



Health Workforce Advocacy Initiative

The Health Workforce Advocacy Initiative is the civil society-led network of the Global Health Workforce Alliance.

SYSTEMS SUPPORT FOR TASK-SHIFTING TO COMMUNITY HEALTH WORKERS

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Task shifting is designed to accomplish four important goals simultaneously: (1) share and assign tasks among health workers in the most efficient manner in order to take advantage of the different competencies of the existing mix of health workers; (2) take advantage of simplified health promotion and treatment protocols that permit task-shifting to less intensively trained and specialized cadres of health workers; (3) shift more health promotion and treatment and care delivery to the community level by introducing new or strengthening existing cadre of community health workers; and (4) increase access to health care and advice in under-served communities, particularly rural communities. However, task-shifting cannot work unless close attention is paid both to the systems that support successful implementation and to needed expansion of human resources within overall health care system.

Much of current discussion of task shifting focuses on community health workers who are seen as relieving doctors, clinical officers, and especially nurses of some of the health promotion and direct care and support work that professional cadres are frequently unable to deliver because of personnel shortages and distance from communities they service. Accordingly, for example, with respect to HIV/AIDS, community health workers are being recruited and trained to provide community support for prevention, testing and treatment literacy, VCT, adherence support, and home and palliative care. In other contexts, community health workers focus on a broader array of other needed health services including community education and services for tuberculosis, malaria, maternal and child health, immunizations, and nutrition.

In the shift to community-based health services utilizing a new or expanded corps of community health workers, there is a risk of neglecting the educational pipeline and the training, selection, referral, and other support systems that are absolutely essential to the long-term success and sustainability of community based interventions and community health worker programs. Without adequate planning and monitoring, the danger exists of generating a fragmented and disjointed system that fails to meet the total health needs of the patient and instead offers a series of disconnected and parallel services that are both inefficient and confusing. Likewise, a lack of a coherent training system and some means of career advancement could lead to demotivation and high attrition rates.

To avoid these risks, first and foremost, as is uniformly agreed in principle, but often breached in practice, community health workers are entitled to compensation and benefits that equal a living wage. All too often, both in government- and donor-sponsored programs, community health workers are referred to as volunteers or care-"givers" who are implicitly presumed to be financially secure. This presumption is maintained by under-resourced NGO/CSO/FBO programs that receive grants from donors, governments, and foundations that are too meager to pay fair wages and often too small to pay the overhead costs needed to properly train, supervise, and support community health worker programs. In the vast majority of cases, this presumption of financial security is deeply flawed, and care labor is being provided by some of the poorest members of the community, usually women, who threaten their own economic wellbeing to attend to those society and health systems have neglected. Stipends are not enough, travel allowances are not enough, and interrupted supplies of materials are not enough to ensure the livelihood of local health workers and the sustainability of community health worker programs.

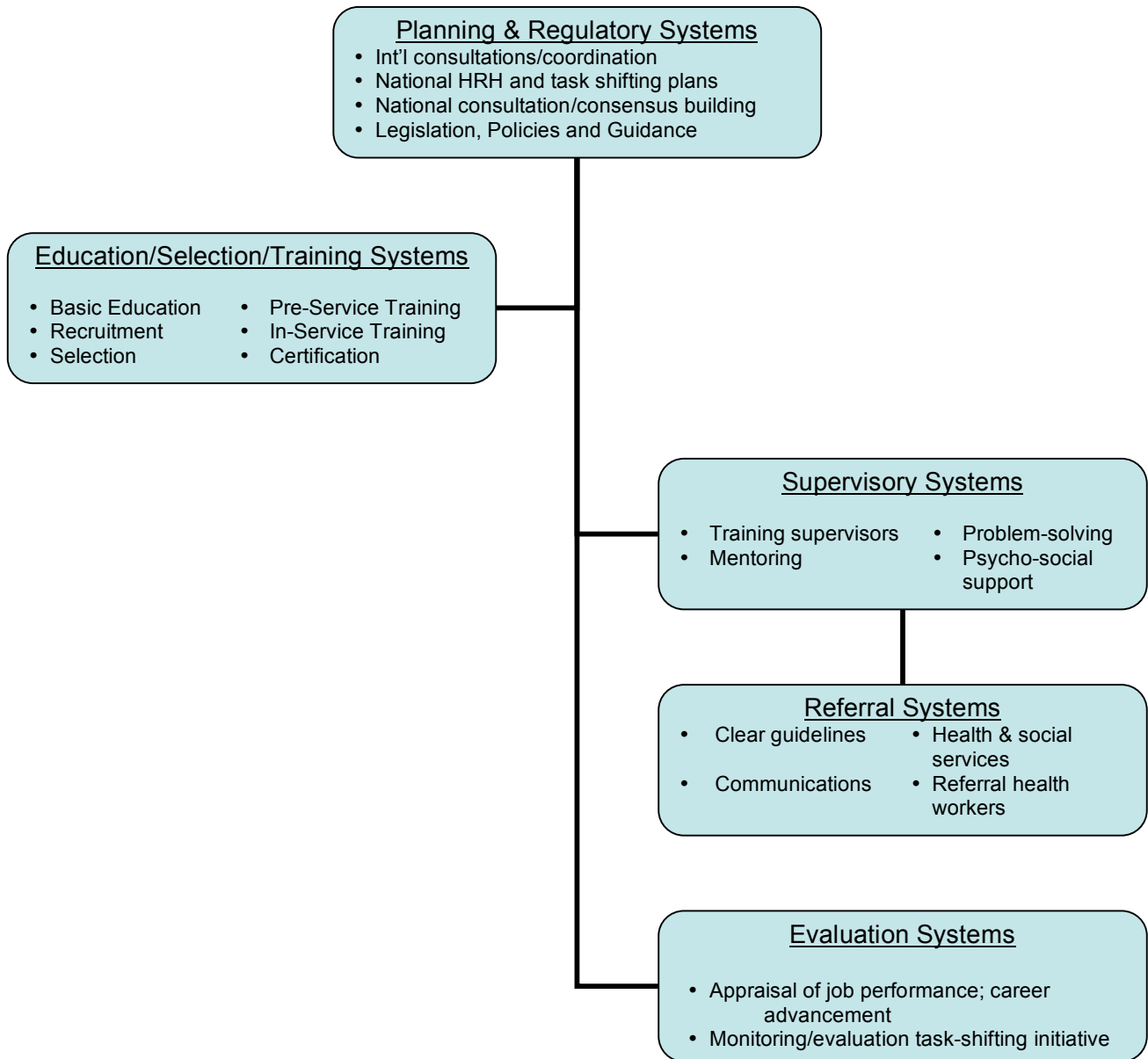
Second, community health workers need to have a safe workplace and adequate supplies both to ensure their own safety and to support the safety of home-care providers. Basic equipment like gloves, soap and detergent, clean water, disinfectants, antiseptics, and other means of maintaining precautions is absolutely essential, and thus logistical systems for supplying rural and peri-urban communities must be strengthened.

Moreover, community health workers, like other health workers, should themselves have access to health services for their own needs.

However, compensation and workplace safety will not be enough to ensure the efficiency and sustainability of task-shifting programs focusing on a new cadre of community health workers. Instead, governments and donors are obligated to fund and implement the planning/regulatory, education/selection/training, supervision, referral, and evaluation systems that are essential to service delivery.

Taking a Systems Approach

The Health Workforce Advocacy Initiative urges WHO/OGAC/UNAIDS to take a systems approach to their task-shifting initiative. It is essential to identify the ancillary systems that are essential to the success of task-shifting, especially, but not exclusively, task shifting that is contemplating the expansion of community health worker programs. The chart below tries to capture the essential components of a systems approach.



Planning and Regulatory Systems

Undoubtedly task-shifting initiatives will ultimately need to be flexible and adaptable to the opportunities and constraints that arise on the ground. However, standard setting, identification of best practices, and close monitoring of existing programs are important first steps to successful planning. Thereafter, in the process of developing their costed human resources for health and health system strengthening (HRH/HSS) plans, individual countries will need to set national guidelines on task-shifting that are then translated into operational implementation plans at the local level. Planning must cover all components of the task-shifting system, such as the need to invest in faculty to teach new and existing cadre of health workers, to consult with professional groups to get their feedback and buy-in, and to amend work rules and standards of practice as needed for all affected cadres. Planning will address how many health workers are needed in what categories to avoid under- and over-supply. It will address selection criteria, training curriculum, new supervisory relationships, and referral systems. Finally, it will add in a systems learning mechanism through a monitoring and evaluation component.

Regulation is used to protect the public by providing frameworks within which the scope of practice, standards of education and codes of conduct for regulated professions is set out. Regulatory processes can take many forms and it is therefore essential that an impact assessment is undertaken when introducing task shifting. Laws may need to be created or changes (e.g. professional regulation, prescriptive authority, etc.), policies developed and guidance issued to ensure the successful and sustainable introduction of new ways of delivering services.

Education, Selection, and Training Systems

A community's resilience to disease and community members' capacity to adopt community health worker roles is greatly enhanced when basic education at the primary and secondary level includes a health curriculum. Basic understanding of the social determinants of health, including clean water, sanitation, and nutrition, and basic understanding of disease mechanisms and the efficacy of medical treatment is critical both for the background training of community health workers and for the preparedness of community members to undertake health promoting behaviors and to seek medical treatment when ill.

In order to identify prospective community health workers with the knowledge, skills, and disposition to be effective on the ground, task-shifting will need an effective and fair system for recruiting and selecting community health workers. Recruitment can take place in educational settings, but it can also take place in community contexts, including among community service organizations that are already providing health services and care at the local level. In some contexts, there may be educational, pre-service training, or certificate programs that are considered to be pre-requisites for selection. In other contexts, and to ensure community acceptance, selection will be mediated through community structure whereby trusted members of the community are identified. In either kind of selection system, or their hybrids, care must be taken to build fair, equitable, and non-discriminatory/non-patronage systems that produce the right candidates with the most potential to serve community health needs.

In addition, and probably in the interim until more robust health curricula are developed and delivered, there needs to be a strong pre-service training program for prospective community health workers that orients them to the basic science of health promotion, disease prevention, and treatment and care. The training should also orient them to governing ethical standards including confidentiality, non-discrimination, and other patient rights. In addition, the pre-service training has to educate community health workers with respect to the priority interventions they will undertake, which in turn is dependent of the epidemiology of disease within their communities. Although HIV/AIDS is likely to be a priority in many African countries, there are other important interventions for community health workers concerning tuberculosis, malaria, and child and maternal health. Because it will not be possible to pre-train community health workers on all their eventual tasks, because of the progression of interventions (for example, with respect to HIV/AIDS, first testing literacy, next VCT, and then treatment literacy, rollout, and adherence), and because of shifting priorities over time, it will be necessary to have on-going in-service training systems specifically designed to improve the skills and service delivery of community health workers.

The current plan in the emerging task shifting framework is to create accreditation and certification programs for newly trained cadre of community health workers and to provide career paths through increased training. However, it will also be important in training programs to evaluate and credit the experience-based competencies of community members who have already been providing community-based service and care. Credit-and-qualification frameworks and prior-learning-assessment-and-recognition models must be established to ensure enlistment and equitable access for the many community members who have already learned many valuable attributes and skills through the pragmatic responses to community needs.

Supervision and Psycho-Social Support Systems

Community health workers cannot be stuck in the field and left on their own to do their jobs without needed supervisory and support services. Pre-service and even in-service training have to be supplemented with mentoring and supervision that help make the training stick and that help adapt it to local circumstances. Community health workers need supervisors who can answer their questions and help them problem-solve the inevitable barriers that arise to service delivery. Moreover, good supervision is essential to facilitating the psycho-social support systems that help community health workers survive the stresses and strains that arise when providing services to desperately ill and dying people.

To provide such supervision and support, supervision capacity has to be built, credited, and rewarded. Much of health and medical training is focused on treatment and care, and yet task-shifting will impose additional supervisory tasks on existing health workers. Not only do some or many of these workers need to be trained in these new supervisory responsibilities, they also need to be relieved of some of their existing responsibilities or patient loads so that they can provide direct supervision in the field to community health workers. In some instances, these new responsibilities should be accompanied with appropriate increased compensation, but the larger underlying task is to ensure that all cadres of health workers are appropriately and fairly compensated so that the assumption of new tasks (and shifting of others) is not automatically accompanied by expectations of increased compensation.

Referral Systems

Despite the best training, community health workers will not be able to deliver all the health care that sick people will need. Instead of creating a go-it-alone and give-up-hope system of pseudo-self-reliance by community health workers, there will have to be highly functional, transparent, and dependable referral systems that permit community health workers to diagnose or triage health care needs, and then know how and to whom to refer patients promptly for appropriate care. Of course, this need for referral systems is also required at clinics and hospitals and for other cadres of health workers, like nurses, and clinical officers, but the need is particularly acute at the community level where the patients' needs are first identified. Thus, one consequence of task-shifting and the development of strong referral systems will be the need to expand the referral workforce to deal with newly identified patients with more complex needs.

Not only do community health workers need referral systems for health care, they also need referral systems for connecting patients and community members to needed social services whether provided by government or NGOs/CSOs. Community members often need grants, identity cards, pensions, legal services, nutrition programs, income-generating opportunities, and school services – connections to services that are themselves determinants of health. Community health workers should be empowered and supported to help facilitate access to social service providers.

Strong referral systems will require clear guidelines or standards for referral, good communication and transportation systems, and, most importantly, an adequate number of more highly trained health workers at the other end of the referral system. An anticipated outcome of community health workers is that they will help promote health and prevent illness in the long term. However, in the short and medium term, community health workers are much more likely to detect medical problems in under-served populations who will thereafter make more demand on the formal health system.

Strengthening the Related Health Workforce

Deploying community health workers will not reduce the need for other more highly trained health worker, it will in fact increase demand on nurses and other health workers in at least three ways: (1) nurses and others will have increased responsibilities as trainers and supervisors, taking scarce time away from other tasks; (2) more nurses, clinical officers, and doctors will be needed to take care of the new patients generated by an efficient community health worker program; and (3) doctors and nurses will be faced with patients who have more complex health needs (the easier cases will be covered by task-shifting) and thus require more sophisticated analytical, diagnostic, and treatment skills. The ratios of supervisory and referral health workers needed for task-shifting to community health workers are still being calculated and might eventually be reduced if preventative services are more effective, but under present conditions the need for significantly increases in adjunct human resources is clear. Needless to say, expanded educational resources and faculty will also be needed to train additional health workers and to train existing workers in their new supervisory and clinical responsibilities. Finally, incentive systems must be created to recruit and retain professional-level health workers in peri-urban and rural communities so that referred patients can more easily access higher level care and so that professionals can carry out their community-based supervisory and mentoring responsibilities.

In most resource-poor settings, expanding human resources for health will depend on educating more and new cadre of health workers. However, there are also pools of under-employed health workers in some countries, including health workers who are forced through irrational mandatory retirement rules to leave their positions while they still have much to offer. Some of these workers are let go because of de facto spending caps in health sector budgets mediated through International Monetary Fund and Ministry of Finance macro-economic restraint policies. These counter-productive caps on health sector spending must be eliminated if the fiscal resources required by high quality task-shifting are to be sufficient.

Task Shifting Across the Continuum of Care

The discussion so far has focused primarily on community health workers and the systems support that they will need, including a new set of responsibilities for community health worker trainers and supervisors. However, the same type of analysis of systems needs should be applied at other levels in continuum of care. For example, in many countries, new cadres of health workers, including auxiliary health workers, clinical officers, nurse practitioners, and other intermediate skilled cadres, must be integrated into the existing professional matrixes. In other countries, there are needs to shift skills so that well-established cadres of health workers, especially nurses, are trained and supported to take on upgraded clinical responsibilities, including, for example, initiation of antiretroviral therapy under simplified treatment guidelines. In both of these contexts, there are important decisions to be made about task-shifting that is a short-term response to critical human resource shortages and task-shifting that is appropriate in a maturing health system where human resources are denser and there are ongoing efforts to rationalize tasks within a continuum of care. In planning the distribution of tasks, health policy makers must also consider the locus of services. They must decide which health services, and thus what tasks performed by which workers, should be delivered at the community and district clinic and which more specialized services at secondary and tertiary facilities. In assigning tasks, policy makers must always address competency issues across the entire health worker continuum of care ranging from community health workers to specialist physicians.

Conclusion

Task shifting can be successfully planned and implemented only if there is buy-in and ownership based on national consensus building and consultation among communities and health workers. Likewise, task-shifting can only be successful if it is embedded in a set of training, supervisory, and referral systems that support the local delivery of health services, especially but not only by community health workers. The greatest dangers in the present task-shifting initiative are that it will underestimate the resource and systems needs of a sustainable community health worker program and that it will distort the response to the broader health worker crises by focusing on downward task-shifting to community health workers as the only critical human resource and task-shifting need. Accordingly, the Health Workforce Advocacy Initiative urges that the guidelines that emerge from the WHO/OGAC/UNAIDS process should explicitly address the systems and continuum-of-care issues described above.