WHO FP Accelerator Plus

BNA Tool Annexes: Module B Task-sharing

Annex B1: TASK-SHARING supplementary information

Background on task-sharing

Task-sharing is the systematic redistribution of FP counselling and method provision to expand the range of health workers who can deliver these services. The WHO recommends that family planning services and methods can be safely and effectively provided by different health worker cadres, under specified circumstances.[1,2] Task-sharing is promoted by USAID and its partners as a high-impact practice that is a safe, effective and efficient means to improve access to voluntary sexual and reproductive health services and reach national FP goals.[3] The growing body of evidence[4] and international guidance promoting the expansion of cadres that can provide family planning to improve access to and use of modern contraception has led several countries to adopt various task sharing policies.[5]

Task-sharing enables lay and mid-level healthcare professionals – such as auxiliary nurses and community health workers – to safely provide clinical services and procedures that would otherwise be restricted to higher level cadres. Even in well-resourced health systems, task sharing can offer a means of providing services more efficiently, more cost effectively and in a less medicalised environment.[2,6]

Task-sharing can improve equitable access to contraceptive services for disenfranchised populations or remote communities. Access and availability of family planning is increased when a wider range of providers is equipped to deliver services, allowing clients to obtain their selected contraceptive method from their preferred provider.[3]

WHO's recommendations on task-sharing are summarized below. There are two task-sharing EBPPs that are of interest for this assessment:

- **Community Health Workers (CHWs) –** which falls within the broad category of **Lay health workers** in WHO guidance. WHO recommends that lay health workers can safely and effectively provide the following contraceptive services: education and counselling, information on SDM, 2Day Method, and LAM; oral contraceptives and condoms; hormonal injectables (under targeted monitoring and evaluation), and implants (under rigorous research). Since CHWs already usually provide contraceptive pills and condoms, this assessment will focus on the provision on injectable contraceptives by CHWs.
- **Auxiliary nurses** – a cadre that WHO recommends can safely and effectively provide education and counselling, information on SDM, 2Day Method, and LAM, oral contraceptives, condoms, hormonal injectables, and contraceptive implants (under targeted monitoring and evaluation). Since auxiliary nurses already usually provide injectables and other short-term methods, this assessment will focus on the provision of implants by auxiliary nurses.

Variations in the terms and definitions used to describe the various cadres of providers makes cross country comparisons (and assessment) difficult. Depending on the country's public health workforce, lay health workers can include **community health workers (CHWs)**, village health workers, traditional birth attendants, lady health workers, community health volunteers, and **community health extension workers (CHEWs)**. Qualifications for this cadre vary greatly from little formal education to secondary school graduate.[5] Table 1 provides detail of these cadres, adapted from the WHO's *Optimizing health worker roles to improve access to key maternal and newborn health interventions through task*

shifting,[1] and *Task sharing to improve access to Family planning/contraception.*[7]

Table 1 Definition of cadre, adapted from National Family Planning Guidelines in 10 Countries: How well do they align with current evidence and WHO recommendations on task-sharing and self-care?

Worker Type	Examples	Training
Lay Health Worker	Community health worker, village health worker, promoter, traditional birth attendant, community health volunteer, *relais*	Varies
	Community Health Extension Worker (CHEW), *Agent de santé communautaire* (ASC)	Secondary school + 1-3 years training
Auxiliary Nurse/midwife	Auxiliary nurse, nurse assistant, enrolled nurse, auxiliary midwife	Some secondary school; cadre training varies from a few months to 2-3 years

Recent reviews[5,8] of task-sharing identify a range of bottlenecks. These are detailed below. In brief, they include a range of health systems factors that are often found to inhibit effective health service delivery in resource-constrained settings, including human resources availability, capacity, motivation and attitudes; supplies/equipment, supply chain logistics; resourcing; health management information systems (HMIS); political leadership, health sector coordination; programme planning and implementation, including large catchment areas, poor/lack of transportation; supervision, changes to protocols, regulations and curricula in order to support the relevant cadre's new scope of practice, and salaries/remuneration to reflect changes in the relevant cadre's scope of work.

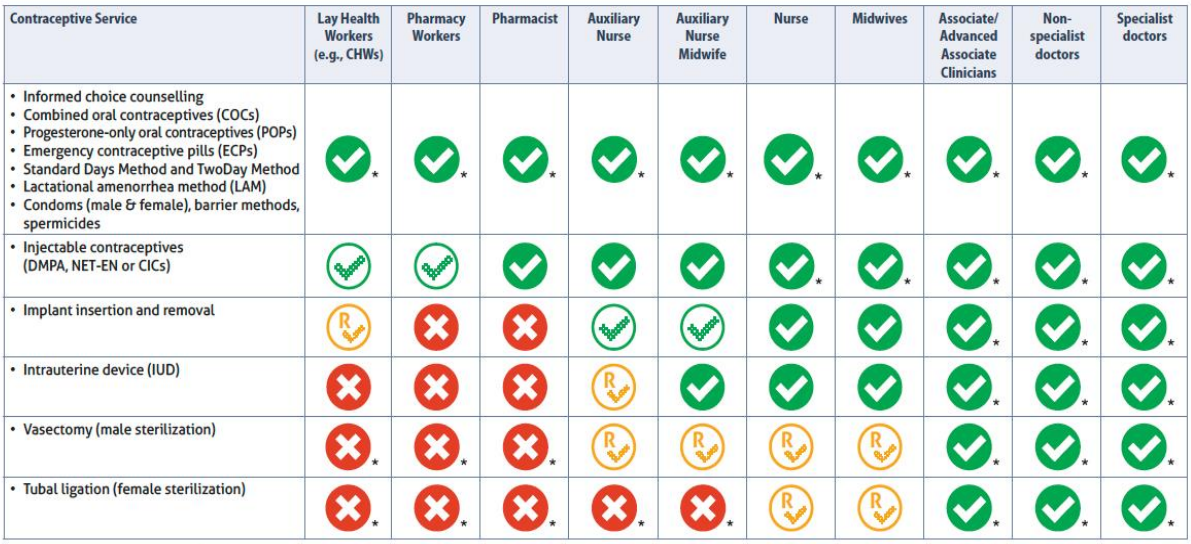
Community Health Workers (CHWs) are increasingly recognized as a critical resource for achieving national and global health goals.[9] Several reviews have identified bottlenecks specific to CHW's reaching their full potential.[10–12] The integration of trained, equipped and supported CHWs into the health system is promoted by USAID and its partners as a proven high-impact practice in family planning service delivery.[13] The support for CHWs and their integration into health systems and communities are uneven across and within countries; good-practice examples are not necessarily replicated and policy options for which there is greater evidence of effectiveness are not uniformly adopted. There is a need for evidence-based guidance on optimal health policy and system support to optimize the performance and impact of these health workers.

WHO recommendations on TASK-SHARING

Table of guideline recommendations for task sharing of contraception

FP Methods and Services Typically Offered by Cadre of Service Provider

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



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

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

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

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

Summary Brief 5

Adapted from the WHO World Health Organization guidelines: *Optimizing health worker roles to improve access to key maternal and newborn interventions through task shifting* and *Health worker roles in providing safe abortion care and post-abortion contraception*.

Bottlenecks identified in WHO systematic review

The following factors were identified in a recent WHO systematic review on TASK-SHARING scale-up,

FACILITATORS (n=21)		
Health worker characteristics (n=19)	**Program planning and implementation (n=17)**	**Program environment (n=16)**
Older age, a higher level of education, or years of practice (n=4)	Continuous commodity supply (n=6) • Gap filling and post-training allocation by implementing partners (n=2) • Stock out refill measures such as burrowing (n=2)	Political priority, government declaration of support, and local ownership (n=6) [14–19]
A native, or selected by or resides in the community (n=7)	Client educational materials such as pictural adaptation of MEC chart, poster, brochures, and leaflets (n=4) [20–23]	Inter-professional harmony (n=7) Inter-cadre agreements, e.g., nurses and pharmacists were required to have professional agreements with obstetrician-gynecologists before offering FP (n=1) • Teamwork (n=6) [15,16,22,24–26] • Support by more experienced CHW leader (n=3)
Positive attitude, motivation, and commitment of HW, e.g., using personal funds (n=7)	Provider training materials and resources (n=11) • Training manuals (n=2) • Competency-based observation checklists (n=8)	Continuous stakeholder collaboration (n=8) • Collaboration between national and subnational levels of government (n=2) [14,26]

FACILITATORS (n=21)		
Health worker characteristics (n=19)	**Program planning and implementation (n=17)**	**Program environment (n=16)**
	• Job aids, decision support tools, and guidelines (n=6) • Special bag called outreach kit for community-based distributors (n=1) • Appraisal instruments to certify trainees (n=3) [16,20,23] • Use of FP models and actual users (n=1)	
Ability to communicate with colleagues, clients and the community (n=4)	Programmatic support and good program management, e.g., better phones, consistent pay, and transportation (n=5)	FP funding (n=5)
Trained HW with Skills and confidence in providing FP services (n=12) [14–16,20,23,26–32]	Planning for all steps involved in providing FP, e.g., planning for Implanon insertion and removal (n=2) [18,24]	Out of health facilities, FP services in regional health and social service organizations and sectors of practice, such as youth or school clinics (n=1)
HW innovation, e.g., date scheduling to dry seasons, disinfection of equipment with chlorine bleach (n=2)	FP Advocacy and public engagement (n=11) • Trust in cadre and building of client confidentiality (n=7) • Adaptation to context (n=1) • Community introduction, continuous stakeholder engagement and collaboration, use of community support groups (n=10)	High knowledge and demand for FP services and suitable demand-generation activities (n=5)
Female cadre or preference for female workers (n=3) [31,33,34]	Supportive supervision (n=6)	Pre-existing FP programs and small catchment areas or short distance to supporting district/regional health facilities (n=3) [31,35]
	Better communication between provider and client (n=2)	
	Availability of data for decision making, including real-time data (n=2) [22,27]	
	Use of M and E reporting tools and QIP Data collection instruments (n=5)	

BARRIERS (n=17)		
HW Characteristics (n=4)	**Program planning and implementatio**n (n=13)	**Program environment (n=15)**
HW's attitude (to clients and to providing FP services) and motivation (n=3)	Poor logistics and supply (n=11) • Insufficient supplies and supply chain challenges, e.g., inadequate supply, over-centralization, erratic, expired, out of stock, poor last mile distribution, lack of recording forms (n=9) • Supply challenge in the private sector (n=1) • Problems of accessibility, e.g., large catchment area, long transit time and high cost, hard-to-reach areas, marginalized groups, poor/lack of transportation for HW or commodities, seasonality (n=8) [14,17,19,21,22,24,26,31]	Inter or within cadre conflicts or resistance to task-sharing policy from other cadres (n=5)

BARRIERS (n=17)		
HW Characteristics (n=4)	**Program planning and implementation** (n=13)	**Program environment (n=15)**
	• Theft of FP commodities (n=1)	
Limited skills in assessing eligibility in first-time users (n=1)	Staff shortage, including mismatch with FP demand or high turnover or low retention, heavy workload, and limited time (n=9)	Policies and regulation (n=6) • Poor political will and lack of local ownership (n=5) • Narrow task-sharing policies, i.e., do not incorporate all potential lower cadres (n=1) • Poor policy dissemination and implementation (n=3) [26,32,34]
Problems in CHW home (n=1)	Suboptimal supervision, e.g., more administrative than supportive (n=2)	Insufficient funding, including financial limitation of MOH (n=6)
HW bias, e.g., staff personal, moral, religious, or ethical objections to FP (n=3)	Monitoring and evaluation challenges (n=7) • Suboptimal monitoring and evaluation (n=5) • High workload for monitoring and evaluation (n=3) • Limited local use of data (n=2) [22,27]	Community and user biases against FP (n=6) [14,22,23,26,31,34] • Myths and misconceptions, especially with tubal ligation and IUD (n=5) • Young people were seen as promiscuous (n=1) • More children more esteem (n=1) • Competing priorities during the farming season (n=1) • Religious beliefs, including that FP is a sin or that it promoted western agenda (n=1) • Problems in the client's home or poor support/need for men's permission or disapproval of client's husband and family support, inadequate male engagement programs (n=4) • Concerns about the safety and quality of new cadres (n=4)
	Too many clients visit to acquire the FP method (n=1)	Regional health and social service organizations and sectors of practice, such as youth or school clinics versus hospitals (n=2)
	Cost of commodity, transport, supplies (n=5)	Poor FP demand, including insufficient women as clients to train HW (n=5)
	Lack, poor or broken down equipment or infrastructure and lack of guidelines or tools or MEC (n=6)	
	Insufficient reimbursement (n=3)	

BARRIERS (n=17)		
HW Characteristics (n=4)	**Program planning and implementatio**n (n=13)	**Program environment (n=15)**
	Politicization of HW selection (n=1)	
	Lack or suboptimal HW training or poor skills (n=10) [18,19,22,24,26,27,30,34,35]	
	Limited training tools for task-sharing cadres or complex job aids (n=2)	
	Management objections and biases (n=2)	

Annex B2: BNA Planning tool

This is a suggested time-frame for implementing BNA activities (modules A-C). This assumes that the different module content can be assessed simultaneously. The editable version is contained in the BNA Excel file.

		Enter progress here:	Week no.							
TASK	ASSIGNED TO, e.g.:	PROGRESS	1	2	3	4	5	6	7	8
Preparation										
Assessment tool review	BNA consultant	0%								
Problem definition, assessment adaptation and optional preparatory field visit	BNA consultant	0%								
Ethics exemption (if required)	BNA consultant	0%								
PPFP Assessment										
National data review	BNA consultant	0%								
Guidance & policy alignment assessment	BNA consultant	0%								
Case studies	BNA consultant	0%								
Open-ended questionnaire	BNA consultant	0%								
Questionnaire analysis	BNA consultant	0%								
Workshop preparation	BNA consultant	0%								
PPFP Consensus workshop	BNA consultant	0%								
Task-sharing assessment										
National data review	BNA consultant	0%								
Guidance & policy alignment assessment	BNA consultant	0%								
Case studies	BNA consultant	0%								
Open-ended questionnaire	BNA consultant	0%								
Questionnaire analysis	BNA consultant	0%								
Workshop preparation	BNA consultant	0%								
TS Consensus workshop	BNA consultant	0%								
SBC assessment										
National data review	BNA consultant	0%								
Guidance & policy alignment assessment	BNA consultant	0%								
Case studies	BNA consultant	0%								
Open-ended questionnaire	BNA consultant	0%								
Questionnaire analysis	BNA consultant	0%								
Workshop preparation	BNA consultant	0%								
SBC Consensus workshop	BNA consultant	0%								

Annex B3: Policy & Guidance Alignment Assessment for TASK-SHARING

Q #	Question	Prompts for question	Level of policy and guidance alignment (full/partial/none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
1	There is a national task-sharing policy for RMNCH including FP				
2	National FP guidelines have been updated with the 2017 WHO *FP Task Sharing guidance*	Record date of publication or last update, or if date of publication/update not available.			
3	National FP / TS policy and guidelines includes *"who can provide"* table.				
4	National FP and TS policies and guidelines use clear and consistent definitions and labels/terms throughout for CHWs and auxiliary nurses/midwives				
5	National FP and TS policies and guidelines provide clear and consistent requirements for CHWs and auxiliary nurses/midwives, specifying education & training, residency etc.				
6	Task-sharing policy, guidelines and tools align precisely with WHO recommendations on practice, namely that **Community health workers** can safely and effectively provide family planning education and counselling, information on SDM, 2Day Method, and LAM; oral contraceptives and condoms; and hormonal injectables, **under targeted monitoring and evaluation.**				
7	Task-sharing policy, guidelines and tools align precisely with WHO recommendations on practice, namely that **auxiliary nurses and**				

Q #	Question	Prompts for question	Level of policy and guidance alignment (full/partial/none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
	auxiliary nurse midwives can safely and effectively provide family planning education and counselling, information on SDM, 2Day Method, and LAM; oral contraceptives and condoms, hormonal injectable, and contraceptive implants; and (for auxiliary nurse midwives) IUDs				
8	TASK-SHARING policies and guidelines align with WHO's human rights framework for the provision of contraception, including on informed consent procedures, offer of range of methods, recommendations on privacy and confidentiality, and non-allowance for conscientious objection to provision of FP information and services	Review WHO Human Rights for Contraceptive Services framework			
9	There are national-level/subnational policies that support the development and deployment of CHW programs				
10	There are national/subnational policies that explicitly refer to CHWs, with a formal governance structure, funding support, training agenda, job description, and appropriate support from public health facilities.				
11	There are national and/or subnational standards on the duration and content of CHW/health workforce education and training				

Q #	Question	Prompts for question	Level of policy and guidance alignment (full/partial/none)	Rationale for level assigned (e.g. conflicting guidance, unclear guidance, ad hoc evidence of implementation etc.)	Information sources (if document, state name of document & year; if key informant, state name/role)
12	There are national and/or subnational mechanisms for accreditation of CHW/health workforce education and training institutions and their programmes				
13	There are national education plans for the health workforce, aligned with the national health plan and the national health workforce strategy/plan, which match health worker competencies with population/health systems/labour market needs				
14	There are national systems for continuing professional development				
15	Clinical regulations, including licensure regulations, stipulate that implants can be provided by auxiliary nurses and injectables can be provided by community health workers.				

Annex B4: Data review for TASK-SHARING

				Responses *(Enter ND if no data available)*				
Background: Current FP status	**Module**	**Potential Data source**	**Suggested breakdown**	**All WRA**	**Rural WRA**	**Urban WRA**	**<20 WRA**	**>=20 WRA**
% of FP accessed in the public sector	All	DHS	Rural/urban, <20/>=20					
% of FP accessed in the non-profit private sector	All	DHS	Rural/urban, <20/>=20					
% of FP accessed in the for-profit private sector	All	DHS	Rural/urban, <20/>=20					
Modern contraceptive prevalence (% among women of reproductive age)	All	DHS or PMA	Rural/urban, <20/>=20					
% all women of reproductive age relying on Long Acting or Permanent methods of FP	All	DHS or PMA	Rural/urban, <20/>=20					
% all current contraceptive users relying on Long Acting or Permanent methods of FP	All	DHS or PMA	Rural/urban, <20/>=20					
% of women with unmet need for FP	All	DHS or PMA	Rural/urban, <20/>=20					
% of women with unmet need for FP for spacing births	All	DHS or PMA	Rural/urban, <20/>=20					
National Family Planning Effort Index	All	Track20						
Number of health workers (all reported cadres) national/subnational	Task-sharing							
Doctors per 1000 population	Task-sharing	National/state Health info stats	Rural/urban or by state					
Nurses per 1000 population	Task-sharing	National/state Health info stats	Rural/urban or by state					
CHWs per 1000 population	Task-sharing	National/state Health info stats	Rural/urban or by state					

				Responses *(Enter ND if no data available)*				
Background: Current FP status	**Module**	**Potential Data source**	**Suggested breakdown**	**All WRA**	**Rural WRA**	**Urban WRA**	**<20 WRA**	**>=20 WRA**
% of workforce that are CHW	Task-sharing	National/state Health info stats	Rural/urban or by state					
Ratio of unfilled posts to total number of posts, by cadre	Task Sharing	National/state Health info stats	Rural/urban or by state					

Annex B5: Case studies summary (use one table per module)

Title of project or programme with short description (Select 2-3 case studies)	Where was the project or programme implemented? (States, regions, districts)	Who implemented it?	What were the achievements?	What were some of the health systems factors that made the project a success? (Review Bottlenecks Framework)	What were some of the challenges? (Review Bottlenecks Framework)	Any other relevant information including lessons learned?

Annex B6: Key informant Questionnaire for TASK-SHARING

WHO Family Planning Accelerator Plus

Bottlenecks Assessment (BNA)

KII Questionnaire – TASK-SHARING

Introduction

Who is running this assessment?

This questionnaire is part of a national 'FP Bottlenecks Assessment' being coordinated by the World Health Organization, investigating the scale-up of evidence-based practices in family planning.

What is the purpose of this questionnaire?

This questionnaire will ask about your opinions on a range of potential health systems 'bottlenecks' (or barriers or factors) that may be inhibiting scale-up of task-sharing in this country. This includes task-sharing of injectables to community health workers, and of implants to auxiliary nurses. You will be asked to rate your agreement out of 5 with a series of statements (from fully agree to fully disagree). You can also add comments about each statement if you wish. At the end, you can mention any potential barriers or challenges that have not been raised in the questionnaire.

Why am I being asked to complete it?

You have been purposefully selected as a person with considerable knowledge on family planning programming and/or task-sharing for health in this country. Your opinions will be greatly valuable for the Bottlenecks Assessment.

What happens afterwards?

A consensus-building workshop will be held with a range of different stakeholders to identify the most important bottlenecks, and to identify solutions to address them.

Is my contribution anonymous?

Everything you write in this questionnaire or tell us in person will be anonymized. We will only ask questions about your work role.

What happens if I refuse or don't have time to participate?

Nothing, please just let us know that you are not able to complete the questionnaire and we will seek another informant. There will be no impact on your employment.

Section		Q #	Preliminary questions	Circle the correct response:	Any comments
Background		**1.**	What type of organization do you work for (circle number that applies)?	1. Government 2. Professional association 3. NGO or civil society 4. Private 5. Other_____	
		2.	What is your role in that organisation (circle number that applies)?	1. Policy 2. Programme management 3. Researcher/M&E 4. Clinician or health worker 5. Other_____	
		3.	At what level to you provide support to FP programmes (circle number that applies):	1. National 2. Sub-national or regional 3. District 4. Community 5. Other_____	
		4.	How long have you been working in or supporting FP programmes (circle number that applies):	1. <1 year 2. 1-3 years 3. 3-10 years 4. >10 years	

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
Implementation status		**5.**	**Task-sharing for family planning is adequately implemented and scaled-up nationally** ***Consider these statements when rating:*** • Auxiliary nurses routinely provide and remove contraceptive implants • Community health workers routinely provide injectable contraceptives • Health facilities follow the clinical and practice guidance on which types of health worker should provide FP as advised by the MOH • Health facilities adhere to local/national guidance on how and from where a community health worker is identified, selected, and assigned to a community. • Task-sharing is adequately implemented and scaled across both public and private/NGO sector providers.		
Governance	**Leadership & commitment**	**6.**	**There is strong leadership and commitment to support scale-up of task-sharing for FP.** ***Consider these statements when rating:*** • There is political support for task-sharing for FP at national level • Task-sharing is included in national FP goals • Task-sharing for FP has champions advocating for the practice at the national level • Task-sharing for FP has champions advocating for the practice at the state/regional level		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• Professional associations endorse the government's task-sharing policies • State/regional and district authorities follow the guidance of the MOPH on task-sharing and do not make autonomous policies and do not make autonomous policies that contradict MOPH guidance • Hospital managers and clinical directors follow the guidance of the MOPH on task-sharing and do not make autonomous policies and do not make autonomous policies that contradict MOPH guidance		
	Accountability	**7.**	**There is strong accountability for task-sharing for FP across different institutions and among policy makers and programme managers** ***Consider these statements when rating:*** • There is accountability and coordination across different institutional structures (public, private and non-governmental authorities) to enable effective task-sharing policy development and programming. • A public officer has accountability* to deliver scale-up of task-sharing for FP at national level • A public officer has accountability* to deliver scale-up of task-sharing for FP at the state/regional level **Accountable means someone is responsible and answerable for the correct and thorough delivery of scale-up*		
	Regulation	**8.**	**There is strong regulation to ensure effective task-sharing for FP.** ***Consider these statements when rating:***		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• An enabling policy environment is in place, with appropriate regulations and guidelines for task-sharing, including licencing • Clinical regulation supports scale-up of task-sharing for FP • There are no laws or policies that require partner consent to receive FP • There are no laws or policies that restrict access for adolescents or unmarried women. • Changes to CHWs and auxiliary nurses scopes of practice are supported by licensure regulations • The private/non-governmental sector is adequately regulated in its task-sharing activities		
	Guidance formulation	**9.**	**There is sufficient guidance (including policies, guidelines and tools) to support scale up of task-sharing for FP** ***Consider these statements when rating:*** • Policy & practice guidance to support implementation of FP task-sharing exists and is up to date. • Policy & practice guidance to support implementation of FP task-sharing is available to all district health teams, health facilities and education establishments • Policy & practice guidance on task-sharing is endorsed by the MoPH • International standards and guidance on task-sharing have been adapted to the national and/or state context • Task-sharing guidance is standardised and does not allow for unwanted flexibility in implementation • Task-sharing guidance is incorporated into programmatic & clinical standards, guidelines and tool		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
Financing	**Budgeting**	**10.**	**There is adequate budget available at all levels to support task-sharing for FP scale up.** ***Consider these statements when rating:*** • There is a costed implementation plan for scale-up of task-sharing for FP • Task-sharing for FP has been included in the FP2020/30 CIP • Task-sharing for FP has been included in the Global Financing Facility (GFF) Investment Case. • Adequate funds are allocated to task-sharing for FP in national budgets • Adequate funds are allocated to task-sharing for FP in state/regional budgets • There is sustainable financing for expanding and transforming the health workforce, including investment in the International Health Regulations core capacities • The health and economic impacts of task-sharing scale up have been demonstrated (e.g. via health/demographic modelling tools) and communicated		
	Donors	**11.**	**Donors sufficiently contribute to financing scale-up of task-sharing for FP** ***Consider these statements when rating:*** • Donor priorities are aligned with MOH policies and priorities for task-sharing scale-up. • Donors commitments are sufficiently financed in budgets.		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
	Insurance	**12.**	**National health insurance schemes cover access to contraception through community health workers**		
	Spending allocation	**13.**	**Government expenditure on task-sharing matches the allocated budget**		
	Planning	**14.**	**There is a coherent national plan for task-sharing scale-up** ***Consider these statements when rating:*** • The extent of task-sharing coverage or gaps have been mapped nationally • A strategic plan for expanding coverage of task-sharing exists and has been effectively communicated and actions are included within annual operating plans. • Potential challenges to implementation are identified and addressed proactively. • Task-sharing scale-up is included in current year national & state/regional annual health operating plans • There are mechanisms and models for health workforce planning (e.g. dedicated and established Human Resources for Health Planning Committee) • Population coverage data are readily available to provide quantitative assessment required for health workforce planning • There are national education plans for the health workforce, aligned with the national health plan and the national health workforce strategy/plan, which match health worker competencies with population/health systems/labour market needs		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
	Equity	**15.**	**There are financing mechanisms and policy actions in place to ensure equitable scale-up of task-sharing** ***Consider these statements when rating:*** • Budget is allocated to areas where rates of FP use are low and unmet needs for FP are high. • Budgeting and programming address the needs of adolescents and women from poor and/or rural contexts. • Programmes address the needs of other marginalized women including women living with HIV, women with disability, women from minority ethic groups and female sex workers. • Data are reviewed regularly to ensure equitable allocation of budget.		
People	**Communication, knowledge & awareness**	**16.**	**There is a high level of knowledge and awareness of recommended task-sharing policies and practices:** ***Consider these statements when rating:*** • There is effective national dissemination of relevant policies and guidance. • Policy-makers & programme managers at the national and state/regional levels fully understand and know task-sharing policies and recommended practices • Healthcare managers and workers (public and private) fully understand and know the recommended practices on task-sharing • There are effective communication channels in place to ensure that stakeholders remain engaged and informed about task-sharing activities and progress.		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
	Acceptability	**17.**	**There is acceptance of recommended task-sharing policies and practices by key stakeholders.** ***Consider these statements:*** • There is agreement among stakeholders that there is sufficient local evidence to support scale-up of task-sharing injectables to CHWs • There is agreement among stakeholders that there is sufficient local evidence to support scale-up of task-sharing implants to auxiliary nurse-midwives • Policy-makers & programme managers at national and regional/state levels fully agree with the need to scale-up task-sharing for FP • Professional associations fully agree with the need to scale-up task-sharing for FP • Senior healthcare managers fully agree with the need to scale up task-sharing for FP • Task-sharing recommendations are easy for facility and community health managers to understand and implement		
	Consultation	**18.**	**Key stakeholders are adequately consulted during task-sharing policy development and rollout** ***Consider these statements:*** • Stakeholders have been adequately consulted during the creation of task-sharing policy and practice guidance. • Groups that maybe opposed to FP scale up are sufficiently consulted (e.g. for religious, cultural, anti-choice reasons etc.)		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• There are established mechanisms for feedback, monitoring, and evaluation to ensure that the scale-up is effective and meeting the needs of clients and communities.		
	Coordination	**19.**	**There is good coordination between different stakeholders to ensure effective scale-up of task-sharing for FP** ***Consider these statements when rating:*** • National policies are effectively transferred to state/regional policies • The MOPH effectively coordinates the different public, NGO and private stakeholders in their efforts to scale-up task-sharing • There are regular interagency meetings during the year that discuss and plan for practice scale-up (with participation of MoH, donors, NGOs, UN, professional associations etc.) • There are regular interagency meetings during the year that discuss and plan for task-sharing scale-up (with participation of MoH, donors, NGOs, UN, professional associations etc.) • The FP teams in the relevant MOPH department jointly plans with professional associations and medical/nursing/midwifery/CHW schools for task-sharing scale-up • Health workforce education and training institutions cooperate with regulatory bodies to agree on accreditation standards • In-service training is integrated into larger national education-wide sector policies, strategies and plans • The MOH coordinates with private and non-governmental providers on task-sharing scale-up		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• OB/GYN and midwifery experts regularly advise the MOH and participate in planning meetings to scale up task-sharing.		
	Networks	**20.**	**There are effective professional networks supporting scale-up of task-sharing** ***Consider these statements when rating:*** • Task-sharing is actively and regularly promoted through professional networks. • There are active regional training networks who support scale-up of task-sharing • The country has learned from other similar country contexts on how to scale-up task-sharing		
	Community engagement	**21.**	**There is adequate community engagement on task-sharing** **Consider this statement:** • There has been health promotion or communication (SBCC/marketing/community outreach/mass media/social media/community group mobilization) to promote acceptability of task-sharing • Health facilities involve communities (any organization or group at the community level) in selection of CHWs • Health facilities offering task-sharing have effective client feedback and engagement mechanisms in place (surveys, suggestion boxes, review groups, etc.)		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
Information	**Reporting**	**22.**	**There is adequate reporting on task-sharing.** ***Consider these statements when rating:*** • There are agreed reporting standards and key performance indicators for monitoring of task-sharing implementation • There is an agreed goal or target for task-sharing coverage. • Data on task-sharing coverage (in both public and private sectors) is received and monitored at national and state/regional levels		
	Data & HMIS	**23.**	**There is an effective HMIS to support data collection on task-sharing and data is used regularly for performance management.** ***Consider these statements when rating:*** • Data trends on task-sharing coverage are shared with district health teams, facilities and program managers to allow regular assessment and comparison of performance • Health facilities and community health programmes share data on provision of FP by different cadres of staff • Health facilities and community health programmes using CHWs report critical incidents by different cadres of staff • There is an effective HMIS collecting necessary datapoints to monitor implementation of task-sharing nationally, including cadres of staff providing FP • CHWs collect, collate and use health data on routine activities including FP • Data on task-sharing is used regularly to assess and manage programming response		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
	Guidelines & tools	**24.**	**Updated guidance on task-sharing is available and widely used.** ***Consider these statements when rating:*** • Service protocols for FP are in place in health facilities, and include updated recommendations on task-sharing • Provider job aids (for CHWs and auxiliary nurses) have been updated to support new FP service provision		
	Client SBC/IEC	**25.**	**SBC/IEC materials exist to support task-sharing** ***Consider these statements when rating:*** • SBC/IEC materials/apps on FP provision by lower cadres exist and are routinely distributed and available for use or take-away at service points where task-sharing is new		
	Health promotion	**26.**	**The benefits of task-sharing are adequately communicated via effective health promotion activities, such as community outreach, mass media, and health education sessions** **Consider these statements:** • Efforts are made to communicate and motivate facility managers and health workers on the benefits of task-sharing. • Task-sharing, including potential access to injectables via community health workers, is promoted via effective health promotion activities.		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
Medicines & technology	**Infrastructure**	**27.**	**There is adequate health infrastructure to deliver task-sharing for FP** ***Consider these statements when rating:*** • Relevant health facilities have physical infrastructure to implement task-sharing		
	Supplies	**28.**	**Health facilities and community health programmes have sufficient commodities, equipment and other supplies required to deliver task-sharing** ***Consider these statements when rating:*** • Relevant health facilities have equipment to support tasks-sharing for FP • Facilities implementing implant task-sharing always have implants in stock. • CHWs implementing task-sharing of injectables always have sufficient supplies of injectables during outreach work. • The FP commodities management system includes orders/demand from CHWs • Health facilities and providers involved in task-sharing have the necessary equipment and supplies required to deliver newly assigned contraceptive methods • There is a functional logistics management information system (electronic or paper) that is able to track use of and provide facilities with required equipment • Access to supplies and commodities is well coordinated across different actors in the health system.		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
Service delivery	**Management**	**29.**	**There is effective health management to support task-sharing** ***Consider these statements when rating:*** • There is a designated manager in health facilities who is accountable for task-sharing success. • Implementation of task-sharing is included in management review processes of district and facility managers. • Quality control and audit processes cover implementation of task-sharing • Clinical leaders advocate for and promote task-sharing in their facilities • The relevant healthcare managers have sufficient capacity to manage the scale-up of task-sharing on top of their other responsibilities • Management tools and procedures exist to support managers address constraints with implementing task-sharing • Managers regularly monitor trends in task-sharing, including incident reports, to assess potential needs and gaps • Facility mangers involved in task-sharing regularly conduct learning reviews to assess what is working well and what needs change/adaptation.		
	Supervision	**30.**	**There is adequate clinical supervision to quality assure task-sharing** ***Consider these statements when rating:*** • All supervisors have been oriented on task-sharing and related service delivery provision requirements		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
			• Competency assessments have been updated to include new FP method provision (CHWs and auxiliary nurses) • Providers involved in task-sharing receive regular supervision on the new practices • Clinical mentorship schemes to promote and supervise task-sharing exist and are widely used • There are sufficient supervisors for national scale-up of tasks-sharing		
	Team work & coordination	**31.**	**Different teams involved in task-sharing work together to ensure its delivery** ***Consider these statements when rating:*** • Higher cadres work in partnership with lower cadres in a coordinated way to increase access to FP (i.e. doctors and nurses coordinate with auxiliary nurses for implant provision; facility clinical providers coordinate with CHWs for injectable provision)		
	Service organization & scheduling	**32.**	**The organization of services makes task-sharing feasible (which providers allocated to which rooms/depts. etc.)**		
	Referral systems	**33.**	**Referral systems support task-sharing** ***Consider these statements when rating:*** • Complex FP provision or removal cases can be easily referred to higher cadre providers or facilities • CHWs have clear guidance/protocols for referrals to health facilities and/or higher cadre providers		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
	Fees	**34.**	**There are no additional fees when FP methods are shared to lower cadre providers (i.e. for injectables when delivered by CHWs, and implants when delivered by auxiliary nurses)**		
Human Resources	**Training & education**	**35.**	**Task-sharing is integrated adequately into pre- and in-service training of health workers** ***Consider these statements when rating:*** • Injectable provision is included in CHW pre-service curricula • Implant provision & removal is included in auxiliary nurse pre-service curricula • Training needs for CHW FP provision are regularly assessed • Training needs for auxiliary nurses' FP provision are regularly assessed • There are national systems for continuing professional development		
	Capacity	**36.**	**Health workers in MNH services have capacity to deliver task-sharing** ***Consider these statements:*** • CHWs have capacity in daily routine to also deliver injectables • Auxiliary nurses have capacity in daily routine to also deliver implants • Staff turnover is low enough to allow institutionalisation of new skills for task-sharing scale-up		
	Roles	**37.**	**The relevant FP method provision is included in job descriptions of staff who are assuming new FP provision**		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments
	Skills & competencies	**38.**	**Competency assessments take account of task-sharing and additional support needs.**		
	Motivation	**39.**	**Providers involved in task-sharing have positive attitudes towards the policy** ***Consider these statements when rating:*** • Cadres 'sharing' roles (i.e. higher level) are supportive of task-sharing policies on FP • Cadres 'receiving' roles (i.e. lower level) are supportive of task-sharing policies • Clinical supervisors and managers are supportive of task-sharing policies • Cadres 'receiving' roles (i.e. lower level) are adequately remunerated for taking on additional responsibilities • There is a supportive institutional culture that prioritises staff team work, staff development and efficiency.		
		40.	**Are there any other challenges, barriers, or 'bottlenecks' that are inhibiting effective scale-up of task-sharing for FP in this country that you would like to mention?** *Enter response here:*		

BNA Framework Theme	Categories	Q #	Respondents to state their level of agreement with the following statements: (1) Fully agree (2) Somewhat agree (3) Neutral (4) Somewhat disagree (5) Fully disagree DK= don't know	Response rating 1-5 or DK:	Any comments

Annex B7: BNA Workshop for Task-sharing

Workshop overview

Workshop Aims: The aim of this workshop is for the group of stakeholders to come to consensus on the most important bottlenecks inhibiting scale-up of task-sharing for family planning in this country, and to identify solutions to address the challenges and barriers.

Who attends: See core module for detailed list of suggested participants. Participants should include

(i) Policy-makers and programme managers at national & state levels
(ii) Facility managers, clinicians and professional association representatives
(iii) Civil Society representatives

Facilitation: The workshop should be facilitated by an experienced facilitator, as well as expert consultant in task-sharing and/or human resources management for FP.

Workshop timing and format: The workshop should last two days. The suggested format is as follows:

Session No.	Session Name	Session Aims	Timings
	DAY 1		
1	Introductions	For the group to know each other and break the ice	45 mins
2	Task-sharing overview	Expert(s) on task-sharing to present key recommended evidence-based policies and practices on task-sharing With Q&A	30 mins
3	Implementation status report	Present and understand: • Policy & guideline alignment • Data review • Questionnaire findings Q&A after each	1 hr 30 mins
4	Case studies	Relevant participants to present lessons learned on EBPP implementation case studies	1 hr
5	Bottlenecks framework update	Bottlenecks framework presentation Any missing bottlenecks? Q&A and update to framework	45 mins
6	Bottleneck group work: ranking	3 groups: Group 1: Governance and financing Group 2: People and information Group 3: Medicines/technology, service delivery & human resources	2 hrs

		To review BNA ranking tool (see below), discuss, and group rate importance of bottlenecks Prioritise the potential bottlenecks inhibiting task-sharing scale-up Come to consensus on the top 10 bottlenecks	
	Day 2		
7	Group report back	3 groups to report back rankings	1 hr 30
8	Root cause analysis	Group work on root causes of the key bottlenecks	2 hrs 30
9	Solutions identification	Group work on solutions identification	2 hrs
10	Group report back and wrap up		1 hr 30

Session 1: Introductions

Facilitators to lead icebreaker to allow everyone to get to know each other. Facilitators to present workshop aims.

Session 2: Task-sharing overview

Expert(s) on task-sharing to present key recommended evidence-based policies and practices on task-sharing. Facilitators should review Annex 1 (above) and ensure the presentation covers the key recommended policies, both of WHO and what is recommended at the national (and/or state levels, where relevant).

Session 3: Implementation status report

Consultant to present their findings from the desk review and questionnaire:

- Policy & guideline alignment
- Data review
- Questionnaire findings

Allow Q&A after each presentation.

Session 4: Case studies

Participants who led or were involved in EBPP case studies to present their experiences of EBPP implementation. The presentation should focus on HOW the programme worked, i.e. what health systems factors helped or hindered the implementation process. Any relevant outcome results can also be presented.

Session 5: BNA framework update

Presentations to be followed by Q&A and group discussion and feedback on findings of the reports. Discussion on 'any missing bottlenecks?' – either not identified from original WHO framework or new ones raised during discussion.

Outcome: Consensus on current state of implementation scale-up and locally relevant bottlenecks.

Session 6: Bottlenecks ranking exercise

Split into 3 groups, ensuring a mix of participant types (policy/programme, clinical, civil society) across the three groups:

Group 1: Governance and financing

Group 2: People and information

Group 3: Medicines/technology, service delivery & human resources

Use the ranking tool (see Annex 8), groups to rate the potential bottlenecks inhibiting scale-up of task-sharing. Ensure one facilitator per group. Group to elect note-taker to feed back later.

Group to consider the following (place of flipchart on wall in each group room!):

- How big of a problem is this factor in preventing scale-up of task-sharing?
- If it was addressed would we see likely improvements in scale and quality of task-sharing?
- Is this a problem preventing nationwide scale-up of task-sharing?
- How urgently does this bottleneck need to be solved?
- How many other bottlenecks does this problem cause?

Groups to proceed as follows:

1) Facilitators to present the prioritisation sheets and encourage group to read the potential bottlenecks at each level (the DETAIL is important!).
2) Group participants to first individually rank the 10-14 bottlenecks they have been allocated, in terms of priority factors inhibiting scale-up of task-sharing. (1=least important)
3) Facilitators to display all the 10-14 sub-categories on flipcharts, and ask everyone to come and write their ranked number against each sub-category.
4) Facilitators to calculate an average ranking score for each bottleneck factor and summarise the top ranked 5 factors.
5) Facilitator to ask for 'voices of dissent' to set out their case for bottlenecks that are missing from the top 5 or which have been prioritised at a low level.
6) Group to come to consensus through discussion on the final top 5 priority bottlenecks.

Group 1: Governance & Financing	**Group 2: People & Information**	**Group 3: Medicines/technology, service delivery & HR**
Governance: • Leadership & commitment • Accountability • Regulation • Guidance formulation & coherence **Financing** • Budgeting • Donors • Insurance • Spending • Planning • Equity	**People:** • Communication, knowledge & awareness • Acceptability • Consultation • Coordination • Networks • Community engagement **Information** • Reporting • Data & HMIS • Guidelines & tools • Client SBC/IEC • Health promotion	**Medicines & technology:** • Infrastructure • Supplies & LMIS • Innovation **Service delivery:** • Management • Supervision • Team work • Service structure & scheduling • Referral systems • Fees **Human Resources:** • Training & education • Capacity • Roles • Skills & competencies • Motivation
Total no. of potential bottlenecks: 10	**Total no. of potential bottlenecks: 11**	**Total no. of potential bottlenecks: 14**

Outcome: Groups have identified 5 important bottlenecks to present to the workshop on Day 2 (15 altogether across the 3 groups)

Facilitators *to write up the 15 top bottlenecks onto a flipchart using large post-it notes (so they can be moved/edited if needed) before session 7.*

Session 7: Group report back and final ranking

Each group to report back on its work, including the types of factors they discussed, the bottleneck ranking, and the rationale for the most important bottlenecks chosen.

Ask the wider group to reflect on what they find surprising or interesting in the rankings. Ask again for 'voices of dissent' for any important bottlenecks that have not been prioritised by other groups.

Once there is consensus on the final 15 bottlenecks, edit the flipcharts to make sure all 15 are displayed.

Give each participant 9 gold stars (or other coloured sticker). Ask them to consider all their discussions and place a gold star on each bottleneck that they would like to discuss solutions for in the next session. Remind them of the five key questions:

- How big of a problem is this factor in preventing scale-up of task-sharing?
- If it was addressed would we see likely improvements in scale and quality of task-sharing?
- Is this a problem preventing nationwide scale-up of task-sharing?
- How urgently does this bottleneck need to be solved?
- How many other bottlenecks does this problem cause?

Also ask them to consider a 6th question:

- Can this bottleneck actually be resolved with careful planning and resource-allocation?

Once that has been completed, the facilitators highlight or circle the final 9 factors (bottlenecks) for root cause analysis and solutions planning. Ask the group to any final voices of dissent along with justified pleas for swapping.

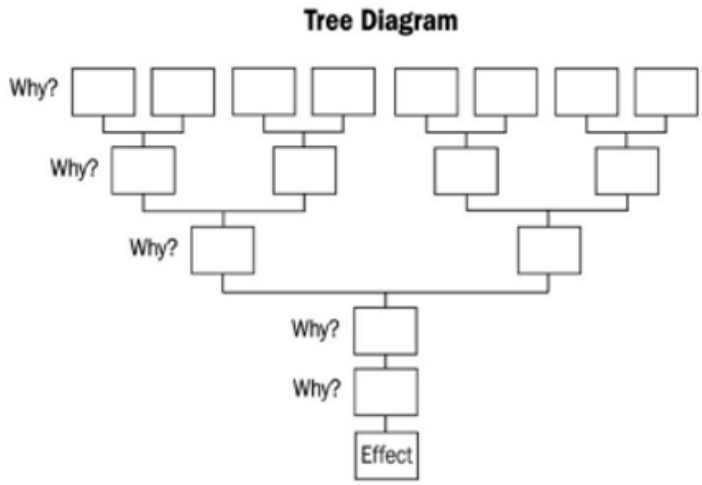
Session 8: Root cause analysis

Divide the large group into three again. The groups can be kept the same or mixed again, depending on dynamics/need.

Divide up the 9 bottlenecks (3-3-3), and either ask participants to select a specific group, or allocate them into groups. Ensure groups are mixed representation again.

Ask each group to develop a 'Problem tree' for each of their 3 bottlenecks. First write the effect (i.e. the bottleneck), and then ask **The 5 Why's** to analyze the root cause of the bottleneck and some solutions. As the diagram shows, there may be multiple reasons, and they should find the root cause of as many as possible!

Figure 1: Root Cause Analysis, URC/USAID Assist Project



Example Root cause analysis

If the group chose 'Role' , the group might brainstorm as follows in one branch of the tree (but do all branches during the workshop!):

Effect: Task-sharing responsibilities do not appear in CHW and auxiliary nurse job descriptions

Question 1: **Why** do they not appear in job descriptions?

Answer 1: Because nobody has updated the relevant job descriptions in the district management team.

Question 2: **Why** has nobody updated the job descriptions in the district management team

Answer 2: Because nobody in the district management team realises that task-sharing is happening?

Question 3: **Why** does nobody in the district management team realise that task-sharing is happening?

Answer 3: Because task-sharing was introduced as a pilot project by NGOs and the DMT were not consulted?

Question 4: **Why** were the DMT not consulted?

Answer 4: Because the MOH only wanted a pilot project and wasn't necessarily intended for task-sharing to continue.

Question 5: **Why** did the MOH not update the DMT on the scale-up of the task-sharing policy?

Answer 5: Because there is no national policy document on task-sharing.

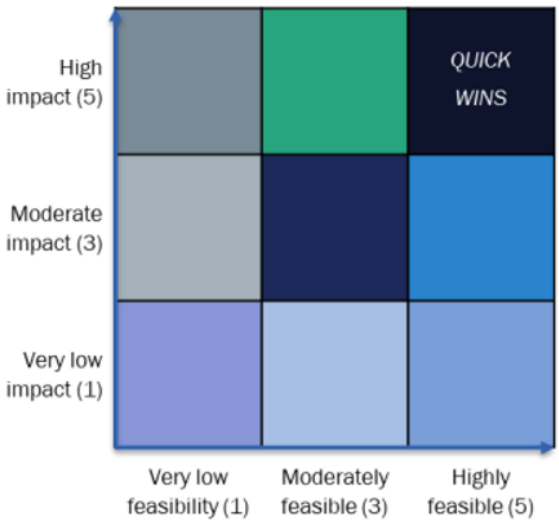
Session 9: Solutions identification

After a break, ask the groups to reconvene to discuss solutions based on their root cause analysis. In the example above, the solutions might be:

1) Work with the relevant Ministry director and technical experts to develop a task-sharing policy
2) Develop a plan with the MOH for policy dissemination and role-out to district health teams

When discussing solutions, try and focus on 'quick wins' – actions that are both highly feasible and likely to have high impact. Feasibility should consider costs, cost-effectiveness and available budgets. Impact should consider likely health and health system outcomes, equity and sustainability.

Figure 2: Impact feasibility matrix, Health Policy Plus



As solutions are discussed and agreed, enter them into the **solutions grid** (see below) (paper or digitally on laptop), and suggest people/groups/organizations who can support in implementing solutions.

Session 10: Report back and wrap up

The three groups should present back their root cause analyses and solutions planning. Note areas of common root causes and/or solutions across the groups. Ask the broader group for comment after report back. Build consensus on final solutions identified.

Discuss next steps required for dissemination and ensure interested and relevant stakeholders are engaged in the process.

TASK-SHARING Solutions Grid

Proposed solution	Which bottleneck does it address?	Check: How feasible is this solution?*	Check: How impactful will this solution be?	Which organizations can support with this solution?	Other comments

**consider available budget, time and funding*

Annex B8: Task-sharing Bottlenecks Ranking Tool

This tool is to be used during the group work in the BNA Task-sharing workshop. There are 3 tables for the 3 groups:

1) Governance & Financing
2) People & Information
3) Medicines & Technology / Service Delivery / Human Resources

TASK-SHARING Workshop Group 1: Governance & Financing

Groups to use this sheet to rank the potential bottlenecks that are inhibiting scale-up of TASK-SHARING.

***10 is the most important bottleneck, 1 is the least important**

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *10 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
Governance	**Leadership & commitment**	**There is strong leadership and commitment to support scale-up of task-sharing for FP.** ***Consider these statements when rating:*** • There is political support for task-sharing for FP at national level • Task-sharing is included in national FP goals • Task-sharing for FP has champions advocating for the practice at the national level • Task-sharing for FP has champions advocating for the practice at the state/regional level • Professional associations endorse the government's task-sharing policies • State/regional and district authorities follow the guidance of the MOPH on task-sharing and do not make autonomous policies • Hospital managers and clinical directors follow the guidance of the MOPH on task-sharing and do not make autonomous policies		
	Accountability	**There is strong accountability for task-sharing for FP across different institutions and among policy makers and programme managers** ***Consider these statements when rating:*** • There is accountability and coordination across different institutional structures (public, private and non-governmental authorities) to enable effective task-sharing policy development and programming. • A public officer has accountability* to deliver scale-up of task-sharing for FP at national level • A public officer has accountability* to deliver scale-up of task-sharing for FP at the state/regional level **Accountable means someone is responsible and answerable for the correct and thorough delivery of scale-up*		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *10 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
	Regulation	**There is strong regulation to ensure effective task-sharing for FP.** ***Consider these statements when rating:*** • An enabling policy environment is in place, with appropriate regulations and guidelines for task-sharing, including licencing • Clinical regulation supports scale-up of task-sharing for FP • There are no laws or policies that require partner consent to receive FP • There are no laws or policies that restrict access for adolescents or unmarried women. • Changes to CHWs and auxiliary nurses scopes of practice are supported by licensure regulations • The private/non-governmental sector is adequately regulated in its task-sharing activities.		
	Guidance formulation	**There is sufficient guidance (including policies, guidelines and tools) to support scale up of task-sharing for FP** ***Consider these statements when rating:*** • Policy & practice guidance to support implementation of FP task-sharing exists and is up to date. • Policy & practice guidance to support implementation of FP task-sharing is available to all district health teams, health facilities and education establishments • Policy & practice guidance on task-sharing is endorsed by the MoPH • International standards and guidance on task-sharing have been adapted to the national and/or state context • Task-sharing guidance is standardised and does not allow for unwanted flexibility in implementation • Task-sharing guidance is incorporated into programmatic & clinical standards, guidelines and tool		
Financing	**Budgeting**	**There is adequate budget available at all levels to support task-sharing for FP scale up.** ***Consider these statements when rating:***		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *10 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		• There is a costed implementation plan for scale-up of task-sharing for FP • Task-sharing for FP has been included in the FP2020/30 CIP • Task-sharing for FP has been included in the Global Financing Facility (GFF) Investment Case. • Adequate funds are allocated to task-sharing for FP in national budgets • Adequate funds are allocated to task-sharing for FP in state/regional budgets • There is sustainable financing for expanding and transforming the health workforce, including investment in the International Health Regulations core capacities • The health and economic impacts of task-sharing scale up have been demonstrated (e.g. via health/demographic modelling tools) and communicated		
	Donors	**Donors sufficiently contribute to financing scale-up of task-sharing for FP** ***Consider these statements when rating:*** • Donor priorities are aligned with MOH policies and priorities for task-sharing scale-up. • Donors commitments are sufficiently financed in budgets.		
	Insurance	**National health insurance schemes cover access to contraception through community health workers**		
	Spending allocation	**Government expenditure on task-sharing matches the allocated budget**		
	Planning	**There is a coherent national plan for task-sharing scale-up** ***Consider these statements when rating:*** • The extent of task-sharing coverage or gaps have been mapped nationally • A strategic plan for expanding coverage of task-sharing exists and has been effectively communicated • Potential challenges to implementation are identified and addressed proactively		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *10 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		• Task-sharing scale-up is included in current year national & state/regional annual health operating plans • There are mechanisms and models for health workforce planning (e.g. dedicated and established Human Resources for Health Planning Committee) • Population coverage data are readily available to provide quantitative assessment required for health workforce planning • There are national education plans for the health workforce, aligned with the national health plan and the national health workforce strategy/plan, which match health worker competencies with population/health systems/labour market needs		
	Equity	**There are financing mechanisms and policy actions in place to ensure equitable scale-up of task-sharing** ***Consider these statements when rating:*** • Budget is allocated to areas where rates of FP use are low and unmet needs for FP are high. • Budgeting and programming address the needs of adolescents and women from poor and/or rural contexts. • Programmes address the needs of other marginalized women including women living with HIV, women with disability, women from minority ethic groups and female sex workers. • Trend data are reviewed regularly to ensure equitable allocation of budget.		

TASK-SHARING Workshop Group 2: People & Information

Groups to use this sheet to rank the potential bottlenecks that are inhibiting scale-up of TASK-SHARING.

***11 is the most important bottleneck, 1 is the least important**

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *11 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
People	**Communication, knowledge & awareness**	**There is a high level of knowledge and awareness of recommended task-sharing policies and practices:** ***Consider these statements when rating:*** • There is effective national dissemination of relevant policies and guidance. • Policy-makers & programme managers at the national and state/regional levels fully understand and know task-sharing policies and recommended practices • Healthcare managers and workers (public and private) fully understand and know the recommended practices on task-sharing • There are effective communication channels in place to ensure that stakeholders remain engaged and informed about task-sharing activities and progress.		
	Acceptability	**There is acceptance of recommended task-sharing policies and practices by key stakeholders.** ***Consider these statements:*** • There is agreement among stakeholders that there is sufficient local evidence to support scale-up of task-sharing injectables to CHWs • There is agreement among stakeholders that there is sufficient local evidence to support scale-up of task-sharing implants to auxiliary nurse-midwives • Policy-makers & programme managers at national and regional/state levels fully agree with the need to scale-up task-sharing for FP • Professional associations fully agree with the need to scale-up task-sharing for FP • Senior healthcare managers fully agree with the need to scale up task-sharing for FP		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *11 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		• Task-sharing recommendations are easy for facility and community health managers to understand and implement		
	Consultation	**Key stakeholders are adequately consulted during task-sharing policy development and rollout** **Consider these statements:** • Stakeholders have been adequately consulted during the creation of task-sharing policy and practice guidance. • Groups with potential opposition to FP scale up are sufficiently consulted (e.g. religious, cultural, anti-choice etc.) • There are established mechanisms for feedback, monitoring, and evaluation to ensure that the scale-up is effective and meeting the needs of clients and communities.		
	Coordination	**There is good coordination between different stakeholders to ensure effective scale-up of task-sharing for FP** ***Consider these statements when rating:*** • National policies are effectively transferred to state/regional policies • The MOPH effectively coordinates the different public, NGO and private stakeholders in their efforts to scale-up task-sharing • There are regular interagency meetings during the year that discuss and plan for practice scale-up (with participation of MoH, donors, NGOs, UN, professional associations etc.) • There are regular interagency meetings during the year that discuss and plan for task-sharing scale-up (with participation of MoH, donors, NGOs, UN, professional associations etc.) • The FP teams in the relevant MOPH department jointly plans with professional associations and medical/nursing/midwifery/CHW schools for task-sharing scale-up • Health workforce education and training institutions cooperate with regulatory bodies to agree on accreditation standards		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *11 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		• In-service training is integrated into larger national education-wide sector policies, strategies and plans • The MOH coordinates with private and non-governmental providers on task-sharing scale-up • OB/GYN and midwifery experts regularly advise the MOH and participate in planning meetings to scale up task-sharing.		
	Networks	**There are effective professional networks supporting scale-up of task-sharing** ***Consider these statements when rating:*** • Task-sharing is actively and regularly promoted through professional networks. • There are active regional training networks who support scale-up of task-sharing • The country has learned from other similar country contexts on how to scale-up task-sharing		
	Community engagement	**There is adequate community engagement on task-sharing** **Consider this statement:** • There has been health promotion or communication (SBCC/marketing/community outreach/mass media/social media/community group mobilization) to promote acceptability of task-sharing • Health facilities involve communities (any organization or group at the community level) in selection of CHWs • Health facilities offering task-sharing have effective client feedback and engagement mechanisms in place (surveys, suggestion boxes, review groups, etc.)		
Information	**Reporting**	**There is adequate reporting on task-sharing.** ***Consider these statements when rating:*** • There are agreed reporting standards and key performance indicators for monitoring of task-sharing implementation • There is an agreed goal or target for task-sharing coverage.		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *11 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		• Data on task-sharing coverage (in both public and private sectors) is received and monitored at national and state/regional levels		
	Data & HMIS	**There is an effective HMIS to support data collection on task-sharing and data is used regularly for performance management.** ***Consider these statements when rating:*** • Data trends on task-sharing coverage are shared with district health teams, facilities and program managers to allow regular assessment and comparison of performance • Health facilities and community health programmes share data on provision of FP by different cadres of staff • Health facilities and community health programmes using CHWs report critical incidents by different cadres of staff • There is an effective HMIS collecting necessary datapoints to monitor implementation of task-sharing nationally, including cadres of staff providing FP • CHWs collect, collate and use health data on routine activities including FP • Data on task-sharing is used regularly to assess and manage programming response		
	Guidelines & tools	**Updated guidance on task-sharing is available and widely used.** ***Consider these statements when rating:*** • Service protocols for FP are in place in health facilities, and include updated recommendations on task-sharing • Provider job aids (for CHWs and auxiliary nurses) have been updated to support new FP service provision		
	Client SBC/IEC	**SBC/IEC materials exist to support task-sharing** ***Consider these statements when rating:*** • SBC/IEC materials/apps on FP provision by lower cadres exist and are routinely distributed		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *11 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		and available for use or take-away at service points where task-sharing is new		
	Health promotion	**The benefits of task-sharing are adequately communicated via effective health promotion activities.** **Consider these statements:** • Efforts are made to communicate and motivate facility managers and health workers on the benefits of task-sharing. • Task-sharing, including potential access to injectables via community health workers, is promoted via effective health promotion activities.		

TASK-SHARING Workshop Group 3: Medicines & Technology / Service Delivery / Human Resources

Groups to use this sheet to rank the potential bottlenecks that are inhibiting scale-up of TASK-SHARING.

***13 is the most important bottleneck, 1 is the least important**

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *13 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
Medicines & technology	**Infrastructure**	**There is adequate health infrastructure to deliver task-sharing for FP** ***Consider these statements when rating:*** • Relevant health facilities have physical infrastructure to implement task-sharing		
	Supplies	**Health facilities and community health programmes have commodities, equipment and other supplies required to deliver task-sharing** ***Consider these statements when rating:*** • Relevant health facilities have equipment to support tasks-sharing for FP • Facilities implementing implant task-sharing always have implants in stock. • CHWs implementing task-sharing of injectables always have sufficient supplies of injectables during outreach work. • The FP commodities management system includes orders/demand from CHWs • Health facilities and providers involved in task-sharing have the necessary equipment and supplies required to deliver newly assigned contraceptive methods • The logistics management information system is functional and able to provide facilities with required equipment • Access to supplies and commodities is well coordinated across different actors in the health system		
Service delivery	**Management**	**There is effective health management to support task-sharing** ***Consider these statements when rating:***		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *13 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		• There is a designated manager in health facilities who is accountable for task-sharing success. • Implementation of task-sharing is included in performance review processes of district and facility managers. • Quality control and audit processes cover implementation of task-sharing • Clinical leaders advocate for and promote task-sharing in their facilities • The relevant healthcare managers have sufficient capacity to manage the scale-up of task-sharing on top of their other responsibilities • Management tools and procedures exist to support managers address constraints with implementing task-sharing • Managers regularly monitor trends in task-sharing, including incident reports, to assess potential needs and gaps • Facility mangers involved in task-sharing regularly conduct learning reviews to assess what is working well and what needs change/adaptation.		
	Supervision	**There is adequate clinical supervision to quality assure task-sharing** ***Consider these statements when rating:*** • All supervisors have been oriented on task-sharing and related service delivery provision requirements • Competency assessments have been updated to include new FP method provision (CHWs and auxiliary nurses) • Providers involved in task-sharing receive regular supervision on the new practices • Clinical mentorship schemes to promote and supervise task-sharing exist and are widely used • There are sufficient supervisors for national scale-up of tasks-sharing		
	Team work & coordination	**Different teams involved in task-sharing work together to ensure its delivery** ***Consider these statements when rating:***		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *13 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		• Higher cadres work in partnership with lower cadres in a coordinated way to increase access to FP (i.e. doctors and nurses coordinate with auxiliary nurses for implant provision; facility clinical providers coordinate with CHWs for injectable provision)		
	Service organization & scheduling	**The organization of services makes task-sharing feasible (which providers allocated to which rooms/depts. etc.)**		
	Referral systems	**Referral systems support task-sharing** ***Consider these statements when rating:*** • Complex FP provision or removal cases can be easily referred to higher cadre providers or facilities • CHWs have clear guidance/protocols for referrals to health facilities and/or higher cadre providers		
	Fees	**There are no additional fees when FP methods are shared to lower cadre providers (i.e. for injectables when delivered by CHWs, and implants when delivered by auxiliary nurses)**		
Human Resources	**Training & education**	**Task-sharing is integrated adequately into pre- and in-service training of health workers** ***Consider these statements when rating:*** • Injectable provision is included in CHW pre-service curricula • Implant provision & removal is included in auxiliary nurse pre-service curricula • Training needs for CHW FP provision are regularly assessed • Training needs for auxiliary nurses' FP provision are regularly assessed • There are national systems for continuing professional development		
	Capacity	**Health workers in MNH services have capacity to deliver task-sharing** ***Consider these statements:*** • CHWs have capacity in daily routine to also deliver injectables • Auxiliary nurses have capacity in daily routine to also deliver implants		

BNA Framework Theme	Categories	Group to consider these statements and then rank how important is this bottleneck *13 is the most important bottleneck, 1 is the least important	Individual Ranking	Final group ranking
		• Staff turnover is low enough to allow institutionalisation of new skills for task-sharing scale-up		
	Roles	**The relevant FP method provision is included in job descriptions of staff who are assuming new FP provision**		
	Skills & competencies	**Competency assessments take account of task-sharing and additional support needs.**		
	Motivation	**Providers involved in task-sharing have positive attitudes towards the policy** ***Consider these statements when rating:*** • Cadres 'sharing' roles (i.e. higher level) are supportive of task-sharing policies on FP • Cadres 'receiving' roles (i.e. lower level) are supportive of task-sharing policies • Clinical supervisors and managers are supportive of task-sharing policies • Cadres 'receiving' roles (i.e. lower level) are adequately remunerated for taking on additional responsibilities • There is a supportive institutional culture that prioritises staff team work, staff development and efficiency		

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