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From Investment to Institution

Institutionalizing Task Shifting Task Sharing to Strengthen Primary Health Care in Kano State

POLICY AND SUSTAINABILTY BRIEF | AUGUST 2026

EXECUTIVE SUMMARY

Kano State, with a population of approximately 15.4 million[1], faces significant health workforce constraints, including shortages and uneven distribution of skilled health workers across primary healthcare (PHC) facilities[2]. Task Shifting Task Sharing (TSTS) provides a practical pathway to optimize the existing workforce, particularly CHEWs and JCHEWs. The National TSTS Policy, first issued in 2014 and revised in 2022, provides a framework for safely redistributing selected responsibilities across health worker cadres. Kano State has domesticated the policy to respond to its health workforce and service delivery needs.

In 2024, Kano State, with support from Pathfinder International and Impact Catalyst, implemented TSTS across 145 PHC facilities in 26 focal LGAs, combining competency-based training, structured clinical mentorship, supportive supervision, routine data review, and quality improvement. Within nine months, skilled birth attendance increased by 12%, postnatal care by 57%, provider competency by 17%, and partograph compliance from 83% to 97% where mentorship was integrated into routine supportive supervision.

Results from October 2025 to June 2026 promising improvements in skilled birth attendance, postnatal care, provider competency, partograph compliance, and data concordance. However, the experience that training alone is not sufficient. Sustaining TSTS require strong governance, continued mentorship and supervision, functional facilities, reliable data and referral systems, and sustainable financing. As external support approaches close-out, the priority is to transition from project-supported implementation to government-owned institutionalization, embedding what works within routine PHC systems and creating the conditions for scale.

WHY TSTS MATTERS FOR KANO

Kano is one of Nigeria's most populous states, and its scale is matched by persistent maternal and child health challenges. Kano's under-five mortality rate is 158 deaths per 1,000 live births, while its total fertility rate is 5.8 children per woman[3]. The state also has a substantial unmet need for family planning, with 26% of currently married women aged 15–49 reporting an unmet need for family planning.[3]

The workforce available to respond is severely constrained. Nigeria's density of physicians, nurses, and midwives remains well below the 44.5 per 10,000 population benchmark developed by WHO in 2016 to assess the workforce required to achieve selected Sustainable Development Goal health targets[4]. Kano operates at a fraction of the density required to deliver essential services. This gap will not be closed by recruitment alone within any realistic planning horizon, which is why the scope of practice permitted to CHEWs and JCHEWs is not a technical detail but a determinant of whether services exist at all. Without these cadres, antenatal care, immunization, family planning, and childhood illness management would not reach the communities that depend on them.

Yet regulatory restriction and the absence of competency-based training long confined these providers to a narrow scope of practice, creating persistent bottlenecks in labor wards, antenatal clinics, family planning services, and integrated management of neonatal and childhood Illness settings.

The National TSTS Policy, first issued in 2014 and revised in 2022, provides a legally grounded and evidence-supported pathway to resolve this tension by shifting roles safely from higher cadres to middle and lower-level cadres. Kano's domestication of that policy in 2025 was shaped by three converging pressures.



Service demand

A rapidly growing population and disease burden are outpacing the capacity of the existing healthcare workforce, placing increasing pressure on PHC facilities.



PHC revitalization

The Federal Government's directive to operationalize at least one PHC per ward reinforces the need to deploy available health workers effectively, with TSTS as a key enabler.



Sustainability

As donor-funded vertical programs wind down, TSTS can help strengthen state-owned systems by building the capacity of the existing health workforce to sustain frontline service delivery.

In communities where no doctor or nurse is realistically reachable, a well-trained and well-supported CHEW is not a compromise. She is the system.

FROM POLICY TO PRACTICE

What the baseline found

Implementation began with a baseline assessment covering key informant interviews with 20 facility in-charges and 26 LGA Maternal and Child Health Coordinators, a readiness assessment of 65 facilities, routine data from DHIS2 and mother-and-child registers, and analysis of the Kano State TSTS Policy 2025 alongside the Health Sector Strategic Plan 2021–2025. The assessment identified five systemic gaps. Together they described a state that had adopted a policy without yet building the infrastructure to make it work.

5 systemic gaps identified at Baseline



Weak Governance and Coordination

No functional TSTS governance structure, LGA focal persons, SOPs, or clear accountability.



Workforce Development Deficits

Training was largely event-based, with limited clinical mentorship and no formal competency certification.



Limited Facility Readiness

Gaps in electricity, referral transport, and essential equipment constrained safe TSTS delivery.



Weak Implementation Systems

No standardized mentorship tools, regular compliance monitoring, or integration of TSTS into facility plans.



Weak Data & Documentation

Poor DHIS2 documentation limited tracking, quality monitoring, and evidence for investment.

Building the TSTS System

The state government, with support from Pathfinder International and Impact Catalyst, operationalized the policy across 145 PHC facilities in 26 focal LGAs. Focal LGAs were selected on population burden, facility readiness, and geographic spread, so that findings would reflect a range of implementation contexts across the state.

A state-level Training of Trainers equipped 26 LGA Master Trainers, who stepped down training to health workers across all focal LGAs. Twenty-six mentors, drawn from resource persons residing in the LGAs they serve, subsequently provided sustained on-site clinical mentoring across implementing facilities. Health workers completed an eight-day competency-based training program, reinforced by monthly structured mentorship rather than treated as a single event.

Mentorship was then integrated into Kano State Primary Healthcare Management Board's (KSPHCMB) quarterly integrated supportive supervision cycle, and monthly data review meetings and quarterly review sessions were convened jointly between the field team, state health officials, and LGA monitoring and evaluation (M&E) officers. This meant that supervision, mentorship, and data use reinforced one another within a single set of government processes.

WHAT IMPLEMENTATION DEMONSTRATED

Nine months of implementation across 26 focal LGAs provide meaningful evidence on three fronts: what providers can safely do, whether practice actually changed, and whether the health system can see it.

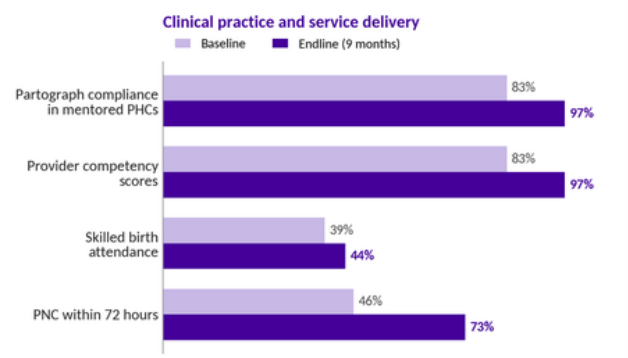


Figure 1. Clinical practice and service delivery, baseline and endline (Oct. 2025- June 2026 -nine months), across 145 PHCs in 26 focal LGAs.

On capability, CHEWs and JCHEWs working under the TSTS framework safely conducted assisted deliveries, inserted intrauterine devices (IUDs), and managed childhood pneumonia. Provider competency scores rose by 17% across mentored facilities. This confirms in Kano what has been demonstrated elsewhere across Africa, with the right training and supervision architecture, mid-level cadres perform these tasks safely and effectively.

On practice and access, partograph compliance rose from 83% to 97% over nine months where mentorship was integrated into the quarterly supportive supervision cycle (Figure 1). Across the supported LGAs, skilled birth attendance and postnatal care increased by 39% and 57%, respectively, within the same period. Not only an incremental improvement on an existing service, but access where little previously existed in hard-to-reach communities in Dawakin Kudu and Gwarzo LGA.

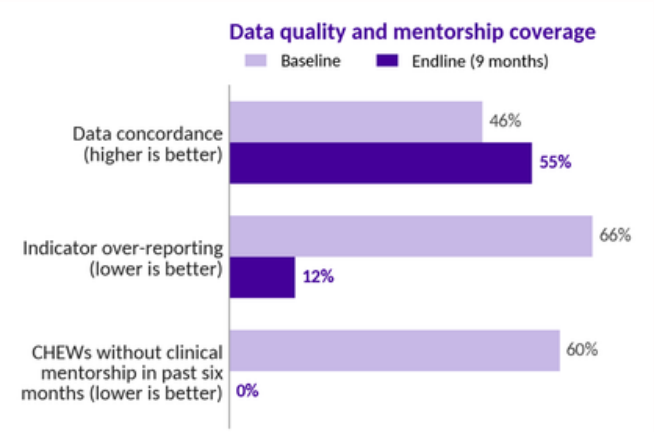


Figure 2:. Data quality and mentorship coverage, baseline and endline (nine months).

On visibility and data use, indicator over-reporting fell from 66% to 12% and data concordance improved from 46% at baseline to 55% at ninth months (Figure 2). Dambatta LGA has used its own DHIS2 data to avert three commodity stock-outs and now anchors peer learning alongside Kibiya, Gwarzo, and Wudil.

FROM IMPLEMENTATION TO GOVERNMENT OWNERSHIP

Kano's readiness for transition can be considered across five functions.

Transition function	Readiness	Evidence
Governance	**Moderate**	Policy domesticated in 2025 and a transition technical committee established. The state TSTS Technical Working Group is not yet inaugurated, focal persons are not designated across all 44 LGAs, and SOPs are not yet standardized and disseminated.
Human resources	**Moderate to High**	26 LGA Master Trainers and 26 mentors in place and provider competency up 97%. No OSCE or certification process linking competency to licensing renewal.
Service delivery	**High**	Mentorship integrated into the quarterly supportive supervision cycle; partograph compliance and skilled birth attendance both improved; expanded tasks performed safely across mentored facilities.
Facility readiness	**Low to Moderate**	40% of assessed facilities without reliable 24-hour power, 55% without functional referral transport, 30% missing essential equipment for expanded tasks.
Financing	**Moderate**	Eight LGAs fund monthly mentorship through routine supervision at no additional project cost, and TSTS activities sit in the 2026 Annual Operational Plan (AOP). No dedicated budget line and BHCPF is not being used as a financing mechanism.

The assessment points to a clear transition priority: build on the gains achieved through implementation while strengthening the government systems needed to sustain them. Kano's pathway to ownership will therefore require focused action across governance, workforce systems, facility readiness, and financing.

Financing the Transition

Financing is the critical next step in Kano's transition. While key implementation practices are increasingly embedded in government systems, the resources required to sustain them are not yet secured. Three complementary financing routes can support this transition:

A dedicated budget line in the 2027 Annual Operational Plan

TSTS activities already appear in the 2026 AOP, but without a dedicated line covering mentor stipends, transport, commodities, and supervision costs. Creating that line in the 2027 AOP is the single most consequential financing decision available, and it is time-bound. If the 2027 budget cycle closes without it, the next opportunity is a year away, by which point the mentor network and peer-learning structure may have dispersed.

BHCPF as a primary financing mechanism

The alignment between BHCPF service delivery criteria and TSTS-expanded roles is explicit, and it has already proved its political value. LGA Chairmen became champions of implementation once they understood that TSTS compliance would improve their facilities' BHCPF eligibility. The same alignment that unlocked buy-in can now carry recurrent cost. This is a financing route available to Kano that few comparable programs have.

LGA counterpart funding for facility readiness

The facility readiness gaps — power supply, equipment maintenance, referral transport — sit within LGA responsibility and are the binding constraint on what mentored providers can safely do. This requires LGAs to allocate counterpart funding for these costs to address the one gap that training and mentorship cannot close.

The affordability evidence already exists

Eight LGAs currently fund monthly mentorship through routine supervision budgets at no additional project cost. That gives the state a real unit cost for one LGA's monthly mentorship cycle. Multiplied across the 26 focal LGAs, and then across all 44 LGAs, it produces the two figures the Ministry of Budget and Planning needs in order to act, and it demonstrates that the ask is a modest recurrent line rather than a new program.

ROADMAP FOR SUSTAINABLE TSTS

Five actions would complete the transition from operational pilot to state-owned system.

1. Strengthen governance

Inaugurate the state TSTS TWG with representation from SMOH, KSPHCMB, regulatory bodies, and implementing partners; designate TSTS focal persons across all 44 LGAs with clear terms of reference and reporting lines; and develop, validate, and disseminate standardized SOPs for mentorship, supervision, and referral, while incorporating TSTS oversight into existing SMOH-KSPHCMB coordination mechanisms rather than creating parallel structures, to establish clear accountability and enable effective monitoring and enforcement of policy compliance.

2. Invest in health workforce development

Shift all TSTS training to competency-based curricula with defined standards, structured mentorship, and verifiable pre- and post-assessments; institutionalize monthly clinical mentorship within routine facility supervision; introduce annual OSCEs for CHEWs and JCHEWs practicing expanded tasks, with results linked to licensing renewal; and engage Schools of Health Technology to integrate TSTS competencies into pre-service curricula, establishing a verifiable competency standard for expanded practice and reducing reliance on in-service training to sustain it.



Health Awareness Talk at Rahama Facility Bebeji, Kano State

3. Enforce regulation and quality

Update scope-of-practice documents for CHEWs and JCHEWs to reflect TSTS-permitted tasks; establish a quality assurance mechanism to monitor adverse events and near-misses; and conduct annual regulatory compliance reviews across focal LGAs, with findings reported to the TWG and acted upon within defined timeframes, ensuring legal clarity for expanded practice and a safety monitoring system commensurate with the expanded scope.



Cross section of Participants during CIP workshop in Kano State

4. Secure financing

Create dedicated budget lines for TSTS activities, including mentor stipends, transport, commodities, and supervision costs, in the 2027 AOP; leverage BHCPF as a primary financing mechanism; and require LGAs to provide counterpart funding for facility readiness, including power supply, equipment maintenance, and referral transport, ensuring TSTS is financed through domestic and pooled sources rather than project funds.

5. Build evidence and accountability

Update scope-of-practice documents for CHEWs and JCHEWs to reflect TSTS-permitted tasks; establish a quality assurance mechanism to monitor adverse events and near-misses; and conduct annual regulatory compliance reviews across focal LGAs, with findings reported to the TWG and acted upon within defined timeframes, ensuring legal clarity for expanded practice and a safety monitoring system commensurate with the expanded scope.

ACTIONS FOR KEY STAKEHOLDERS

Stakeholder	Priority action
Federal Ministry of Health (FMOH) and National Primary Healthcare Development Agency (NPHCDA)	Formally include TSTS performance indicators in national PHC quality assurance frameworks and provide technical guidance supporting Kano's transition to a state-owned, competency-based implementation model.
Honorable Commissioner of Health and DG, KSPHCMB	Approve the governance structures set out in this brief and champion the inclusion of dedicated TSTS budget lines in the 2027 AOP before the budget cycle closes.
Ministry of Budget and Planning	Establish and protect the TSTS budget line and confirm BHCPF as an eligible financing route for mentorship and supervision costs.
Local Government Areas	Allocate counterpart funding for facility readiness, designate TSTS focal persons, and recognize that TSTS compliance is a prerequisite for BHCPF eligibility in their facilities.

Stakeholder	Priority action
Regulatory bodies (Nursing and Midwifery Council of Nigeria (NMCN), Medical Laboratory Science Council of Nigeria (MLSCN) and Community Health Practitioners Registration Board of Nigeria (CHPRBN)	Update scope-of-practice documents to reflect TSTS-permitted tasks and link OSCE performance to licensing renewal for practitioners in expanded roles.
Schools of Health Technology	Integrate TSTS competencies into pre-service curricula so that new CHEWs and JCHEWs enter service already prepared for expanded scope.
Development partners	Align technical and financial support to the state TSTS roadmap. Specifically, co-invest in infrastructure upgrades in the lowest-performing facilities and support integration of TSTS indicators into DHIS2.

CONCLUSION

Kano's experience demonstrates that task shifting and task sharing can strengthen primary health care when frontline workers are equipped with the right competencies, mentorship, supervision, data, and systems of support. The challenge is no longer whether CHEWs and JCHEWs can take on expanded roles. The experience shows that they can. The priority now is to strengthen the system around them so that these gains can be sustained beyond project support.

Kano has already laid important foundations through policy domestication, competency-based training, clinical mentorship, supportive supervision, data use, and emerging government financing. The next step is to institutionalize these mechanisms through stronger governance, clear regulatory frameworks, sustainable financing, facility readiness, and routine data systems.

Kano has the policy. Kano has the workforce. Now Kano must make TSTS part of the system.



Hand over of Calibrated drapes to the Kano State Primary Healthcare Management Board

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The Task-Shifting/Sharing initiative, implemented in partnership with Impact Catalysts and state governments, strengthens primary health care services in Kaduna and Kano and seeks to improve health workforce distribution and service quality in rural and underserved areas. The initiative takes a holistic strategy to supporting current health systems and personnel, providing high-quality, sustainable, and gender-responsive health care for all.

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