



## Joint WHO/PEPFAR Meeting on Task Shifting

Kigali, 14 June 2007

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### SUMMARY OF KEY ISSUES ARISING

#### Background

In February 2007 the World Health Organization and the Office of the U.S. Global AIDS Coordinator (OGAC) convened a meeting in Geneva that was to signal the beginning of a new expert partnership to support Task Shifting in the context of the wider HIV/AIDS and health workforce “Treat, Train, Retain” plan.

Members of the partnership, which includes representatives from HIV programmes and human resources departments from ministries of health, UN agencies, professional associations, academic institutions and representatives from workers associations, reconvened in Kigali, Rwanda on 14 June. This one day meeting represented the continuation of the process of consultation that began in Geneva four months ago.

In the four months since the Geneva consultation there has been remarkable progress. Activities already undertaken, at both the country level and the global level, will lay the groundwork for the development of global guidelines on Task Shifting.

#### Objectives

The objectives of the meeting were:

- To review the evidence gathered so far to support the development of global guidelines on Task Shifting.
- To identify the gaps and suggest appropriate ways to address these.
- To further strengthen the Task Shifting partnership that began in Geneva in February 2007.

#### Presentations

A wide range of presentations by participants included the following:

- The TTR Plan: an update – Badara Samb, WHO

- The WHO/PEPFAR Task Shifting Project: objectives, scope of work, expected outcomes – Joan Holloway, OGAC
- Task Shifting and ongoing clinical practices: a multi-country perspective. Wim Van Damme and Louise Ivers – Antwerp Institute of Tropical Medicine and Partners in Health/Harvard Medical School
- Regulatory issues and Task Shifting: a multi-country perspective – John Palen, Seble Frehywot and Anne Markus – George Washington University
- Credentialing/certifying health care workers to undertake new tasks - José Zuniga and David Benton, IAPAC and ICN
- Task Shifting, the viewpoint of MSF – Mit Philips, MSF Belgium
- Moving towards global guidelines on Task Shifting: the needed evidence and the key issues – Joan Holloway, Francesca Celletti and Badara Samb
- Best practice country experiences:
  - Malawi – Kelita Kamoto, Ministry of Health
  - Rwanda – Anita Asimwe, Ministry of Health
  - Ethiopia – Ybeltal Assefa, Ministry of Health
  - Uganda – Kenneth Mugisha, TASO

Copies of all presentations are available on a link to be provided separately

### **Main outcomes and areas of consensus**

The meeting intended to draw on the expertise and advice of the gathered partners to help clarify the detail and identify the concrete actions needed to move the Task Shifting Project forward. Presentations and discussion focused on further informing and invigorating the development of global guidelines which the partnership will finalize and reach agreement on before the end of 2007.

The meeting included both discussion on broad principles and challenges for wide scale implementation of Task Shifting as well as detailed discussion on technical issues. The key points arising are summarized as follows:

#### *a) Task Shifting is essential*

There was general consensus that increasing human resources for health must be understood as an urgent priority and that Task Shifting is an essential part of any efforts to achieve universal access to HIV/AIDS prevention, treatment and care.

#### *b) Task Shifting is a strategy for overall health systems strengthening*

It was also recognized that Task Shifting represents a major departure from the standard approach to health care and, as such, can significantly change the health care delivery system. Addressing some of the underlying structural challenges for widespread service delivery will result in increased access, expanded coverage and improved quality of care. Furthermore, by allowing the decentralization of services to underserved areas the Task Shifting approach will contribute to strengthening primary health care services and systems. Participants stressed

the importance of communicating the fact that Task Shifting represents a sustainable strategy for health systems strengthening, not simply a short term response to the HIV/AIDS emergency.

*c) Task Shifting is safe and efficient*

The current experience in implementing Task Shifting in selected countries was presented along with the interim results of two external evaluations of the Task Shifting approach. There is growing evidence from both the internal and external assessments that Task Shifting can improve the quality of care, improve efficiency and increase access to services.

*d) Further data analysis and data collection is needed*

Data are being gathered to support an assessment of the clinical and regulatory aspects of Task Shifting, but further data analysis is needed to provide assurances that the model is appropriate in a wide variety of different contexts. This work will be undertaken in the coming months. Additional information will also be collected on the cost and financing of task shifting. Further work is also needed to understand the experiences and position of people living with HIV/AIDS to help ascertain the role PLHA may play in the Task Shifting model of service delivery.

*e) Evidence versus speed and the need to be pragmatic*

There was agreement that wider implementation of the Task Shifting approach must be evidence-based but also that a balance must be struck between the desire to inform the work with extensive data and the necessity to work within an ambitious time frame. A pragmatic approach was advised, whereby the partnership will agree on a minimum amount of robust evidence that will be needed to support the development and approval of guidelines, while also ensuring that ongoing evaluation and research is built into the plans for implementation.

*f) Country leadership and country responsibility is of paramount importance*

The importance of country ownership of the Task Shifting Project was stressed while also confirming the active involvement and support of all the international bodies represented in the partnership. Ultimately it is individual countries themselves who can drive positive change by taking responsibility for the wellbeing of their own people.

*g) Task Shifting must be sustainable*

The importance of ensuring that Task Shifting is implemented in a way that is sustainable and flexible enough to accommodate future scenarios and varying country contexts was noted. To this end, the approach must be properly integrated into health systems. It was agreed that adopting a regulatory framework and methods of credentialing that legitimize the delegation of authority and formalize lines of accountability will help ensure sustainability. Adequate financing to properly pay health workers will also be essential if the approach is to be sustained and contribute to long term health systems strengthening.

*b) Task Shifting does NOT mean replacing professional doctors and nurses with lay providers*

There was some concern that the Task Shifting model could result in the replacement of well-trained health professionals with non-professional health workers. Experience has shown that this is not the intention behind Task Shifting. Task Shifting is about improving the efficiency of the current workforce through a more rational division of labour and shared responsibilities among the various cadres of health workers. By extension, Task Shifting can expand the overall pool of human resources for health quickly by delegating appropriate tasks to community health workers and other lay providers. Task Shifting will not remove the need to increase the overall numbers of health workers being recruited, trained and retained at all levels including the senior professional cadres. The Task Shifting recommendations will help to establish the appropriate numbers of workers needed in each cadre for the delivery of effective HIV services and propose ways in which those numbers can be recruited and retained. The participants agreed that successful Task Shifting will generate additional human resources throughout the health system. Countries adopting the approach will have to develop strategies to meet the specified personnel requirements.

*i) Health workers must be treated fairly and be justly rewarded*

Care must be taken to ensure that Task Shifting does not result in excessive additional workloads for certain cadres of health workers; health workers must also not be expected to take on new responsibilities without adequate pay. Past examples of Task Shifting that did not provide remuneration often failed. Proper pay and improvements in efficiency and in working conditions should result in improved retention and recruitment rates and may even reduce absenteeism.

*j) Under-employment and under-recruitment must be addressed*

Some countries or localities are finding that significant numbers of health professionals, particularly highly qualified physicians and nurses, remain unemployed amid the generalized health worker shortage. This situation also exacerbates the “brain drain” as professional health workers who cannot quickly find suitable work at home are very likely to be attracted to jobs abroad. Under-employment is sometimes the result of ceilings that are imposed on public expenditure in order to preserve macroeconomic stability. Such macroeconomic constraints can best be addressed through a multi-sectoral approach that includes the World Bank and the IMF. It was also noted however, that even if all qualified personnel were recruited and employed in the health sector there would still be an overall shortage of health workers. Under-employment must not be ignored but the priority is for an overall expansion of the pool of human resources for health.

*k) People living with HIV/AIDS must be involved*

PLHA are key stakeholders in the Task Shifting process and there was discussion about how best to involve them in the project. The Task Shifting model envisages the active involvement of expert patients, yet, in certain contexts there may be sensitivities around disclosure of HIV status. The consensus was that each specific scenario should be

considered on the basis of the particular circumstances that prevail in the country and locality. It was further agreed that associations representing PLHA should be encouraged to join the Task Shifting partnership so that the views of these stakeholders are fully represented in the decision making and so that PLHA can play an active role in supporting the Task Shifting approach.

*l) The partnership is growing in strength*

The meeting welcomed two significant developments in the partnership: first, the engagement of UNAIDS which has now joined WHO and PEPFAR as partners in the Task Shifting Project; second, a major commitment from the Office of the U.S. Global AIDS Coordinator to continue to support the Task Shifting Project and to remain engaged through the implementation phase. The meeting heard that PEPFAR now regards Task Shifting as a top priority.

*m) Task Shifting is country driven and internationally supported*

The Task Shifting Project is country driven but is reinforced by strong and broad based commitment from the international community including the major multilateral and bilateral agencies. This commitment includes political, technical and financial support.

*n) Costing and financing will require innovation and negotiation*

Task Shifting may bring cost savings in certain circumstances but it should not be viewed as a cost cutting measure. Participants noted that Task Shifting is a major undertaking which involves remodeling the health system and as such will require significant additional resources. Financing will be needed for salaries for new cadres of health workers and to support the increased supervisory responsibilities of currently employed health professionals. Finding resources for salaries is traditionally challenging and innovative financing mechanisms will be needed that can ensure sustainability and stability. A thorough costing of the Task Shifting model is required to facilitate discussion and negotiations as well as planning for scale up.

## **NEXT STEPS**

The meeting agreed a series of next steps:

- Documentation will be completed and results will be analyzed and made available by the end of September 2007.
- Draft global guidelines on Task Shifting will be prepared and made available to the partners in late October.
- The group will reconvene once again at the end of November to approve the guidelines. This meeting will take place in Addis Ababa at the invitation of the Ethiopian Government. Participants will be notified of the dates as soon as possible.

- The Global Fund for AIDS, TB and Malaria will be encouraged to integrate the Task Shifting concept as an element of health systems strengthening in proposals submitted to the Fund.
- In early 2008 the Task Shifting approach will be implemented in three or four selected countries. The implementation will be combined with a strong evaluation component so that the process of evidence gathering and refinement and can continue.
- The Task Shifting approach will implemented, where appropriate, in PEPFAR countries. The guidelines will facilitate the widespread implementation of Task Shifting in all countries that chose to adopt the approach.
- The partnership will continue and engagement will grow.

### **List of Participants**

Yibeltal Assefa, Anita Assimawe, Bonita Baigana, David Benton, Agnès Binagwaho, Francesca Celletti, Ben Chirwa, Anna Viladot Cirera, Ethel Dauya, Kevin De Cock, Charles Frank Farthing, Seble Frehywot, Sandy Gove, Peter Graaff, Carolyn Greene, Jean Pierre Hindura, Joan Parise Holloway, Louise Ivers, Kelita Kamoto, Cathérine Kantengwa, Sunkuto Kanyanta, Caroline Kayonga, Tom Kenyon, Wesler Lambert, Stefano Lazzari, Luis Loures, Marina Madeo, Elizabeth Madraa, Anne Markus, William Massavon, Jane Miller, Kenneth Mugisha, Mary Murebwayire, Désiré Ndushabandi, Diodato Vicente Nsue-Milang, Hubert Nzanze, Mit Philips, Asia Russell, Badara Samb, Erik Schouten, Claude Sekabaraga, Michel Sidibe, Sisay Sirgu, Francois Sobela, William Stones, Benjamin Udongo, Wim Van Damme, Eric Van Praag, Adam Was, and Jose Zuniga