
SUMMARY OF KEY ISSUES ARISING

The World Health Organization (WHO) and the Office of the US Global AIDS Coordinator (OGAC) convened representatives from HIV Programmes and Human Resources for Health Departments from Ministries of Health, Professional Associations, Academic Institutions and representatives from workers associations in Geneva for a two day technical consultation about the need for a regulatory framework in support of Task Shifting. The meeting signaled the beginning of a new expert partnership for driving forward the Task Shifting Project in the context of the wider HIV/AIDS and health workforce plan "Treat, Train, Retain".

Objectives

The stated objectives of the meeting were:
1. To agree on the need for a draft regulatory framework for Task Shifting that can be validated at the country level before being recommended to countries.
2. To agree on a series of steps towards the development and the implementation of certification and credentialing mechanisms to support Task Shifting for HIV service delivery in countries.

Inputs

1. Working papers

A range of substantive working papers were provided as input to the meeting. These included:
a) Task Shifting – State of Affairs and Overview of Literature
b) Competency-Based Task Shifting In Support of Universal Access to HIV Services
c) Clinical Care Competencies for HIV/AIDS Service Delivery Providers
d) Competency-based certification and credentialing of health cadres in support of task shifting: Definitions, existing models, and recommended framework for moving forward
e) WHO IMAI: a public health approach to task shifting in the context of rapid scale up of HIV prevention, care and treatment in resource-constrained settings
f) Literature Review on Certification and Credentialing) The WHO public-health approach to antiretroviral treatment against HIV in resource-limited settings
g) Building Stronger Human Resources for Health through Licensure, Certification and Accreditation

2. Presentations

A wide range of presentations by participants included the following:
a) The Treat, Train, Retain Plan – Badara Samb, WHO
b) Overview of the WHO/OGAC Task Shifting project – Joan Holloway, OGAC
c) Core competencies of licensed and non-licensed health workers – Bob Colebunders, Institute of Tropical Medicine, Belgium; Wesler Lambert, Partners in Health, Haiti; and Francesca Celletti, WHO
d) Task Shifting in selected countries: current practices, enabling conditions and gaps – Kelita Kamoto, Malawi Ministry of Health; Wesler Lambert, Haiti Ministry of Health; Elizabeth Madraa, Uganda Ministry of Health; Yibeltal Assefa, Ethiopia National HIV/AIDS Prevention and Control Office
e) A regulatory framework for health care providers – Alan Greenberg, John Palen, Anne Markus, and Seble Frehywot, George Washington University
f) The uniqueness of the regulatory framework in Francophone Africa – Yann Bourgueil, IRDES
g) Translating competencies into certification/credentialing exams – José Zuniga, IAPAC, Adele Webb, ANAC
h) Model certification/credentialing programs – Greg Grevera, HIV/AIDS Nursing Certification Board
i) The WHO/IMAI package – Sandy Gove, WHO
j) A regulatory framework for certification/credentialing – Alan Greenberg, John Palen, Anne Markus, and Seble Frehywot, George Washington University

The consultation concluded with a series of group meetings to plan country activities.

Full copies of all presentations are attached as annexes to this note.

Background - the concept of Task Shifting

The Treat, Train, Retain (TTR) plan, being undertaken under the umbrella of the Global Health Workforce Alliance, is an important component of WHO's efforts to strengthen human resources for health (HRH) and to promote comprehensive national strategies for HRH development across different disease programmes. It is also part of WHO's work to promote universal access to HIV services. TTR strengthens the health workforce by addressing both the causes and the effects of HIV on health workers. It includes 3 components:

Treat – a package of HIV treatment, prevention, care and support services for health workers who may be infected or affected by HIV and AIDS.
Train – measures to empower health workers to deliver universal access to HIV services including pre-service and in-service training for a 'public health' approach.

Retain – strategies to enable public health systems to retain workers, including financial and other incentives, occupational health and safety and other measures to improve the workplace as well as initiatives to reduce the migration of health care workers.

Specifically, the Train component includes measures to empower health workers to deliver universal access to HIV services including pre-service and in-service training for a 'public health' approach. There are two courses of action that must be taken in parallel: increase the number of doctors, nurses, midwives, pharmacists and technicians who are entering the workforce; and at the same time finding alternative and simplified models that can quickly expand the current health workforce, such as Task Shifting.

Task Shifting involves shifting tasks among and between cadres of health workers and to trained members of the community including people living with HIV. This has potential to rapidly expand the resource pool and to maximize the availability of the more skilled workers.

Main outcomes and areas of consensus

During the two day consultation there was consensus on the need for urgent action on Task Shifting.

Most importantly the meeting agreed on the need to adopt task shifting as one method of addressing the health workforce crisis and to move fast with implementation. The meeting also agreed on the need to develop a regulatory framework to enable task shifting to take place more widely than is currently the case. It was agreed that the purpose of such a framework is to protect the patient through quality assurance and to protect health workers through appropriate endorsement. It was also agreed that any such regulatory framework must recognize that every country is different, must build on what is already happening rather that undermine current efforts, must be flexible enough to accommodate present and future scenarios and must contribute to overall health systems strengthening.

Consensus also emerged on broad principles, priorities and challenges for wide-scale implementation. These are summarized as follows:

1. Task shifting is essential

The HIV pandemic represents a crisis. Provision of HIV treatment and care must be expanded. One of the major constraints is a serious shortage of human resources.

One part of the solution lies in a simplification and standardization of ART delivery models and a reorganization of the demography of the health workforce through expansion and decentralization with a new emphasis on community level services that are close to service users.

Task Shifting is now essential but a number of issues must be intelligently addressed to ensure success.

- Task Shifting must be implemented in such a way that it will improve the overall quality of care. It should not, and must not, be associated with second rate services.

- Task Shifting must be implemented within systems that contain checks and balances that are sufficient to protect both health workers and patients. This will involve both regulation and certification and also demands solutions to the issue of appropriate remuneration.

- Regulation and certification must neither decelerate the speed at which action is already taking place nor usher in restrictions that may have a constraining effect on other or on future public health service delivery efforts.

- Task shifting must make a positive contribution to overall health systems strengthening.

2. Task Shifting is not new

The term Task Shifting is a recent one but there has been a long history of such practices outside HIV service delivery and more recently in HIV treatment and care. The experience of Task Shifting within health teams has been a generally positive one. Experiences which involve shifting tasks even further to community members are more complex and difficult to evaluate.

Country representatives from Ethiopia, Haiti, Malawi and Uganda reported that Task Shifting for the delivery of HIV treatment and care is already being practiced and tolerated outside the current regulatory framework of the countries.

In many cases this toleration is possible because the law remains silent on the specificity of tasks and those who can perform them. In others the practice is taking place outside the formal public health system (for example by NGOs rather than in government-run health facilities).

3. Making Task Shifting work well requires a Regulatory Framework

One of the barriers to successful and sustained Task Shifting in the past has been a lack of both a regulatory framework and proper financial mechanisms to sustain it. A regulatory framework is essential to ensure government support, protection of patients and health workers and sustainability as well as resource flow. The existing barriers to task shifting must be identified and minimised.

WHO/OGAC and the partners gathered at the consultation intend to help address this by working towards a guideline Regulatory Framework that can be recommended to countries wishing to implement Task Shifting on a wide scale.

As a first step in this process George Washington University (GWU) were asked by WHO to help develop a draft regulatory framework. The team presented their preliminary thinking in a series of presentations to the meeting and welcomed feedback.

The GWU team will now visit a range of countries to further inform their work before returning to consult again with those who attended this meeting.

It was agreed by all that the framework must be flexible enough to suit different country situations and requirements and that it must be permissive rather then preventive.

It was noted that the work should take into account current labour legislation that exists within countries.

It was recognised that legal change can take years and that approaches that build upon existing legislation or use other regulatory methods such as an executive order or agreed upon standards may be more expedient — especially considering the urgency of the current situation.

The group advised that the views of all stakeholders, not just those in recognised positions of authority, must be incorporated into the process if it is to succeed. The involvement of trade unions will provide a means of giving voice to lower level cadres who are not represented by professional organizations.

Care must be taken not to "outlaw front line health workers" who are currently working without regulatory framework.

This project must balance regulatory work with complete support for other quality assurance mechanisms.

The meeting advised that close attention should be given to the matter of process if the initiative is to prove sustainable. GWU were encouraged to study how change has been implemented at the country level and how challenges around budgetary issues etc. have been dealt with — especially bearing in mind that outside funding will not be available in the longer term.

4. Need to define tasks and competencies and to coordinate and standardize training

Research has already been undertaken to document clinical care competencies and define tasks. This process has identified 242 tasks. A further survey which is examining the acceptability of Task Shifting and exploring which tasks can be shared is ongoing.

It was noted that definitions of cadres can vary widely from country to country.

It was agreed that health care must be understood as a continuum and a matter of shared responsibility requiring team work.

It was noted that the ability of management and administration to respond must be addressed. It was suggested that administrative and managerial structures must be included in the research agenda.

It must be understood that Task Shifting will have an impact throughout the totality of the health system.

Within the health profession there has historically been opposition to new categories of workers. The attitude of health professionals towards community health workers can also be obstructive. However, if all health professionals are properly consulted and are made to feel valued and understood it is likely that Task Shifting will find acceptance over time — especially once it is shown to work. In relation to this, it is important to address the current imbalance in some countries which are experiencing a shortage of health workers alongside significant unemployment among higher level cadres such as doctors and nurses.

The requirements of up-skilling will place additional burden on already stressed training institutions.

The way in which increases in responsibility created by Task Shifting will be expected to translate into increased pay or career opportunities is cause for concern and must be addressed. The matter of payment versus volunteerism must also be resolved.

5. The importance of quality assurance

Although Task Shifting has been born out of need to address a chronic shortage of health workers, the strategy could and should be seen as a means of improving the overall quality of health services. Task Shifting must not signify second rate service.

For example, doctors are often disconnected from the reality of life in community and may not, therefore, be the best equipped to deliver certain services. Greater use of Community Health Workers, with appropriate competencies, will locate services at the community level closer to the client and can mean an improvement in service.

In the light of this there was discussion on the matter of appropriate terminology. Some expressed concern that the term "Task Shifting" itself implies a linear downward trajectory that is not truly representative of the positive nature of the process. "Task Sharing" was used by some as an alternative. But the term "Task Shifting" has already become accepted and is widely used so name change may be difficult and counter productive. Even so, efforts must be made to use sensitive language and to avoid misleading vocabulary such as "down" and "lowest level" wherever possible.

6. The value of certification as a tool for ensuring quality of service and benefits to health workers

Participants agreed the there are significant benefits of certification and credentialing of health workers both in terms of retention, job satisfaction and patient outcomes. However there is an absence of internationally agreed definitions or standards. This needs to be addressed as part of the project.

Education and training represent a long path and retraining and updating will bring faster results to the system.

The concern was raised that certification processes could have the detrimental effect of slowing down efforts to scale up treatment and care. It was also noted that there is often a discrepancy between the theory as represented by national regulations and the reality of practise at the community level.

7. Task Shifting may not be cost saving

The meeting agreed that Task Shifting may bring some cost benefits in certain circumstances. However, training, remuneration and the need for additional levels of supervision will, in fact, often mean additional cost. Therefore it would be wrong to promote the strategy on the basis of cost saving as this would involve a misrepresentation that will ultimately lead to disappointment and failure.

Instead Task Shifting should be promoted on the basis of its potential for improving care – not saving money.

8. Burden of Supervision

Task Shifting is proposed as a response to a shortage of human resources but the meeting agreed that, in reality, Task Shifting can also generate a new range of additional tasks and responsibilities – particularly in the area of supervision. The workload involved in reporting to funders and other partners is also significant.

9. Task Shifting does not stand alone but must be set in the context of other elements of the TTR plan

Participants stressed that work to progress Task Shifting must always be seen as one part of a range of strategies under the TTR plan which includes treatment of health workers infected with or affected by HIV, training of new and greater numbers of health professionals, and retention strategies to reduce exit rates from public health service.

10. This is an emergency.

The meeting cautioned that the emergency nature of the climate in which the Task Shifting project is being proposed could result in action that is urgent rather than appropriate. It is accepted that the urgent objective is to achieve universal access to HIV treatment and care and that available opportunities must be used to make this possible. But at the same time, every care must be taken to consider the long term consequences of what is done. In particular care must be taken to ensure that work to scale up the response to HIV/AIDS does not undermine other priorities in public health or in any way reduce the system's capacity to respond adequately to other new or changing disease burdens in the future.

11. Task Shifting and any proposed regulatory framework must contribute to broader health systems strengthening

Task Shifting could represent a "quick fix" solution to human resources for health shortages. But Task Shifting has the potential to make a positive contribution to health systems strengthening. Just as the crisis represented by the HIV pandemic has, in some countries, had the effect of generating new and increased funds for the health care system, Task Shifting for the delivery of HIV/AIDS treatment and care could also be

part of the solution to increasing health workforce capacity generally. Every effort must be made to ensure that such opportunities are not wasted.

The aim should be for a flexible workforce that is able to respond to the changing landscape of public health needs. In the past this has not been the case due to the very strict and often limiting delineations of roles and responsibilities of the various cadres of health workers. Now that must and can change.

The meeting agreed that treating HIV as a single or isolated disease is a mistake. Not only must work on the Task Shifting project be sure not to detract or divert resources from work on other diseases and health priorities it must also make a real and positive contribution to health systems strengthening.

It was noted that it is often the momentum generated by those with an urgent agenda that provides the enabling environment and the availability of resources to introduce innovative approaches in public services.

12. The consultative process is just beginning

The process of consultation and partnership building involved in this Task Shifting project will be as important as the global guidelines that are the anticipated product.

The GWU team, while being charged with the assignment of developing the guidelines for a regulatory framework, were clear in their desire for guidance and active involvement from the gathered participants and from those with whom they will be liaising in the countries they visit. They stressed that the intention is for this to be a country-driven process and the plan is for GWU to partner with an appropriate academic or other institution in each participating country. The role of the GWU team is to provide the technical support that is required to make it happen and to make it happen fast.

The GWU team stated that they would welcome the participants remaining continually in contact so that entire group feels ownership of this process and work. Participants were asked to share any relevant secondary data that they know about with Francesca Celletti at WHO so that it can be passed to the GWU team.

NEXT STEPS

The meeting agreed to a series of next steps:

1. The creation of an advisory group on Task Shifting. It is hoped that this group will gather for their first teleconference in 3 weeks time.

2. The GWU team will pair with country-based institutions and conduct a series of country visits starting with Uganda or Ethiopia.

3. The participants will reconvene for a second meeting during the PEPFAR implementing meeting on 16 June 2007 in Kigali, Rwanda. By 16 June the GWU team

will have visited at least 2 countries so will have more substantive material to discuss with the expert group. WHO and OGAC hope that all participants will be able to attend.

4. A third meeting will be scheduled for Oct-Nov 2007 prior to the consultation on Task Shifting guidelines in Geneva.

5. Then real work starts…

List of Participants

Benjamin Alli, Yibeltal Assefa, Madga Awases, David Benton, Angela Bergeret, Yan Bourgueil, Jean Marc Braichet, Linda Carrier-Walker, Francesca Celletti, Immaculate Chamangwana, Anna Cirera, Robert Colebunders, Veronique Collard, Shaun Conway, Manuel Dayrit, Mamadou Diallo, Norbert Dreesch, Tim Evans, Benjamin Fouquet, Seble Frehywot, Alan Greenberg, Peter Graaff, Gregory Grevera, Sandy Gove, Teguest Guerma, Vincent Habiyambere, Fatoumata Hane, Joan Holloway, Brian Hujdich, Veerle Huyst, Kelita Kamoto, Otmar Kloiber, Lesley Lawson, Alan Leather, Elizabeth Madraa, Marina Madeo, Jorge Mancillas, Tim Martineau, Nester Moyo, Cheryl Mayo, Anne Markus, Craig McClure, Hugo Mercer, Anne Nirva Metellus, Mwansa Nkowame, Francis Omaswa, Judith Oulten, John Palen, Jos Perriens, Rose Pray, Myat Htoo Razak, Alasdair Reid, Badara Samb, Erik Schouten, Sirgu Sisay, Benjamin Udongo, Adele Webb, Lambert Wesler, Anna Wright, Jean Yan, Jose Zuniga