summary strategies for planning, implementing and scaling up task sharing for contraceptive programmes

PHASE	The planning phase		The implementation phase	The scaling up phase
STRATEGIES	**Strategy 1:** Advocacy and stakeholder engagement	**Strategy 2:** Landscape analysis and planning	**Strategy 3:** Implementation	**Strategy 4:** Monitoring and quality assurance at scale

Information, recommended actions and considerations include…	• Identify leadership
	• Identify task sharing methods and cadres
	• Advocate with evidence and modelling
	• Identify and engage key stakeholders
	• Consider backlash
	• Form a task sharing oversight mechanism
	• Formulate a budget
	• Secure funding
		• Retrieve and analyse relevant data
		• Understand previous bottlenecks to task sharing
		• Understand WHO guidelines for task sharing
		• Develop a plan
		• Feasibility test (where needed)
			• Define roles and responsibilities for all cadres
			• Update scopes of practice for health workers, including regulations and guidelines
			• Update remuneration schemes
			• Design pre- and in-service training
			• Design a supportive supervision and management system
			• Design a referral system
			• Update the health management information systems (HMISs)
			• Update the supply and logistics system
			• Design communication and demand-generation strategies
			• Planning and assessment for medium- and long-term scale-up
				• Integration/roll out within the health system
				• Coordinate efforts across the health system
				• Continuous community and stakeholder engagement
				• Upholding standards through the following:
				  ◦ Quality monitoring, including incident reporting
				  ◦ Client feedback monitoring
				  ◦ Performance assessments (including provision, referral and supervision)
				• Budgeting/financing

Countries/ organizations should prioritize this area if…	No task sharing for contraceptive services is taking place, and/or a policy change is needed.	Little or no task sharing for contraceptive services is taking place, but policy is in place and/or scale-up is imminent.	Task sharing for contraceptive services is already taking place, but perhaps not at scale, and a new or refined strategy is needed.	Task sharing for contraception is widely practised, but system improvements are needed.

Several cross-cutting considerations span many or all scenarios.

These considerations include advocacy, stakeholder engagement (including consultations with the community/the public), considerations of vulnerable groups, monitoring activities, research and learning, and financing.

3.2 Strategy 1: Advocacy and stakeholder engagement

Advocacy and stakeholder engagement are crucial for task sharing for contraceptive services because they help build awareness and support for these policies, ensuring that diverse perspectives are heard early in the process. Engaging stakeholders fosters collaboration, prevents potential backlash, enhances resource allocation and leads to more effective, tailored solutions, ultimately improving access to and quality of contraceptive services.

BOX 5

Understanding WHO guidelines on task sharing for contraception

The full summary brief and recommendations table for WHO guidelines for task sharing for contraception can be accessed here. Table 1 in Section 1 of this document contains updated recommendations on which cadre can provide which method.

WHO also recommends the following key considerations to enable health care cadres to provide an additional service safely: initial and ongoing training for service providers and their supervisors and trainers to maintain competence and confidence; supplies of drugs and other commodities; supervisory responsibilities; lines of referral for management of complications; monitoring and evaluation systems; necessary changes to protocols, regulations and curricula to support the relevant cadre's new scope of practice; and salaries or remuneration to reflect changes in the relevant cadre's scope of practice *(10)*. Also, note that the option of task sharing in contraceptive services is recommended for consideration in the following situations:

1. Access to services is limited by either an overall shortage of health workers qualified to provide specific methods or by their uneven distribution across a country or region.
2. There are difficulties in ensuring staff retention of more specialized cadres in certain settings, such as rural areas.
3. The lower salary levels of mid- or less specialized health worker cadres can reduce the budgetary cost of providing contraceptive services without compromising client safety.
4. There is a need to free the time of more specialized health worker cadres so that they may better focus on the provision of services requiring a higher level of technical proficiency *(10)*.

Identify which method of family planning could or should be task shared and to which cadre: Map current provision regulations and practices by different cadres and WHO recommendations. Common opportunities for task sharing recommended by WHO include the following:

- Associate/advanced associate clinicians can safely provide vasectomy and tubal ligation.
- Nurses, midwives and auxiliary nurses/midwives can safely insert IUDs.
- Auxiliary nurses/midwives can safely insert and remove implants.
- Community health workers can safely provide condoms, pills and injectables.
- Users can safely self-administer DMPA-SC (self-care).

[9] Note that, while salaries of less specialized cadres of staff may be lower than that of more specialized cadres, WHO recommends that appropriate remuneration be given once the cadre has been trained and begins delivering the task shared family planning services.

(Continued from page 18)

BOX 5

If an opportunity for task sharing is identified, review the current training that the identified cadre receives and assess what additional training would be required to enable safe and effective provision. Also, assess if local evidence will need to be generated through a pilot test or evaluation or if the WHO guidelines are an acceptable starting point.

On the role of self-care in well-being

Note that when task sharing injectables to clients (women, users of family planning), specifically DMPA-SC, this is classified as self-care. Self-care is defined by WHO as the ability of individuals, families and communities to promote health, prevent disease, maintain health and cope with illness and disability with or without the support of a health care worker *(11)*. Special considerations must be given when offering DMPA-SC as self-care, including being delivered in a safe and supportive environment. Special attention should be paid to some of the considerations laid out in this guidance document, especially the development of a referral system, adequate monitoring and quality assurance of commodities.

The following is an overview of eight actions that can be taken when beginning a task sharing for contraceptive services initiative:

1. **Review and fully understand the WHO guidelines and recommendations on task sharing for contraceptive services:** This includes understanding which health care cadres have been recommended to provide which method of family planning and under which circumstances task sharing is recommended. Please see Box 5 for details.

2. **Identify leadership:** Identify leaders, ideally staff from the Ministry of Health, to direct the strategy and see it through to implementation and national scale-up. Strong project leadership can support the vision, mobilize resources effectively and help motivate those in positions of power to act. If a country is initiating task sharing, early leadership will ensure clear communication of goals, establish accountability and help foster a supportive environment thus reducing the risk of backlash later in the process.

3. **Advocate for task sharing for contraceptive services with evidence and modelling:** To build awareness and support for a task sharing policy or strategy, use the PowerPoint presentation included in Annex 1 to advocate for the benefits of task sharing for contraceptive services. This PowerPoint presentation can be loaded with country- or setting-relevant data and used to communicate the benefits of task sharing for expanding access to contraceptive services. Modelling tools, available online, can be used to demonstrate potential impacts, costs and cost savings, which may be helpful for advocacy purposes. See Box 7 for links to modelling tools.

4. **Engage key stakeholders to gain support, insights and feedback:** While it may not be necessary to engage with all the stakeholders on this list, it is important to think strategically about task sharing goals and which stakeholders would be pertinent. For example, if you are using a task sharing strategy to expand access to contraception among adolescents, then it is critical to prioritize youth groups. Consider how task sharing in contraceptive services affects and, in turn, is potentially affected by task sharing efforts in other areas such as safe delivery, prenatal and postnatal care, safe abortion or mental health. Consider if there are stakeholders from these other areas who can provide linkages and support to the task sharing initiative.

A list of key stakeholders may include (but are not limited to) the following:

- Government health departments (such as those dealing with human resources for health and health policy/planning)
- Training institutions
- Government financial departments (for securing funding)
- Professional bodies and associations (such as GP associations, obs/gyn associations, nurses/midwives associations, pharmacists associations, allied health workers associations, or others)
- Regulatory bodies
- Patient representation groups
- Community leaders
- Non-governmental organizations;
- Youth groups or adolescent groups (or adolescent sexual and reproductive health groups, if they exist)
- Family planning and reproductive health researchers in local or international universities
- Research ethics committees (if a significant research or evaluation component is required).

5. **Consider the potential for backlash to task sharing and develop strategies to prevent it:** Backlash to task sharing for contraceptive services could arise for any number of reasons, from concerns about service provision quality, resistance from established providers fearing loss of status and income to cultural opposition to contraception in general. This backlash may come from politicians, professional associations, the community, the public (including social and print media) or all four. To reduce the likelihood of backlash, prioritize comprehensive training and supportive supervision of staff to ensure a high quality of service provision and communicate and engage with stakeholders about these activities from the start before scale-up. Box 6 contains several tips to reduce backlash and professional territorialism.

BOX 6

Tips to reduce backlash and professional territorialism

To reduce professional territorialism and rivalry, it is important to do the following:

- Emphasize the benefits of task sharing, namely that it expands access to contraceptive services and improves methods choice and that this will improve health outcomes.
- De-emphasize any hierarchy mindset, which may occur among health professionals, and try to bring providers together with the goal of efficient health resource distribution, ultimately leading to improved health outcomes.
- Establish clear roles and responsibilities for each cadre, emphasizing the importance and value each one brings.
- Foster a culture of teamwork that removes the hierarchy mindset from different provider cadres. It may help to reiterate that everyone is working together to expand access to a full choice of family planning methods and that each provider has an important role to play.
- Consider creating a feedback mechanism where staff can voice concerns.
- Share successes, reinforcing a sense of shared purpose.
- Consider creating rewards, such as additional training courses or other professional development activities, to recognize collaborative efforts and reduce competition.

6. **Form a task sharing oversight mechanism:** An oversight mechanism (such as a committee, task force, working group, etc.) will be helpful to steer the task sharing initiative and provide programme stewardship. The oversight group should include leadership from the Ministry of Health as well as other key stakeholders (many examples are listed earlier in Strategy 1 – for example, if the purpose of your strategy is to reach more adolescents, then consider including representatives from youth groups). If there are existing national, regional or global groups tasked with oversight and already dedicated to family planning, consider linkages to those groups as well. The group should agree on their mission and outputs and capture these in written and agreed-upon terms of reference. Additionally, a task sharing executive committee may be formed. This group is a subset of the larger group and would consist of three to four people who are responsible for leadership and decision-making on behalf of the group. At this stage, people/positions who are responsible and accountable for implementation should also be defined.

7. **Formulate a budget:** Setting a budget early in the task sharing process is crucial. This will help prioritize resources, manage stakeholder expectations and ensure that any financial constraints are considered in decision-making processes. Use the example budget items template in the Annex 2 if needed. It has line items that consider personnel (including updating remuneration schemes for cadres delivering new methods), training costs (both initial and follow-up), demand generation, monitoring, evaluation and continuous supportive supervision. Ensure that the budget aligns with project goals and the project goals align with the amount of funding that is available. For countries embarking on a task sharing strategy, there may be a need for an initial investment of time and resources, but once task sharing is in place and functioning effectively, cost savings should be observed.

8. **Secure funding:** If the task sharing project is being funded through domestic financing, ensure that resources are earmarked within departmental budgets. If donor funding is necessary, research potential sources (government grants, private foundations and NGO partners). At this stage, consider potential partnerships with others in the health ecosystem (such as NGOs or charities) that have similar goals and are aligned with task sharing for contraceptive services; this may also help increase project credibility and raise funds.

BOX 7

Modelling tools for estimating impacts of contraceptive programmes

The following tools are publicly available and when combined with service statistics and other data can estimate various public health impacts of contraceptive service delivery programmes, including the impacts of expanded service delivery from task sharing programmes:

- **Impact 2 from MSI Reproductive Choices:** Impact 2 - MSI Reproductive Choices can estimate the health impacts of service provision based on the number and type of services provided. It can be used from a national perspective or an organizational perspective.
- **Guttmacher Family Planning Investment Impact Calculator:** The Family Planning Investment Impact Calculator | Guttmacher Institute can estimate the impacts of actual, planned or hypothetical investments in family planning, including cost savings.
- **Avenir Health Spectrum Models:** Avenir Health can project family planning requirements needed to reach national goals for addressing unmet needs or achieving desired fertility.

3.3 Strategy 2: Landscape analysis and planning

This strategy has two components. The first is to understand the health landscape through data and guidelines, to be demand-driven and to develop an evidence-informed rationale for task sharing. The second component is the development of a strategic plan for task sharing contraceptive services based on a comprehensive understanding of the health landscape.

Understanding the health landscape

It is essential at the start of any task sharing project to analyse the health landscape to effectively plan for implementation or scale-up. Analysing the relevant data will allow for a tailored, effective and culturally sensitive approach to task sharing implementation or scale-up and will ultimately improve the likelihood that the project will achieve its goals. Task sharing is about resource optimization, and thus, it is important to look beyond just the family planning sector to the health system landscape in a country to make efficient and strategic use of available resources. The table below provides types of data and indicators to analyse as well as data sources. For each data type, consider the key stakeholders to involve in the assessment of data.

Table 3. Data to understand the health landscape

TYPE OF INFORMATION	INDICATORS AND ACTIVITIES	DATA SOURCE	QUESTIONS TO GUIDE PLANNING
Family planning/ contraception	Contraceptive method use and mix (types of methods used) Identify gaps in contraceptive service delivery and the potential reasons why (for example, is it due to provider shortages, high unmet need for contraception, low demand for services, geographic barriers or something else?). Analyse the data in different ways, for example, by age, parity, geography, rural/ urban, ethnicity, education or wealth quintiles. Analyse data by contraceptive type.	Demographic and Health Survey (DHS)*/ DHS Stat Compiler UNICEF's Multiple Indicator Cluster Survey (MICS) Health management information system (HMIS) Programme level data where relevant WHO's bottleneck assessment tool can support the user in assessing trends in contraceptive and other demographic indicators: https://www.who.int/publications/m/item/rapid-assessment-of-bottlenecks-inhibiting-the-scale-up-of-evidence-based-family-planning-practices *Useful DHS data include the women's questionnaire as well as service provision assessment data	Which contraceptive methods are most used? Which groups have the lowest use of contraception? Which groups have the greatest unmet need for family planning? Which groups have the greatest demand (current use and unmet need)? Which groups have the highest levels of intention to use in the future? What are the reasons for non-use in those with unmet needs? What is the method mix among different groups?
Acceptability amongst clients and providers	Qualitative indicators of acceptability and satisfaction are useful.	Use databases, such as Google Scholar or PubMed, to search for local, relevant articles about task sharing acceptability among different groups, such as clients, providers or special groups (such as adolescents or sex workers). See also the section below on conducting feasibility studies.	Is task sharing (specify contraceptive type) acceptable amongst (specify group)? Does the (specify group, for example, adolescents) already prefer to access services from the task shared provider, or from somewhere else?
Health workforce and service provision points	Look at the number and distribution of health workers by cadre and location (state, region). Also, look at the type of facilities currently providing contraception. Categorizing facilities based on their type (private/ public, clinic/hospital/pharmacy/drug shop) acknowledges that certain types of facilities may be preferred or are the only viable option for specific (or more vulnerable) population groups. Factoring in task sharing among the cadres providing services at these facilities, particularly for groups such as adolescents, could further optimize service delivery.	Check to see if your country has a Health Labour Market Assessment Report from the Ministry of Health. Here is an example report from Kenya, which formed the basis of its national task sharing policy: Final_Kenya_HLMA_Report_2023_v8.pdf (labourmarket.go.ke)	Review data on your health system and determine who can currently provide contraceptive services. What types of contraceptive services can they provide? How is contraceptive service delivery currently organized and what are the key points of contact and other pertinent information? Assessing the availability and capacity of service providers at facilities that are preferred by certain groups (for example, adolescents) could inform targeted interventions to improve access and equity.
Regulatory environment	Review national and local policies, regulations and guidelines that govern task sharing, including the scope of practice for different health worker cadres. Reach out to the Ministry of Health and other regulatory stakeholders as early as possible to determine the necessary regulatory steps, if any, to advance task sharing. Cadres absorbing new responsibilities may need additional legal protections to adequately perform their roles. If regulations need to be changed, it can be a multi-year process. Ensure all necessary contraceptive-related supplies and commodities are available. Refer to the Essential Medicines List and if anything needs to be added, make sure it is.	Ministry of Health Check to see if your country has a Health Labour Market Assessment Report from the Ministry of Health (see Kenyan example above). Essential Medicines List	Is the regulatory environment and health system set up to cope with task sharing? If not, what needs to be changed? Will newly trained cadres assuming new responsibilities be offered adequate legal protection for their new roles through updated laws, regulations, policies and guidelines? Is the Essential Medicines List fully up to date or does it need to be updated?

In addition to the health landscape data, it is also important to understand the following information and guidelines:

Assess any bottlenecks to task sharing for family planning. WHO has developed a tool to help identify bottlenecks and prioritize solutions if task sharing has stalled following a successful pilot programme. Typical task sharing bottlenecks cover a range of health systems factors, including health worker regulations and curricula (to support the relevant cadre's new scope of practice); health worker motivation and incentivization (including salaries/remuneration to reflect changes in the relevant cadre's scope of work); HMIS; budgetary prioritization (at different levels of the health system); and sector/public/community engagement (to help prevent backlash to task sharing (amongst providers, clients or other stakeholders)). The WHO Bottlenecks Assessment Tool can be accessed here: https://www.who.int/publications/m/item/rapid-assessment-of-bottlenecks-inhibiting-the-scale-up-of-evidence-based-family-planning-practices.

Understand WHO call-to-action: WHO has set forth a call-to-action for advancing the public sector scale-up of health innovations. The call-to-action asks governments and their ecosystem partners to accelerate the achievement of the Sustainable Development Goals through health innovations such as task sharing for contraceptive services *(38)*. It is imperative to understand the specific and different "asks" (meaning various roles and responsibilities) of government versus other partners in scaling up task sharing, as detailed here:

- The specific areas required of governments include being demand-driven, conducting assessments to identify appropriate innovations, piloting, appropriate scaling up pathways, resourcing, implementation plans, learning and iteration, and institutionalization.
- Ecosystem partners (such as NGOs) are requested to focus on facilitating consultations (this is especially pertinent to reducing the likelihood that task sharing faces significant backlash), showcasing innovations, assisting decision-making, suppling resources, assessing implementation and enabling sustainability.

Develop a plan

After all the relevant data have been analysed, and the relevant recommendations and guidance reviewed, an appropriate strategy can be developed and implemented. The task sharing oversight mechanism, in partnership with the Ministry of Health, should have stewardship over this process. A strategy can be developed through the following actions:

1. **Develop a theory of change (ToC) and a logical framework.** Developing a ToC and a subsequent logical framework will help you think about how to define the success of your project (for example, is success an increase in contraceptive prevalence, the increased uptake of an under-used method, a reduction in unintended pregnancies or greater cost-saving and efficiency?) as well as the required strategies to achieve it. The ToC will also inform a monitoring, evaluation and learning (MEL) plan later and can be used to communicate the aims of the work.

   For many task sharing for contraceptive services projects, the goal, which should align with the ToC and logical framework, will be "to increase access to contraceptive services". From there, outcomes, outputs and activities will be developed in support of the goal. For each outcome, output and activity, indicators should be developed as a way of measuring progress. Please note that all indicators should be specific, measurable, achievable, relevant and timebound (SMART). An example ToC and logical framework for task sharing for contraceptive services, with example indicators, can be found in Annex 3 and Annex 4.

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2. **Feasibility assessment.** Since task sharing for contraceptive services is a well-tested and proven strategy for expanding access to contraceptives, if there are clear protocols for health

worker training, a formal pilot test or evaluation is generally not needed. However, when implementing task sharing in a specific context for the first time, it may be important to assess the feasibility and effectiveness of implementation strategies before scaling up. In some instances, a larger pilot test or evaluation may be needed to provide strong local evidence to advocate for the safety and effectiveness of task sharing. Different approaches are described in Box 8. It is essential to monitor the process regularly and closely, with the goals of iterating and learning for scale-up.

BOX 8

What type of assessment should be considered?

The scale and type of assessment needed may depend on the level of clinical risk accompanied by task sharing the contraceptive method. Different types of assessments include the following:

Feasibility studies: These are small-scale assessments of implementation processes to support WHO-recommended task sharing (for example, the provision of DMPA-SC by CHWs). Assessments are usually conducted in a limited geographic area or selected health facilities to measure implementation processes and outcomes such as resource requirements, managerial processes, acceptability and/or costs. These are likely to rely on routine programme or financial data, supplemented by managerial feedback data (for example informal interviews or focus groups with providers or managers). Data collection for a feasibility test should include routine monitoring data on service provision (client characteristics, service provision and clinical quality indicators) as well as any other data collected, such as qualitative feedback from family planning users, providers (all cadres involved in the project) or other relevant stakeholders in the community.

Pilot test: A quantitative pilot test may be required by policy-makers to produce robust local evidence on the effectiveness and/or acceptability of task sharing, particularly if there are doubts about cost-effectiveness or acceptability. Pilot testing may also need to assess the effectiveness of demand-generation activities if these are required to enable effective task sharing (see section below). Depending on the size of the pilot test and the research methods being used, research ethics committee approval will usually be required.

Evaluation research: For task sharing that is only recommended under research conditions (Table 1, Section 1), larger-scale evaluation research may be required. For example, evaluating the safety of IUD provision by auxiliary nurses or implants by community health workers. Data collection for a clinical evaluation must be extremely rigorous to ensure results are reliable, valid and replicable. Clinical evaluations will also need approval from a research ethics committee and will entail a far longer research process.

3. **Use assessment data to improve processes.** Use data from the feasibility assessment to review performance and identify areas for improved service delivery and programme implementation. See Annex 7 for a template of an action-after-review (AAR) tool. This tool, and others like it, may help focus on areas of improvement and can ensure adherence to standards and reinforce positive outcomes. The AAR tool may be used after key interventions are delivered, when performance concerns arise or after training has been conducted. The frequency of the AAR will vary based on the providers' experience and the nature of the service provision, but it should always be part of a broader quality assurance system. Providers should always be informed upfront about the AAR and provide consent before the review is conducted.

4. **Share findings.** The findings from the feasibility test should be shared (through presentations, reports and meetings) with key stakeholders, including clients, providers, funders and other partners. Discuss any challenges identified during the pilot, changes that need to be made and how they will look in practice. Request feedback from key stakeholders. Finalize any findings with clear recommendations for improved and scaled-up implementation of task sharing in the specific context.

5. **Refine the approach.** Based on the feasibility test results and feedback from key stakeholders, refine the implementation approach for task sharing for contraceptive services. This may include revisions to training materials, SOPs, support systems (such as quality assurance systems or referral systems) or even data collection tools, as needed. When planning for scale-up, the theory of change and logical framework may need revising as well.

3.4 Strategy 3: Task sharing implementation

There are 11 key actions to take for programme implementation at scale:

1. **Define roles and responsibilities for all staff.** Create and/or update SOPs to provide clear guidance on the types of contraceptive services that can be safely and effectively delivered and by whom. Develop SOPs that detail each task, including counselling (if applicable); the eligibility criteria for clients receiving the contraceptive method; step-by-step instructions for delivering the method and any follow-up care, if applicable; and protocols for follow-ups, referrals, and emergencies. An example SOP can be found in Annex 6.

2. **Update regulations and guidelines.** Update any existing regulations to ensure that they align with WHO task sharing recommendations as required. Ensure they include provisions for training, remuneration, oversight and quality assurance.

3. **Remuneration schemes.** The way health workers are compensated can provide incentives for productivity and quality of care. WHO recommends that any health worker newly providing a contraceptive method receive appropriate and commensurate remuneration once they have been adequately trained and are providing services. Ensure that the remuneration schemes (or agreements) are appropriately updated and that an amount or commensurate recognition has been agreed upon by all parties involved. Ensure that contracts are updated to reflect new responsibilities and any additional pay or other rewards or recognitions. Consider if the remuneration will be in the form of a salary or something else, such as a performance-based payment. If the positions that are being task shared are volunteer positions, consider how to leverage non-financial incentives. Some countries have provided training, clothing and supplies or free health services for CHWs and their families.

4. **Design pre- and in-service training.** Develop comprehensive training modules tailored to the level of the providers, focusing on knowledge, skills and competency. If the task sharing programme is designed to reach certain vulnerable groups, training sessions should include considerations on working with those groups. For example, when working with young people, particularly adolescents, there are extra privacy concerns around accessing family planning. Programmes need to take their particular needs into account, such as the disposal of DMPA-SC (which has privacy implications). For all aspects of training, include practical sessions, simulations and supervised practice as well as clinical mentorship. Additional considerations for training include the following:

    - **Using or adapting publicly available training resources:** The WHO USAID UNFPA Contraceptive Training Resource Package has been developed to be an online resource for training modules on various contraceptive methods and tools. It is available here: http://www.fptraining.org. The document “Ensuring human rights in the provision of contraceptive information and services: Guidance and recommendations” is available here: Ensuring human rights in the provision of contraceptive information and services.
    - **Pre-service training:** Consider how and whether it is possible to integrate these training modules into the curricula of nursing and midwifery schools or technical training programmes. If task sharing involves CHWs, identify and review their relevant training programmes and consider integrating method-appropriate modules in those programmes.
    - **In-service training:** Consider how in-service training will be conducted. As new cadres absorb new responsibilities of service provision, there may be a need to provide continuous training opportunities as they develop their skills.

- **Different training modalities include the following:**
  - » group training and teacher demonstration (practicum)
  - » e-learning – which may be helpful depending on which method of contraception is being task shared (for example, for methods such as emergency contraception, oral contraceptive pills and injectables)
  - » in-person supportive supervision with on-the-job training and observational checklists;
  - » remote virtual supervision (using video observation)
  - » study tours for task sharing team members or head trainers
  - » information and experience sharing workshops
  - » integrating into the pre-service curricula and continuous professional activities for providers.

5. **Assess the need/relevance for a national licencing system.** The need for licensing systems in many LMICs has increased in recent years as countries look toward achieving UHC. A national licensing system would be significant in health system development, helping to ensure the competency of health care professionals by utilizing a national examination, continuing professional development and revoking licences when appropriate (39). Appropriate national licencing schemes may also help further legitimise service delivery among cadres who are facing backlash for task sharing services.

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6. **Design a supportive supervision and management system.** Plan for ongoing supervision, mentorship and support systems to ensure quality service delivery and address challenges promptly. Plan for which staff members will do the supervising, using which method (such as an observational checklist), the supervisory intervals and make plans for eventually absorbing the supervision into regular quality assurance activities. Plan and budget accordingly for any electronic data collection or apps that will be used for supervision and/or quality assurance.

7. **Develop or update HMIS tools for monitoring service delivery.** Assess current monitoring tools and the HMIS for collecting routine data on service delivery and quality to assess if they should be amended for task sharing measurement (for example, by capturing provider type within the HMIS). Ensure that HMIS reporting is covered in provider training, making sure that the newly trained cadre understands the importance of data collected through the HMIS as well as understanding how the reporting tools and systems work.

   Also, consider research and evaluation. Think about evaluations that will occur down the road, and if any additional data will need to be collected in routine monitoring tools.

8. **Design referral systems to ensure a continuum of care.** It is imperative to ensure an effective referral system when task sharing in the event of a complication or need for follow-up care or contraceptive removal. WHO always recommends that where providers are trained on implant and IUD insertion, they must also be trained on removal. If, however, in exceptional circumstances, this is not the case, then a clear, accessible and well-functioning referral system must be in place and referrals monitored. There must be a clear referral pathway for women to seek removal of IUDs and any additional care outside the remit of the cadre providing the original service.

9. **Update supply and logistics systems.** Task sharing will likely expand access to contraceptive services and methods, so the supplies and logistics systems will need to account for this. Some steps to take include the following:

   - Ensure that the Essential Medicines List is up to date and adequately reflects contraceptive service delivery needs since the lack of appropriate commodities can be a barrier to implementing many contraceptive programmes.

- Consult with supply chain teams to support effective demand forecasting processes in light of new task sharing and likely expanded use.
- Assess your current inventory and distribution process and identify areas for improvement.
- Establish clear protocols for stocking and distributing supplies to newly included service providers and areas.
- Implement (or improve) a tracking system to monitor supply levels and usage and ensure newly trained providers have access to necessary supplies.
- If necessary, provide training and resources to everyone to ensure they understand the updated system and processes. Consider if e-learning would be appropriate here.

10. **Design social and behaviour change communication (SBCC) or demand-generation strategies (where appropriate).** If task sharing is occurring with a less-utilized method of family planning, it may be important to raise awareness of the method and generate demand for the services to ensure the task sharing programme is successful. If there is inadequate demand, providers may rapidly de-skill and lose confidence in method provision. Consider strategies to engage the community, such as awareness campaigns highlighting the benefits of contraception through the use of workshops, informational sessions, community engagement and mass media (including social media); partnering with local influencers and/or health care providers to share key messages; or outreach initiatives such as mobile clinics or community health fairs, providing key information and resources. Any newly introduced method is promoted in the context of fully informed choice, with counselling provided and access assured to a full basket of contraceptive methods.

11. **Plan for scale-up in the medium and long term.** Consider how all the above steps will need to be continued to achieve and maintain service provision through task sharing at scale. Also, consider where medium- and long-term financing will come from and what budget will be needed to maintain service provision. For example, if the project is funded through an external donor, consider how it could be financed after the donor funding expires.

3.5 Strategy 4: Monitoring and quality assurance at scale

A key factor for the long-term success of task sharing is the ability to monitor and provide quality assurance at scale. Here are some key considerations:

1. **Integrate into the health system using a phased approach.** If the task sharing for contraceptive services programme has not yet been scaled up fully, consider doing so using a phased approach to rollout. Concurrent with a feasibility test or pilot programme, a needs assessment may be conducted to identify priority regions or types of facilities. Indicators in the needs assessment may include contraceptive prevalence, availability of providers by cadre type, resource availability, demand for contraception and community needs/attitudes, including attitudes toward the provider cadre that will be providing the service. Following initial implementation phases, a phased approach to scaling up will allow opportunities for programme review and adjustment before fully integrating the scale-up.

2. **Coordinate communication about the task sharing strategy across the health system.** These efforts should be led by the Ministry of Health and the task sharing oversight mechanism/group. Some communication strategies include the following:
    - Implementation of regular communication (such as quarterly meetings or regular reports) to share updates, challenges and best practices with all key stakeholders (including providers and clients) involved.
    - Foster collaboration through joint training sessions and workshops to ensure alignment of goals and strengthen partnerships (and to reduce the likelihood of professional territorialism and any backlash that the task sharing provider cadres may face).
    - Consider a communication strategy to engage the community/public to ensure that the task sharing approach meets their needs and expectations. Methods could include the use of social media or mass media campaigns highlighting task sharing successes (including improved access to services and

increased client satisfaction). Communicate the successes and challenges of the task sharing strategy and request feedback on opportunities for improvement. Make sure these activities are integrated into routine community outreach and engagement activities.

3. **Routinely and closely monitor service provision quality to uphold standards.** Establish quality assurance mechanisms, including routine supervision, periodic evaluations and use of performance indicators (such as complications, client satisfaction and service uptake). Continuously collect data on service delivery, quality and outcomes. Use the data for ongoing decision-making and improvement, and ensure that the evidence on cost, capacity and contextual considerations is reported back to the health system for future improvements. Data collection activities can include the following:
    - **Incident reporting:** Adverse events should be reported and periodically reviewed by staff members responsible for providing supportive supervision, including by facility (if applicable) and by type of provider. Periodic review may include opportunities for training interventions.
    - **Client feedback monitoring:** Client feedback on satisfaction with care should be routinely collected and analysed. Data collection tools could include exit interviews, focus groups, suggestion boxes, follow-up surveys and even the formation of client advisory groups.
    - **Client follow-up support and referrals in the context of self-care:** Supporting and referring clients may be especially important in the context of self-care (self-injection) where women may not have regular interactions with the provider after receiving their method. Any follow-up surveys need to be designed to protect privacy and ensure confidentiality. Informed consent should be sought before contacting a client for follow-up, and no client who did not provide informed consent should be followed up for monitoring purposes. Referral pathways should be made clear to clients before they leave the service point.
    - **Performance assessments (including provision, referral and supervision):** Make sure that quality is routinely monitored through the assessment of service provision (including adverse events) and referrals. Note that ethical approval may need to be sought for some of these activities. There are various ways to conduct performance assessments, including through any of the following tools:
        - » Clinical reviews or audits to assess structures, practices and outcomes against established standards.
        - » Client satisfaction surveys to collect feedback from clients regarding their experiences with providers and service provision (can focus on communication, professionalism and quality of care).
        - » Provider satisfaction surveys can be used to assess the acceptability of service provision among providers who are providing the task shared service. For example, do they feel they are receiving appropriate support and do they feel confident with their training? It may also be useful to seek the feedback of the more specialized cadre providers to ensure their support.
        - » Direct observation to monitor the provision of care against a checklist (measures adherence to a clinical protocol). See Annex 7 for an AAR template, which can be used to work with providers on improvements.
        - » Mystery client surveys are where trained researchers act as clients and report on certain aspects of service provision, mainly the intake process and counselling, using a checklist. Note that mystery clients should never actually accept a service other than counselling.
        - » Self-assessment can encourage providers to evaluate their performance and identify areas they would like more training or information on.
    - **Product quality assurance:** This is critical for all contraceptive commodities and supplies. Ensure that products are safe and efficacious via the usual measures, including ensuring manufacturers adhere to regulatory compliance (this can be done through supplier audits and product testing), proper training (including on product use and storage) for distributors and users, and the establishment of feedback mechanisms for users. This is particularly important for self-care, as injectable products such as DMPA-SC need to be quality-assured since women will be using them at home. These activities will reduce the likelihood of complications and will enhance user satisfaction and confidence over time.
4. **Consider longer term financing/budget:** Routine training and monitoring activities, performance assessments

and product quality assurance activities will all need to be adequately financed in the longer term. Consider where these types of activities can be integrated with existing service delivery activities and what, if any, additional funding will be needed. Annex 2 contains an example budget with details.

3.6 Research

As noted above, implementing WHO task sharing guidance may not require additional pilots and research – feasibility assessments will often be sufficient. Robust programme monitoring and learning processes are also essential to ensure programmes are well managed and improvement is continuous. But in some instances, further in-depth research on task sharing may be helpful to increase access, equity and quality in the family planning sector. Researchers can help identify best practices, assess the impact on service delivery and strategize how to optimize care for diverse populations. Rigorous research can help ensure that task sharing is not only effective but also safe and equitable, addressing any potential disparities that may arise.

Study design

Wherever possible, when conducting evaluations of task sharing, the study design should use at least two study groups: one that will receive the intervention (for task sharing, this will be the group that receives a service from the task sharing cadre), and the other group that will receive the status-quo service provision. Other robust study designs, such as the randomized cluster trial or a step-wedged randomized cluster trial, are considered the gold standard but may not be necessary given the research question that is being studied. When considering questions around describing strategies or collecting perspectives, qualitative methods (such as key informant interviews or focus groups) will be more appropriate.

Strengthening the evidence base

In September 2024, the World Health Organization hosted a *Task Sharing Technical Working Group* meeting, comprised of reproductive health and task sharing experts from the medical, research, scientific and NGO communities. This group jointly identified and agreed on strengthening the evidence base on task sharing for contraceptive services by conducting rigorous research on the following:

- Descriptions of task sharing implementation strategies and analysis of which models work the best to reach which specific groups of people.
- Effective models of task sharing for vulnerable groups (including adolescents, sex workers, minorities and excluded populations). For example, adolescents may not present at clinics or seek care from established cadres, so what models are safe and effective for reaching them?
- The costs and cost-effectiveness of task sharing and specifically cost savings that can come from task sharing for contraceptive services.
- Questions on stakeholder perspectives, including the following:
  - » evaluation of mechanisms to improve the collection of client feedback data;
  - » perspectives and acceptability of task sharing among various health care provider cadres;
  - » perspectives and acceptability of task sharing amongst other stakeholders in task sharing, such as Ministries of Health, community groups and others; and
  - » perspectives of task sharing in the private and for-profit sectors, and lessons that can be learned.
- The impact of task sharing on expanded method choice, modern contraceptive prevalence and unintended pregnancy.
- Evaluation of the safety and effectiveness of method/cadre combinations that WHO states require additional research or that lack a strong evidence base include the following:
  - » injectable provision by pharmacists and pharmacy workers
  - » implant provision by CHWs
  - » implant provision by pharmacists
  - » IUD provision by auxiliary nurses/nurse-midwives.

In summary

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Task sharing is a strategy to address high levels of demand for health care given the shortage of skilled providers within the health system. This document presents some of the strong evidence for the safety and effectiveness of task sharing for family planning as well as evidence-based guidance to help plan, implement and scale up task sharing for contraception services. This guidance, coupled with the tools provided in the following annexes, aims to support national ministries of health and other implementing bodies to utilize task sharing as a strategy to optimize available resources and ultimately ensure that as many people as possible have access to a wide range of contraceptive methods and services.

Section four

Annexes

These annexes contain tools and templates to support the implementation of task sharing for contraceptive services and its scale-up as well as the methodology used for the narrative review of evidence, a list of key terminology and definitions for task sharing contraceptive services and several case studies from countries that have implemented various forms of task sharing for contraceptive services. The following is a complete list of the annexes:

1. PowerPoint presentation on task sharing in contraceptive services
2. Budget template
3. Theory of change template
4. Example log frame
5. Cadre mapping table
6. Standard operating procedure template
7. Action after review template
8. Methodology for narrative review and guidance
9. Key terms
10. Country case studies

Annex 1. PowerPoint presentation

Here is a link to a shell PowerPoint presentation, which can be filled in with relevant country data and used to advocate for task sharing for contraceptive services.

Annex 2. Budget template for the implementation of task sharing for contraceptive services

This table contains a list of the items that may need to be budgeted for when implementing a task sharing for contraceptive services project. The budget is broken down by the four strategies in the guidance: advocacy and stakeholder engagement, landscape analysis and planning, task sharing implementation, and monitoring and quality assurance at scale. While this is a comprehensive list of budget considerations, it can be amended as necessary. Depending on the project and the context, monitoring, research and evaluation activities may account for 5% to 10% of the total budget.

Table 4. Example budget

STRATEGY	BUDGET ITEM	TYPES OF COST (MANY OF THESE CAN BE INTEGRATED INTO EXISTING ACTIVITIES)
Advocacy and stakeholder engagement	Full time equivalency (FTE)/ consultancy for task sharing coordination	Ministry of Health, consultant or partner staff costs (to cover task sharing coordination, meeting organization, fundraising, stakeholder engagement and review/analysis)
	Other coordination costs	Includes office supplies and communication costs
	Advocacy and stakeholder engagement meetings costs	Includes venue/refreshment costs, communication (such as printed materials) and meeting per diems
	Public engagement costs	Social or mass media and PR costs
Landscape analysis and planning	FTE/consultancy for task sharing coordination	Ministry of Health, consultant or partner staff costs to cover landscape and bottlenecks analyses (if needed, strategic plan development)
	Feasibility assessment costs (see below for research costs)	Costs will vary depending on the type of assessment chosen (small feasibility assessment, pilot or evaluation). Costs to cover design, data collection, analysis and dissemination
Task sharing implementation	Human resource system activities (FTE/consultancy for task sharing coordination)	Covers SOP development/updates, regulation updates, guideline updates, remuneration schemes and licencing system updates
	Staff remuneration	Covers any changes in staff costs related to task sharing (either salary changes or other changes to remuneration packages)
	Training – pre-service curricula development	Covers staff time for engagement with education departments, universities and colleges; for content updates and training tests/evaluations
	Training – in-service training schemes	Includes training curriculum development, e-learning platforms (if used), trainer costs (including head trainers), transport, training venue/refreshments, staff absence cover and per diems
	Supervision and management	Includes supervisor training costs, updated supervisory and quality monitoring tools (may entail digital development costs), supervisor aides (manuals, guides) and transport costs for any enhanced supervision needed

STRATEGY	BUDGET ITEM	TYPES OF COST (MANY OF THESE CAN BE INTEGRATED INTO EXISTING ACTIVITIES)
	Health management information system (HMIS) update and other programme monitoring	Covers development or staff time costs to update the HMIS, if needed; training costs for any updated HMIS data entry changes
	Referral system update	Covers updated referral form/guidance development and rollout (including training, communication costs and HMIS update costs)
	Supplies	Includes increased contraceptive commodities required and associated provision equipment (e.g., speculums, PPE etc.)
	Social and behaviour change communication (SBCC), community engagement and demand generation	Includes printed promotional materials, mass and social media campaign costs, community engagement costs (meetings or events, hiring of peer educators/mobilizers/CHWs)
Monitoring and quality assurance at scale	Coordination and communication	Covers staff and communication costs
	Routine monitoring	Covers updates to incident reporting, client feedback and client follow-up systems, if needed
	Performance assessment	Covers any updates to routine quality monitoring including audits, client/staff surveys, clinical observation tools/systems or product quality monitoring
	Research costs (only if pilot test or evaluation planned)	Covers research team/contractor costs, including research staff time, submissions for ethical approval, survey digitization, printing (consent forms etc), training, digital data collection tools, analysis software and dissemination of materials/meeting information

Annex 3. Theory of change template

A theory of change (ToC) is a comprehensive narrative of how a change will happen in a particular context. It outlines the pathway from specific activities to short-term outputs, medium-term outcomes and long-term goals. It can define project objectives and provide a clear framework for implementation. A ToC can be presented in a diagram or narrative write-up and should contain the following information:

1. **Goal:** This is the overall objective of the project. For task sharing contraceptive services, this could be "improve access to contraceptive services (in specified population/setting)".
2. **Inputs:** These are the basic resources needed to achieve project goals. Examples include training materials and resources, specific staff cadres, funding, and support from key stakeholders.
3. **Activities:** These are the things that need to happen to translate the inputs into outputs. Examples include training staff cadres, developing demand-generation activities, establishing referral pathways, monitoring progress and developing quality assurance tools.
4. **Outputs:** Outputs refer to the things that will happen in the short term as a direct result of activities and inputs. They can include things like the number of health workers trained, the number of events conducted, referral protocols established and the number of services delivered.
5. **Outcomes:** These are the medium-term, specific changes that will occur as a result of outputs. Examples include increases in couple-years of protection (CYPs), increases in new users of contraceptives or increases in modern contraceptive prevalence rate (mCPR).
6. **Assumptions:** These are the underlying beliefs or conditions that need to happen to support the ToC. They can include contextual and other external factors, for example, that the community is receptive to task sharing.

Please refer to Annex 4, which has an example of a logical framework and lays out these categories using specific indicators.

Annex 4. Example of a logical framework for implementing a task sharing for contraceptive services project

This is an example of a logical framework for a task sharing for contraceptive services project. To create a logical framework for a new project, each indicator will need to be assigned a specific value (indicated below by Xs and Ys). Additionally, each indicator will need to be SMART (specific, measurable, achievable, realistic, and time-bound).

The goals, outcomes and outputs must be aligned to a theory of change.

Table 5. Example logical framework for task sharing family planning

	SUMMARY	INDICATORS	MEANS OF VERIFICATION
Goals	Improve access to contraceptive services in (specify population/setting)	Increase in mCPR from X to Y	DHS, if available, or community surveys or modelling
Outcomes	Increase use and knowledge of contraceptive services in (specify population)	Increase in CYPs from X to Y Increase in new users of contraception from X to Y Decrease in cost for a new user of contraception from X to Y (note that initial start-up costs may be higher and thus this indicator may need to be reported on in the longer term)	Programme data on service provision or HMIS data with USAID CYP conversion factors applied Service statistics Service statistics and cost data
Outputs	Increase (specify task shared cadre) provider skills to provide (specify task shared) method	X number of training sessions conducted X number of (specify cadre) providers trained X number of (specify type) contraceptive services delivered % of service delivery points that have a staff of (specify cadre) routinely offering methods % of (specify task shared contraceptive method) provided by each cadre At least X% of clients reporting high levels of satisfaction with task shared service At least X% of clients reached with contraception in (specify underserved group such as adolescents, women living in rural areas or urban slums, etc.)	Training reports Training logs Service statistics Facility audit/observation Check HMIS availability Client exit interviews Client exit interviews
Activities	Activities to enable task sharing of (method) to (provider)	Some common examples of activities could include the following, but note that each activity would be very specific to the programme or project: 1. Train (specify task shared cadre) on (specify method of) contraception 2. Establish a mechanism for clients to provide feedback on experiences and satisfaction 3. Ensure routine data collection methods can capture logical framework indicators	

Annex 5. Cadre mapping table for task sharing for contraceptive services

Below is a table with detailed cadre definitions, including training processes and examples of names for each cadre. When planning and scaling up task sharing for contraception, it is important to understand which WHO cadre definition the task shared cadre belongs to. For each cadre involved in the project, look at the cadre definitions (rather than just the cadre name) and ensure that the cadre is recommended by WHO to perform the task shared service (see Table 1).

Table 6. WHO cadre definitions with examples

WHO DEFINED CADRE (WITH CITATIONS)	DEFINITION	EXAMPLES
Specialist doctor *(40)*	Specialist medical doctors diagnose, treat and prevent illness, disease, injury and other physical and mental impairments using specialized testing and diagnostic, medical, surgical, physical and psychiatric techniques through the application of the principles and procedures of modern medicine. They plan, supervise and evaluate the implementation of care and treatment plans by other health care providers. They specialize in certain disease categories, types of patient or methods of treatment and may conduct medical education and research activities in their chosen areas of specialization. Occupations included in this category require completion of a university-level degree in basic medical education plus postgraduate clinical training in a medical specialization or equivalent. Resident medical officers training as specialist practitioners (except general practice) are included here. Doctors in obstetric and gynaecological specialties and related branches focusing on the care of the reproductive system of women including before, during and after pregnancy and childbirth are classified as specialist doctors.	Gynaecologist, obstetrician
Non-specialist doctor *(40)*	Generalist medical doctors (including family and primary care doctors) diagnose, treat and prevent illness, disease, injury and other physical and mental impairments and maintain general health in humans through the application of the principles and procedures of modern medicine. They plan, supervise and evaluate the implementation of care and treatment plans by other health care providers. They do not limit their practice to certain disease categories or methods of treatment and may assume responsibility for the provision of continuing and comprehensive medical care to individuals, families and communities. Occupations included in this category require completion of a university-level degree in basic medical education plus postgraduate clinical training or equivalent. Medical interns who have completed their university education in basic medical education and are undertaking postgraduate clinical training are included here. Although in some countries "general practice" and "family medicine" may be considered medical specializations, these occupations should always be classified here.	Family doctor, general practitioner (GP), medical doctor (general), medical officer (general), physician (general), family medical practitioner, primary health care physician, district medical doctor, resident medical officer specializing in general practice, township medical officer, station medical officer, specialist in family medicine, medical officer
Advanced associate and associate clinician *(1)*	Advanced clinicians are professional clinicians with advanced competencies to diagnose and manage the most common medical, maternal, child health and surgical conditions, including obstetric and gynaecological surgery (e.g., caesarean sections). Advanced associate clinicians are generally trained for 4 to 5 years in established higher education institutions and/or 3 years post initial associate clinician training. The clinicians are registered and their practice is regulated by their national or subnational regulatory authority.	Assistant medical officer, clinical officer, medical licentiate practitioner, health officer, physician assistant, surgical technician, non-physician clinician, medical assistant, nurse practitioner
Midwife *(1)*	A midwife is a person who has been assessed and registered by a state midwifery regulatory authority or similar regulatory authority. They offer care to childbearing women during pregnancy, labour and birth, and the postpartum period. They also care for the newborn and assist the mother with breastfeeding. Their education lasts 3 to 4 or more years in nursing school and leads to a university or postgraduate university degree or the equivalent. A registered midwife has the full range of midwifery skills.	Registered midwife, midwife, community midwife, nurse-midwife
Nurse *(1)*	A nurse is a graduate who has been legally authorized (registered) to practice after examination by a state board of nurse examiners or similar regulatory authority. Education includes 3 to 4 or more years in nursing school and leads to a university or postgraduate university degree or the equivalent. A registered nurse has the full range of nursing skills. Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well, and in all settings. Nursing includes the promotion of health, prevention of illness and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are key nursing roles.	Registered nurse, clinical nurse specialist, licensed nurse, BSc nurse

WHO DEFINED CADRE (WITH CITATIONS)	DEFINITION	EXAMPLES
Auxiliary nurse *(1)*	Auxiliary nurses have some training in secondary school. A period of on-the-job training may be included and sometimes formalised in apprenticeships. An auxiliary nurse has basic nursing skills and no training in nursing decision-making. However, in different countries, the level of training may vary between a few months to 2–3 years.	Auxiliary nurse, community health extension worker in Nigeria, health extension worker in Ethiopia
Auxiliary nurse midwife (ANM) *(1)*	ANMs have some training in secondary school. A period of on-the-job training may be included and sometimes formalised in apprenticeships. Like an auxiliary nurse, an auxiliary nurse midwife has basic nursing skills and no training in nursing decision-making. ANMs assist in the provision of maternal and newborn health care, particularly during childbirth but also in the prenatal and postpartum periods. They possess some of the competencies in midwifery but are not fully qualified as midwives.	ANMs, family welfare visitor
Pharmacist *(40)*	Pharmacists store, preserve, compound and dispense medicinal products. They counsel on the proper use and adverse effects of drugs and medicines following prescriptions issued by medical doctors and other health professionals. They contribute to researching, testing, preparing, prescribing and monitoring medicinal therapies for optimizing human health. Occupations included in this category normally require completion of university-level training in theoretical and practical pharmacy, pharmaceutical chemistry or a related field.	Pharmacist, chemist, clinical pharmacist, community pharmacist
Pharmacy worker *(40)*	Pharmaceutical technicians and assistants perform a variety of tasks associated with dispensing medicinal products under the guidance of a pharmacist or other health professional. They inventory, prepare and store medications and other pharmaceutical compounds and supplies and may dispense medicines and drugs to clients and instruct on their use as prescribed by health professionals. Occupations included in this category normally require knowledge and skills in pharmaceutical services obtained through formal training.	Pharmacy assistant, pharmacy technician dispenser, pharmacist aide, drug shop owner/worker/employee, medicine vendor
Lay health worker (1)	A lay health worker is any health worker who performs functions related to health care delivery and was trained in some way in the context of the intervention but has received no formal professional or paraprofessional certificate or tertiary education degree. Traditional birth attendant (TBA): A person who assists the mother during childbirth and who initially acquired their skills by delivering babies themselves or through an apprenticeship to other TBAs. Trained traditional birth attendants have received some level of biomedical training in pregnancy and childbirth care.	Community health worker, village health worker, traditional birth attendant, female community health volunteer, treatment supporter, promoter, health surveillance assistant in Malawi
User/self	The person who is accepting the method of contraception.	Women, men

Annex 6: Standard operating procedure template

A standard operating procedure (SOP) is a documented set of instructions and processes written out to help staff members (in this case, the specific task shared cadre) carry out routine responsibilities consistently. Having written SOPs can help ensure that all services are provided correctly and consistently.

SOP for staff cadre who have been task shared a contraceptive service should clearly outline the following:

1. **Purpose:** Outline the objectives of the SOP, emphasizing the importance of providing standardized contraceptive services to ensure quality care and client safety.
2. **Scope:** Define the applicability of the SOP, including which staff members, departments or facilities it covers as well as the contraceptive method or methods.
3. **Definitions:** Provide clear definitions for key terms used in the SOP, such as “contraceptive”, “counselling”, “informed consent”, “rights-based” etc.
4. **Responsibilities:** Detail the roles and responsibilities of staff involved in supporting and delivering the contraceptive services, including health care providers, nurses and administrative personnel.
5. **Procedures:** Break down the step-by-step processes for delivering contraceptive services, which may include client intake (procedures for initial assessment and data collection), counselling (guidelines for providing education on contraception and other sexual and reproductive health topics), provision of services (steps for delivering services and providing referrals) and follow-up care (protocols for scheduling and conducting follow-up appointments).

6. **Client confidentiality:** Outline procedures to ensure client confidentiality and data protection in accordance with legal and ethical standards.
7. **Informed consent:** Describe the process for obtaining informed consent from clients before any services are provided, including documentation requirements.
8. **Emergency procedures:** Provide guidelines for handling medical emergencies related to contraceptive services, including referral protocols and emergency contact information.
9. **Training requirements:** Specify the training and continuing education necessary for staff to effectively provide contraceptive services.
10. **Quality assurance and improvement:** Describe methods for monitoring service quality, including feedback mechanisms from clients and performance evaluations of staff.
11. **Documentation and record keeping:** Outline requirements for maintaining accurate and secure records of client interactions, consent forms and service provision.
12. **Compliance and regulations:** Summarize relevant legal and regulatory requirements that govern contraceptive services, ensuring staff are aware of compliance obligations.
13. **References:** List any guidelines, best practices or relevant literature that informed the SOP.
14. **Appendices:** Include any supplementary materials, such as templates for consent forms, client education materials or checklists for service provision.

Annex 7: Action after review (AAR) template

Date of Review: (The date on which the review took place)

Reviewed by: (The name and title of the person conducting the review)

Provider information (optional):

- Provider ID/name: (If applicable or keep it anonymous for reporting purposes)
- Other information: (For example, how long has a provider been on staff, training completed etc.)

1. Review area: (Briefly describe the area or issue that was reviewed, such as counselling, side effects etc.)
   - Comprehensive counselling
   - Client medical history (e.g., sexually transmitted infections, health history)
   - Referral/follow-up needs
   - Other (Specify)
2. Action items after review

   Describe the issue:
   - Issue identified: (Briefly describe the issue or situation being reviewed)
   - Action plan: (Outline the immediate next steps to address the issue. This could include a one-on-one with a supervisor, refresher training etc.)
   - Responsible party: (Who is responsible for taking the next action, such as the medical provider, nurse, patient or follow-up coordinator?)
   - Timeline for action: (Provide a date or timeframe for completing the action, such as “Follow-up training completed in 2 weeks.”)
   - Additional notes

Signature of Reviewer:

Annex 8: Methodology for narrative review and guidance

A narrative review approach has been used to collect and synthesize evidence to develop this task sharing for contraceptive services implementation guidance. To start, we searched Google Scholar and PubMed to identify reviews (narrative, rapid or systematic) focused specifically on task sharing for contraceptive services. These reviews (n=5) were identified:

- *Getting up to date with what works: A systematic review on the effectiveness and safety of task sharing of modern methods in family planning services* (includes six studies) *(13)*
- *Towards achieving the family planning targets in the African region: a rapid review of task sharing policies* (includes four countries, multiple studies) *(19)*
- *Lessons from community-based distribution of family planning in Africa* (includes multiple countries and studies) *(20)*
- *Optimizing the delivery of contraceptives in low- and middle-income countries through task shifting: a systematic review of effectiveness and safety* (includes six studies) *(14)*
- *The safety, efficacy and acceptability of task sharing tubal sterilization to midlevel providers: a systematic review* (includes nine studies) *(15)*

Next, using the review strategy, we re-ran the review from Millogo et al. *(13)* to identify additional studies to review (published after Nov 2021, which is the last time Millogo et al. ran their research terms), which contained details relevant to task sharing implementation and scale-up. We further researched 21 studies and identified 10 to include in the review. We then accessed and re-researched 21 studies that were included in an unpublished WHO systematic review on task sharing bottlenecks (protocol is available from *(41)*) to identify those which contained details relevant to task sharing implementation and scale-up, and 20 studies were identified. We searched an existing database of 56 task sharing for contraceptive services papers (a mix of peer-reviewed publications and research briefs) that had been created for a different task sharing for contraceptives project. We identified four studies to include. Finally, we did a Google Scholar search for studies related to the implementation of task sharing for contraceptives and found an additional 16 studies.

To create the narrative review, we synthesized the results of these studies (N=55) according to key themes of effectiveness, contraceptive uptake, cost-effectiveness and implementation (subthemes include advocacy and stakeholder engagement, landscape analysis and planning, strategy implementation, and monitoring and quality assurance).

Annex 9: Key terminologies for task sharing for contraceptive services

These are the key terminologies commonly used in the context of task sharing in contraceptive services. Many of these terms are defined by the WHO Human Resources for Health Workforce Terms unless otherwise specified *(42)*.

Task sharing terms:

- **Task sharing:** This refers to the rational redistribution of responsibilities among health workforce teams. Specific tasks or roles are shared, where appropriate, with less specialized health workers to make more efficient use of the available personnel. It should be accompanied by appropriate measures in terms of education, supervision, management support, licensing, regulation and remuneration. The term is synonymous with terms like role optimization, role delegation, role substitution and optimal skills mix *(42)*.
- **Task shifting:** This specifically refers to the delegation of tasks from more specialized health workers to less specialized health workers to address workforce shortages and improve service coverage. This term is discouraged from use, as it is inappropriate and typically implies the simple shifting (sometimes dumping) of tasks in isolation and, therefore, lacks the accompanying support measures indicated with task sharing *(42)*.

Contraceptive terms

- **Modern contraceptive prevalence (mCPR):** This is the percentage of all women of reproductive age (women 15–49 years of age) who are using (or report their partner is using) a modern contraceptive method in a specific year at a particular point in time. This indicator is calculated by (# of women aged 15–49 using a modern contraceptive method / total # of women aged 15–49) x 100. This indicator is calculated using Track20's Family Planning Estimation Tool (FPET) (which uses a Bayesian, hierarchical approach) and includes all available surveys in a country, such as historic and recent DHS; MICS; Performance, Monitoring and Action (PMA) and other national survey data. Based on these data, FPET produces estimates for mCPR among all women, married women and unmarried women *(43)*.
- **Percentage of women estimated to have an unmet need for contraception:** This is the percentage of fecund women of reproductive age who want no more children or want to postpone having the next child but are not using a contraceptive method. In addition, women who are currently using a traditional method of contraception and women who are pregnant with or postpartum amenorrhoeic after an unintended pregnancy are also added to the estimate of women who have an unmet need for modern contraception *(43)*.
- **The percentage of women estimated to have their demand met by modern contraception:** This is the percentage of women of reproductive age who want no more children or want to postpone childbearing who are currently using (or their partners are using) a modern contraceptive method. The indicator assumes that all couples currently using modern contraception want to avoid a pregnancy and thus have their demand for modern contraception satisfied/met *(43)*.
- **Contraceptive methods:** For analytical purposes, contraceptive methods are often classified as either modern or traditional. Modern methods of contraception include female and male sterilization, intrauterine devices (IUDs), implants, injectables, oral contraceptive pills, male and female condoms, vaginal barrier methods (including the diaphragm, cervical cap and spermicidal foam, jelly, cream and sponge), the lactational amenorrhea method (LAM), emergency contraception and other modern methods. Traditional methods of contraception include rhythm (such as fertility awareness-based methods and periodic abstinence), withdrawal and other traditional methods *(44)*.
- **Family planning services:** These are a range of services that support individuals and couples in making decisions about the timing, spacing and number of children, typically including counselling, the provision of contraceptives, follow-up care and reproductive health education. Family planning allows people to attain their desired number of children, if any, and to determine the spacing of their pregnancies.
- **Contraceptive method mix:** The percent distribution of contraceptive or family planning users by modern method of contraception at a defined point in time *(43)*.
- **Couple-years of protection (CYPs):** This is the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. This includes permanent methods, such as sterilization and the lactational amenorrhea method *(45)*.

Human resources terms:

- **Health worker:** Health workers are all people primarily engaged in actions with the primary intent of enhancing health. The term is synonymous with health care worker *(42)*.
- **Health workforce:** This refers to all health workers collectively. It can also refer to the policy area, field of study or health system component. It is synonymous with the terms human resources for health and health personnel *(42)*.
- **Health professionals:** Health professionals conduct research; improve or develop concepts, theories and operational methods; and apply scientific knowledge relating to medicine, nursing, dentistry, veterinary medicine, pharmacy and promotion of health *(42)*.

- **Health associate professionals:** Health associate professionals perform technical and practical tasks to support the diagnosis and treatment of illness, disease, injuries and impairments in humans and to support the implementation of health care, treatment and referral plans usually established by health professionals *(42)*.
- **Health practitioner:** This refers to any health worker who has acquired health-related qualifications. It comprises both health professionals, health associate professionals and health providers *(42)*.
- **Health care specialist:** This is a health worker who has obtained advanced degree/formal qualifications following the completion of further studies beyond their initial health qualification *(42)*.
- **Primary health care worker:** This is a health worker operating in primary health care services *(42)*.
- **Non-physician provider:** This is a health worker who is not a doctor but is trained to perform certain medical tasks, such as nurses, midwives, physician assistants and other allied health professionals involved in providing contraceptive services *(42)*.
- **WHO core competencies for health workers:** The WHO global competency framework for universal health coverage identifies 24 competencies for health workers, organized into six domains. Although presented as a list, the competencies are interrelated and interdependent. The six domains are people-centredness, decision-making, communication, collaboration, evidence-informed practice and personal conduct *(46)*.

Administrative terms:

- **Monitoring, evaluation and learning (MEL):** Together MEL activities provide a comprehensive framework for tracking a project's progress and measuring its impact. This framework helps ensure learning, accountability and continuous improvement and ensures that resources are used efficiently and the desired outcomes are achieved.
  - » Monitoring is the continuous process of tracking the implementation of activities to assess if they are proceeding as planned. It involves the routine collection of data and analysis of information on the progress of a programme or intervention against pre-determined targets and objectives. Monitoring is primarily concerned with the measurement of inputs, processes and outputs, and aids in making real-time adjustments to improve programme performance.
  - » Evaluation is the systematic and objective assessment of the design, implementation and outcomes of an intervention or programme. It is conducted at pre-determined points in time and aims to determine the relevance, efficiency, effectiveness, impact or sustainability of the intervention. Evaluation helps to understand what works or doesn't work and why.
  - » Learning is the process through which experience and reflection lead to changes in the design and implementation of the intervention to improve results.
- **Supportive supervision:** This is the ongoing guidance, support and oversight provided to health workers, including those in task sharing roles, to ensure adherence to clinical guidelines, to maintain service quality and to provide professional development.
- **Scopes of practice:** This refers to the defined roles and responsibilities of health workers, including what tasks they are legally permitted to perform. Task sharing often involves expanding scopes of practice to allow less specialized providers to deliver specific contraceptive services.
- **Quality of care:** A measure of how well contraceptive services are being provided according to established standards, including safety, effectiveness, client satisfaction and the ability of task sharing providers to meet these standards.
- **Universal health coverage (UHC):** UHC is achieved when all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care and includes contraceptive services *(47)*.

Annex 10. Country case studies

Selected country case studies are presented to illustrate task sharing experiences.

Case Study 1: The Kenyan experience of policy change and task sharing

COUNTRY CONTEXT	TYPE(S) OF TASK SHARING	PROCESS	LESSONS LEARNT
Kenya is one of 37 WHO Regional Office for Africa countries with a critical health worker shortage. The shortage of workers and their inequitable geographic distribution is a major barrier to access to essential health care services. Kenyan workforce density: 13.8 health workers per 10,000 people (far below the WHO recommendation of 44.5 health workers per 10,000 people).	Community-based family planning is when community-based promoters provide injectables, condoms, cycle beads and pills coupled with demand-generation activities in the communities where they live. Community health promoters provide DMPA-SC as well as support effective referral pathways to care, particularly with marginalised and hard-to-reach communities. Pharmacies administering injectables usually charge a small fee. It is difficult to quantify the services provided by pharmacies as the data are not available in the HMIS. Clinical officers have been providing vasectomies since 2002.	Historically, task sharing has occurred informally and established organically to adapt to human resources shortages. However, starting in 2015, the Kenyan government (through the Ministry of Health) developed a national task sharing policy and guidelines in collaboration with other organizations. A policy advisory committee was set up to work with various technical working groups in the formulation of the policy. It was developed in five phases between February 2015 and May 2017. In June 2017, only one month after the policy was launched by the government, a medical laboratory association asked Kenya's High Court to stop its implementation. The Court ruled to halt implementation of the task sharing policy as of April 2019.	In Kenya, numerous stakeholders agreed on the need for a task sharing policy. The policy was scoped and developed; however, one stakeholder group challenged the policy and stopped its implementation through the courts. A systematic stakeholder analysis at the beginning of the process might have mitigated such a risk, as would the capacity development of key stakeholders. However, just as it started – organically and informally – task sharing continues to be used as a strategy to increase access to services.

Case Study 2: Nigeria's experience of task sharing implant service provision to community health extension workers

COUNTRY CONTEXT	PROCESS	RESEARCH CONDUCTED AND TYPE(S) OF TASK SHARING	LESSONS LEARNT
In Nigeria, the shortage of workers and their inequitable geographic distribution is a major barrier to access to family planning services. The workforce density of 18.3 health workers per 10,000 people is far below the WHO recommendation of 44.5 health workers per 10,000 people. Task sharing implant provision to community health extension workers (CHEWs) significantly expands access to services. CHEWs are a cadre of auxiliary nurses, and in Nigeria, they outnumber nurses 3 to 1, and 80% of CHEWs are already stationed in rural areas where the unmet need for family planning is the greatest.	In 2014, the Nigerian Federal Ministry of Health adopted the National Task Shifting/ Sharing Policy, which authorizes less specialized health worker cadres, including CHEWs, to provide contraceptive implants and intrauterine contraceptive devices (IUDs). The implementation of this policy is part of a broader effort by the Nigerian government and various NGOs to improve reproductive health outcomes and ensure that women have access to family planning services.	CHEWs receive 3 years of training in an institution approved by the Community Health Practitioners Registration Board. As of 2017, all newly qualified CHEWs receive pre-service training on insertion and removal of both implants and IUDs. Marie Stopes Nigeria and the Nigerian Federal Ministry of Health designed a study to evaluate whether CHEWs could insert implants to the same high-quality standards as nurses/midwives. The study sought to assess the safety and quality of implant insertions and client satisfaction following implant insertion.	Task sharing implant provision to CHEWs is feasible and safe, provided adequate monitoring and supervision are put in place. Supportive supervision, provided in four tiers at various points in time, was impactful and improved the quality of service provision. Demand-generation activities, including advocacy (with community members and leaders), community mobilization activities and outreach via health facilities, were critical to both the success of the research and to ensure the clinical improvement in the skills of the CHEWs.

Case Study 3: Pakistan's experience introducing DMPA-SC

COUNTRY CONTEXT	PROCESS AND TYPE OF TASK SHARING	RESEARCH CONDUCTED	RECOMMENDATIONS
Pakistan as a nation is currently experiencing rapid population growth, exceeding 240 million people in 2024. Coupled with a high unmet need for family planning (17%) and a low health workforce density of just 11 physicians per 10 000 people, there is an opportunity to expand access to family planning using task sharing. In more rural parts of the country, lady health workers (a type of CHW) and their supervisors number 100 000 and are often the first port of call for health services in the community. Pakistan has also struggled with procurement, logistics and distribution challenges for family planning commodities and services.	In Pakistan, only a licensed and skilled health care provider (registered with their respective council) can administer an injection. Lady health workers are not graduates of the health department nor are they registered or licensed with any council or regulatory authority in Pakistan. Yet, the Department of Health in Pakistan's Sindh province has allowed them to administer DMPA-SC as a special case. This has not been replicated in other provinces since regulations are done province by province. However, in Sindh province, self-injection is seen as self-medication, so an eligible woman seeking injectables as a preferred birth spacing method can be trained for administering subcutaneous injections (as many people inject insulin for their diabetes care without supervision).	A policy landscape analysis was commissioned to build and justify a case for the introduction and scalability of DMPA-SC in Pakistan. The High-Impact Practices in Family Planning Strategic Framework for Contraceptive Method Introduction to Expand Choice was used to design the framework for the national landscape analysis of existing policies and practices on contraceptive self-injection DMPA-SC *(48)*. A report was delivered in 2023 outlining recommendations for the scale-up of DMPA-SC in Pakistan *(49)*.	1. Use data from Sindh province as a pilot to advocate for the national scale-up of DMPA-SC. 2. Create an express budget line for DMPA-SC to ensure procurement. 3. Engage key stakeholders to assess the receptiveness to DMPA-SC. 4. Demand generation and counselling by the service providers play a crucial role in determining whether women purchase this new product and overcome the fear of self-injection. 5. Regulatory approvals must be sought. 6. Lady health workers must be trained to administer the first dose, which would require health departments' approval. 7. Use the existing HMIS for reporting. 8. Training lady health workers on service provision and counselling will ensure quality service provision, which is critical for achieving high levels of client satisfaction. 9. Specific performance indicators must be developed and agreed upon to include DMPA-SC in the existing monitoring tools.

Case Study 4: The exemplar analysis of Kenya, Malawi and Senegal's experience expanding CHW programme access to family planning services

The Exemplars in Global Health Family Planning Project seeks to understand drivers of increased voluntary modern contraceptive use (mCPR) and demand satisfaction and to examine the programmes and policies that led to those increases, with a focus on how the rights of women and vulnerable groups were addressed. For this case study, positive outlier countries are identified by assessing changes in countries' mCPR and demand satisfied for modern family planning relative to the Human Development Index (HDI) over several different time intervals between 1994 and 2000. The FP exemplar countries included in this case study are Kenya, Malawi and Senegal.

Analysis suggests an association between task sharing initiatives and contraceptive uptake. All possible 5-year intervals between 1994 and 2020 were analysed and the metrics of change are presented in Table 7. Hypothesized drivers of FP progress (i.e., policies, programmes and interventions) were cross-referenced with the results of the change interval analysis. In Malawi, Kenya and Senegal, the introduction of task sharing policies closely preceded or corresponded with rapid mCPR growth intervals, specifically the community-based distribution of injectable contraception (Table 7). Country details are below.

Table 7. Key drivers of mCPR change based on exemplars analysis

	MAX GROWTH INTERVALS	ABSOLUTE MCPR CHANGE	KEY DRIVERS
Malawi	2009–2014	11.1	2008: CBD injectables
Kenya	2010–2015	10.8	2006: Community health strategy 2011: CBD injectables
Senegal	2012–2017	6.6	2006-2011: CHW program scaled up 2014: CBD injectables

Key Findings

- All three countries' CBD/CHW programmes began by offering pills and condoms and eventually expanded to provide injectable contraceptives.
- Each exemplar country developed "task-shifting" protocols to enable injectable provision, drawing on evidence of the effectiveness of this approach in their own and peer countries. The expansion to include injectables often caused key moments of acceleration in each country's journey of expanding modern contraceptive use.

Education and background requirements

- In all three countries, CHWs must live in the communities they serve. Often, they are recruited by local community boards as opposed to regional or national health systems. When communities participate in selecting and monitoring CHWs, it can facilitate acceptance and ensure that community needs are appropriately met.
- In Kenya and Senegal, the CHW programmes have a literacy requirement, and Bajenu Gox (the name of the CHW programme in Senegal) must also demonstrate proof of employment, although there are some challenges with ensuring compliance.

Incentives and compensation

- Senegal, Malawi and Kenya have each taken a unique approach to CHW remuneration, using a combination of volunteer and paid positions.
- In Kenya, only 14 of 47 counties offer community health volunteers (CHVs) some monthly incentives and even fewer counties have done so consistently.
- All three countries have leveraged non-financial incentives, such as training, clothing and supplies or free health services for them and their families.

Training

- Each exemplar country has an established training protocol for CHWs, which typically includes initial formal training, consisting of both classroom instruction and practical experience as well as ongoing refresher training, although these may be inconsistent and dependent on funding.
- In Senegal, Bajenu Gox have also been trained to respond to emerging national health priorities, thus becoming a flexible part of the health care workforce.

Reporting and supervision structures

- While CHW programmes in each country operate at the community level and care often takes place inside clients' homes, they are connected to the rest of the health system through reporting and supervision structures that typically extend up through the national level. This gives ministries of health the ability to roll out updated training and guidelines and to perform quality control across the distributed community health systems.
- In all countries, CHWs report to a full-time employee who is affiliated with a health facility, helping to stabilize the infrastructure of the community-based system.

Digital tools and data management

- Senegal and Malawi rely on CHWs to input data directly into their national reporting systems, the DHIS2 and HMIS respectively, and have implemented other digital tools to improve coordination and training. While mobile phones have not been rolled out widely or consistently, in both countries, they have played an important role in improving coordination among the CHW population where available.

Table 8. Community health worker programmatic details in Kenya, Malawi and Senegal

	KENYA	MALAWI	SENEGAL
Cadres of CHWs	CHVs: Community health volunteers; provide information services and male condoms CBDs: Community-based distributors; a subset of CHVs that can provide pills and injectables CHEWs: Community health extension workers; supervise CHVs	CBDAs: Community-based distribution agents; distribute condoms and pills HSAs: Health surveillance assistants; provide health promotion and care beyond FP; can also provide injectables	ASC: Agents de sante communautaires; provide FP commodities via health huts Matrones: Focused on maternal and child health ; provide FP commodities via health huts DSDOM: Dispensateurs de sante a domicile; provide home visits; do not provide FP services but can make referrals Bajenu Gox: Generally older women from the communities they serve; provide counselling and referrals for FP and other MCH services Relais communautaires: Provide general health education and promotion
Population served	~500 people, up to 5 000 people Each community health unit has approximately 5 000 people and is served by ~10 CHVs and 1-2 CHEWs	~1 500 people (HSAs; #CBDAs unknown)	10 000 people One Bajenu Gox typically serves a community of 10 000 people within a 3.5km radius
Number of CHWs	88 403 CHVs (2020) 1 569 CHEWs (2019)	11 000 HSAs (2018) Unknown number of CBDAs	4 646 ASCs 3 154 matrones 9 609 Bajenu Gox 19 687 relais

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