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MSF Satellite 'Mind the Gaps'

Trends & challenges of task shifting to lay providers / CHWs

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Overview

1. ART & HRH shortage: Who will do the job?
2. Task shifting to lay providers / CHWs
3. 'Trends' in lay workers / CHWs today in sub-Saharan Africa
4. Lessons learnt? 10 conditions for success
5. Conclusion

HRH & PLwHAs

Data 2004
WHO &
UNAIDS

	PLwHAs per medical doctor	PLwHAs per nurse
Malawi	7,435	286
Mozambique	3,446	328
Zimbabwe	2,337	260
Tanzania	2,164	117
Rwanda	1,490	142
Zambia	1,216	75
Swaziland	1,135	64
Botswana	676	81
Uganda	397	37
South Africa	171	30
Cambodia	75	20
Thailand	30	6
Brazil	2	7

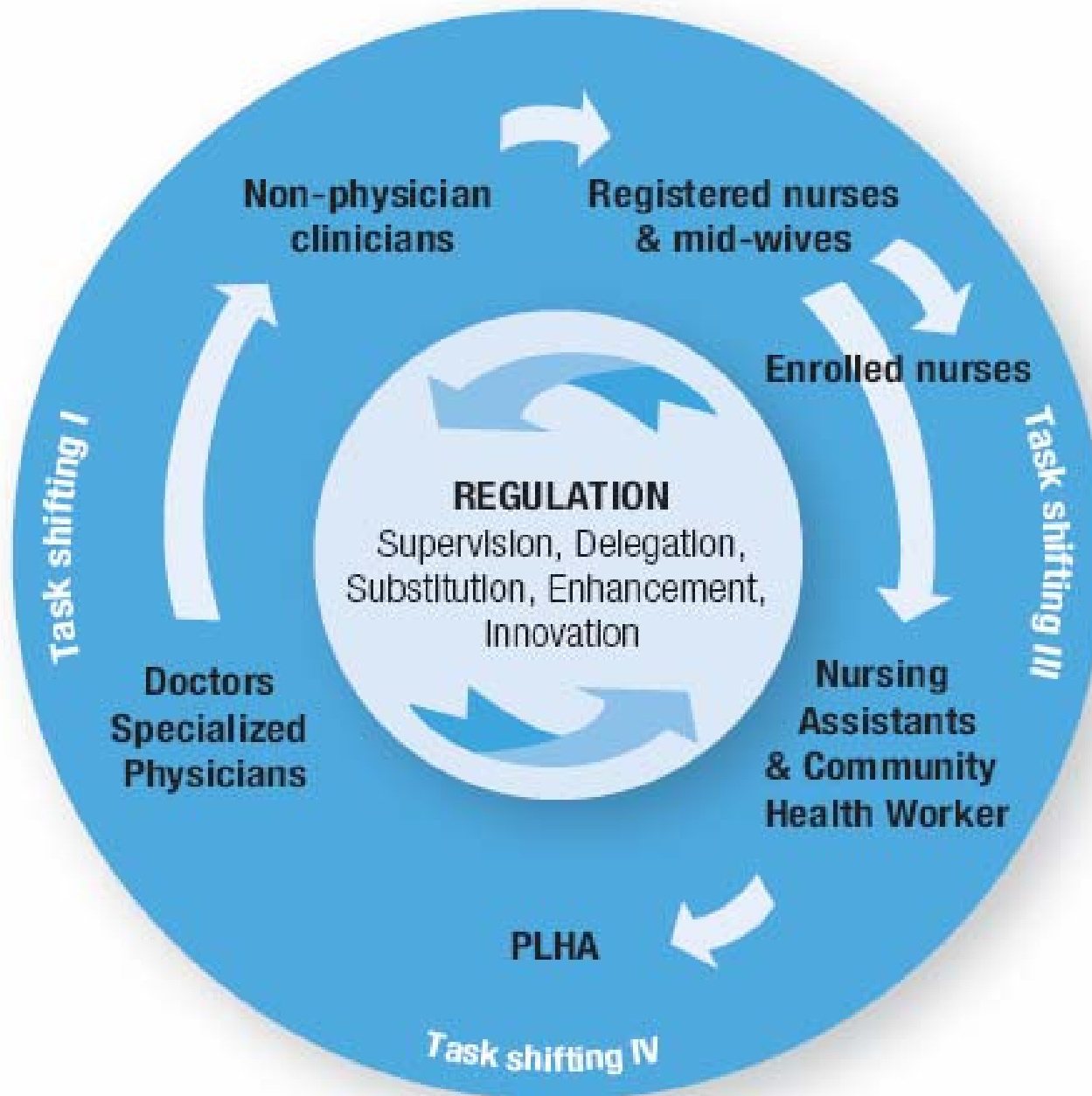
Task shifting

= one possible approach to help overcome HRH shortage

WHO definition:

“a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers.”

Task shifting: expanding the pool of human resources for health



Prior experience with task shifting

- Type I: **non-physician clinicians** in primary health care (PHC)
- Type II: de facto happening in many places: **nurse-practitioners**
- Type III:
 - community health workers = lay providers
 - Counsellors = quite new to HIV/AIDS
 - Expert patients = quite new...
- Type IV: self-management (diabetes &c)

Lessons learnt?

5 + 3 + 2 conditions

- 5 basic conditions for success
(task shifting in general)
- 3 conditions for scale-up
(of CHW programmes)
- 2 ART-specific 'opportunities'

Lay providers today in sub-Saharan Africa 'trends'

- Three overlapping 'drivers'
- Wide variety of 'lay providers' / CHWs
- Very different scales

Lay providers / CHWs: three 'drivers'

- 'New', **AIDS-specific** lay providers:
VCT counsellors, M2M in PMTCT, expert patients in ART, ART adherence supporters, &c &c
- 'Revival' of CHWs for **general PHC**:
village health workers (VHWs), health surveillance assistants (HSAs), ... adding HIV/AIDS tasks(?)
- 'New', **(other) disease-specific** lay workers:
malaria village volunteers, TB-DOTS supervisors, ivermectin distributors, &c &c

Lay providers / CHWs: wide variety of realities

Facility-based

Specialised / disease-specific
(VCT, ART, PMTCT, ...)

Limited tasks

Full-time

Remunerated 'ancillary' staff

People with life experience
(PLWHA, mothers, ...)

Educated

NGO / CBO - organised

Community-based

Generalist (PHC)

Broad job description

Part-time

Village volunteer

School leavers

Little or no formal education

Government organised

Different scales

- Many small pilot projects, mainly NGO-initiated
- Some larger programmes, mostly donor-supported
- In some countries: national scale-up, usually donor-funded

Lessons learnt?

- Malawi: national scale-up of Health Surveillance Assistants (HSAs)
- Uganda: variety of NGO-initiated lay provider initiatives: ART aides, HIV medics, TASO field officers, CATTs, expert patients, ...
- Ethiopia: national scale-up of Health Extension Workers (HEWs)

Key questions

(1) Are lessons from the past being learnt? (or: Are past mistakes being repeated?)

&

(2) Are ART-specific 'opportunities' being seized?

5 basic conditions for success in task shifting

Selection & intrinsic motivation?	Mixed
Initial training?	Mixed
Simple guidelines & standardised protocols? Realistic job descriptions?	Quite good
Supervision, support, supply & referral possibilities to formal health service?	Mixed
Adequate remuneration / career structure?	Receives due attention!!

3 conditions for scale-up of CHW programmes

Political support & regulatory framework	Ethiopia +++ Malawi ++ Uganda??
Alignment with broader health systems strengthening, incl. more HRH	Ethiopia +++ Malawi ++ Uganda ??
Flexibility and dynamism	Remains to be seen

2 ART specific 'opportunities'

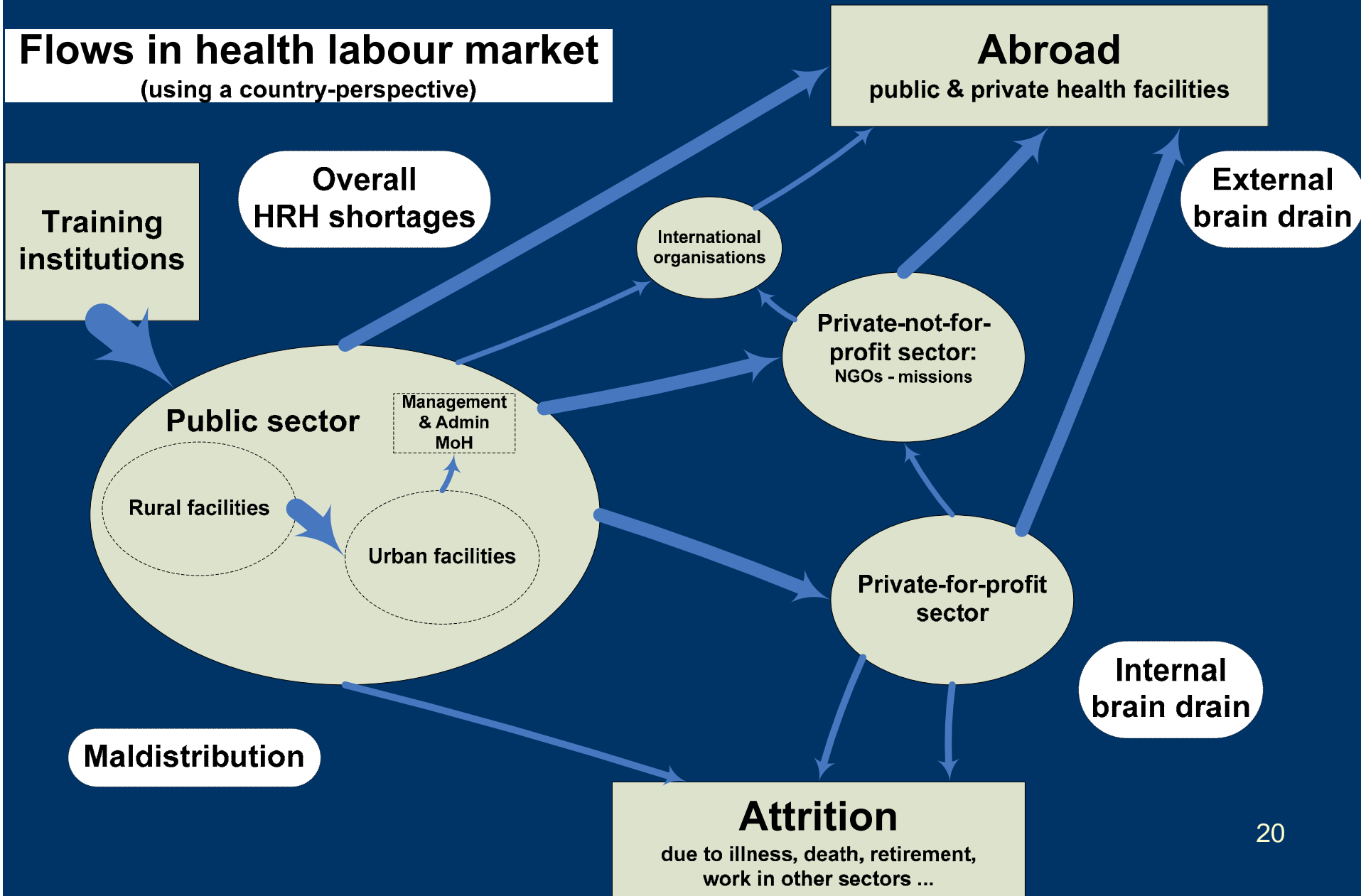
Using life-experience of PLWHAs	In NGO projects +++; but seems to be abandoned / forgotten in national scale-up!!!
Using chronic care models, with special focus on ART adherence & retention in care	Uganda ++++ Ethiopia? & Malawi? (role in ART not clear yet!)

Conclusion

- Some lessons are learnt, especially Re remuneration
- Some mistakes are repeated, especially Re support
- New opportunities are missed in scale-up
- Still time to get it right, hopefully, ...

Bonus materials

HRH framework



Impact of AIDS on HRH

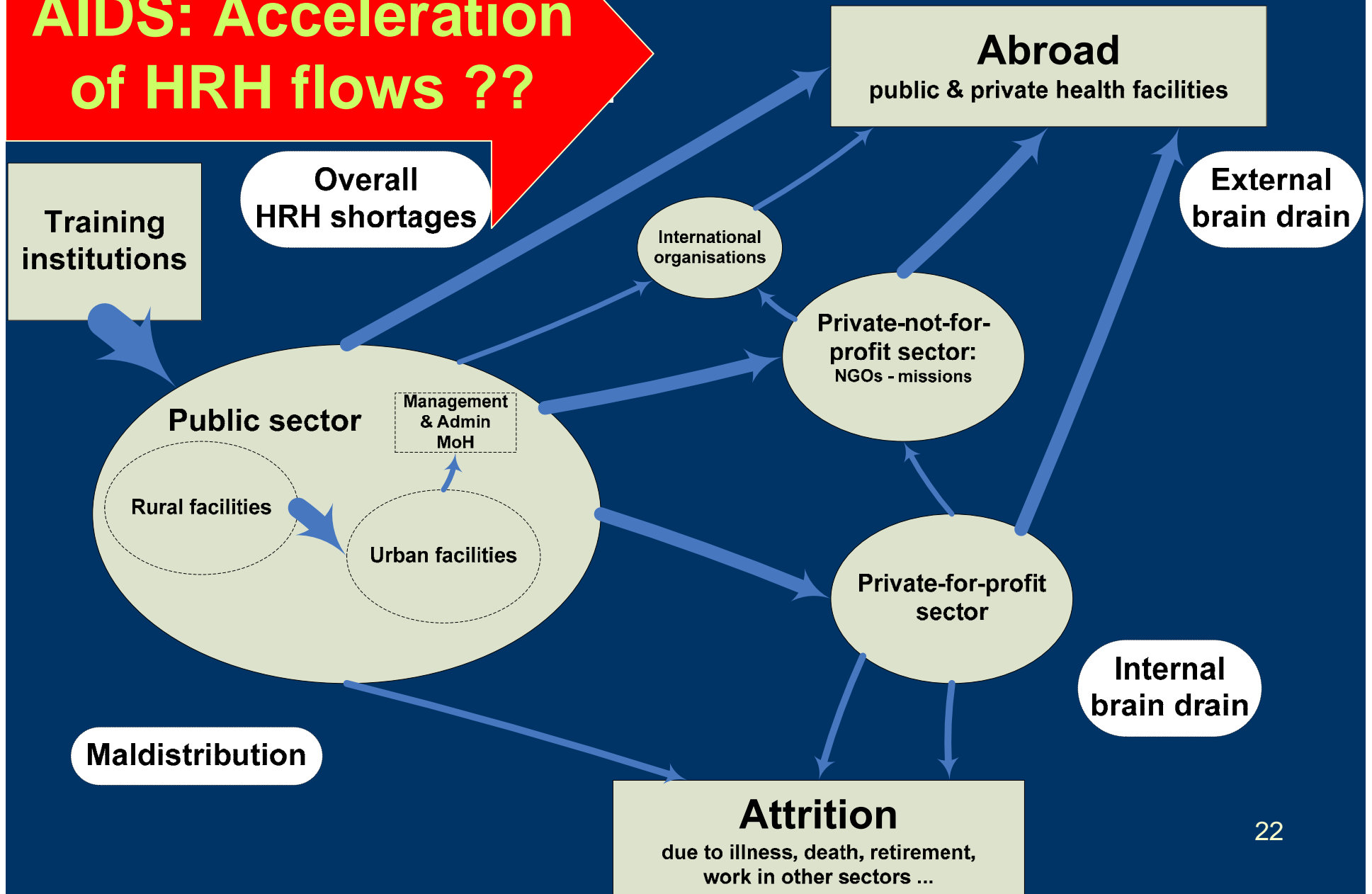
Increased health worker attrition & absenteeism

- Health workers are dying from AIDS
- Increased absenteeism due to
 - own illness
 - illness of family members
 - funerals

Consequences for the remaining carers

- Increased workload
- Compelled to work longer hours, see more patients, assume more tasks (for which often poorly prepared)
→ “Burn-out”
- (Perceived?) risk of HIV infection at the workplace

AIDS: Acceleration of HRH flows ??



	Professional level	Mid-level	Auxiliary	Without diploma in health (=Lay persons)
Clinical staff	Medical doctor	Clinical officer	Medical assistant	Lay provider
Nursing staff	Nurse with university degree	Registered nurse	Enrolled nurse	Nursing aids
Educator / counsellor	Counsellor with relevant university degree			Lay counsellor

5 basic conditions for success in task shifting

1. Selection & intrinsic motivation
2. Initial training
3. Simple guidelines & standardised protocols, 'realistic' job descriptions
4. Supervision, support, supply & relationship with formal health service
5. Adequate remuneration / career structure

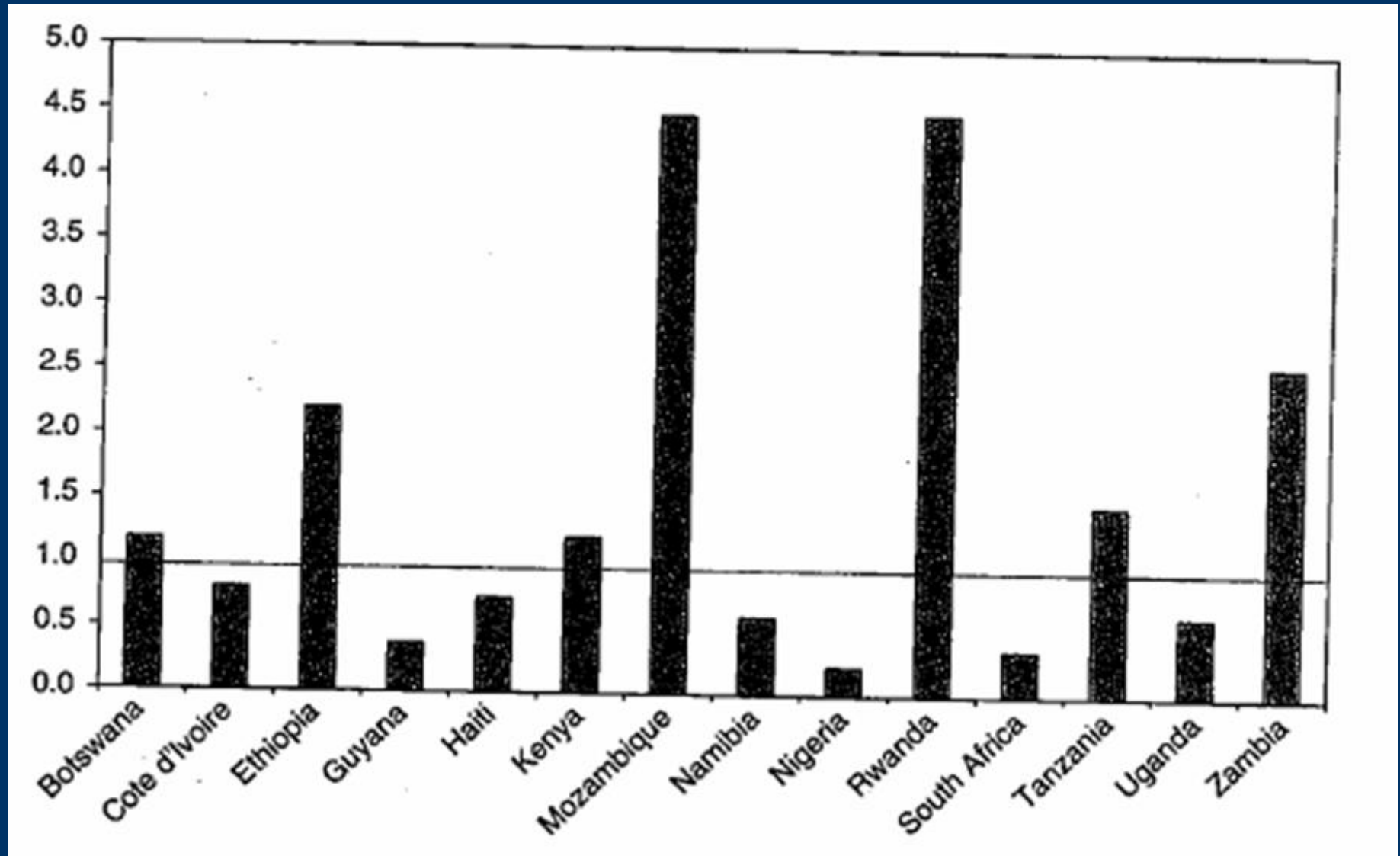
3 conditions for scale-up of CHW programmes

6. Political support & regulatory framework
7. Alignment broader health systems strengthening
8. Flexibility and dynamism

2 ART specific 'opportunities'

9. Using life-experience of PLwHAs
10. Using chronic care models, with special focus on ART adherence & retention in care

PEPFAR estimates, 2004



Doctors needed for ART (full coverage in 10 years)

Possible solutions?: two tracks

- **Investment in HRH & health systems**

Need for more HRH through

- Increased production (Training)!!!
- Retention!!
- Importation??

- **Adapt ART delivery models**

“Task shifting” ...

... from doctors to clinical officers to nurses to ... ‘lay providers’? Or community health workers?

Task shifting priorities for HIV/AIDS

'Medical tasks'

- clinical officers; nurse-practitioners
- nurse-based ART delivery

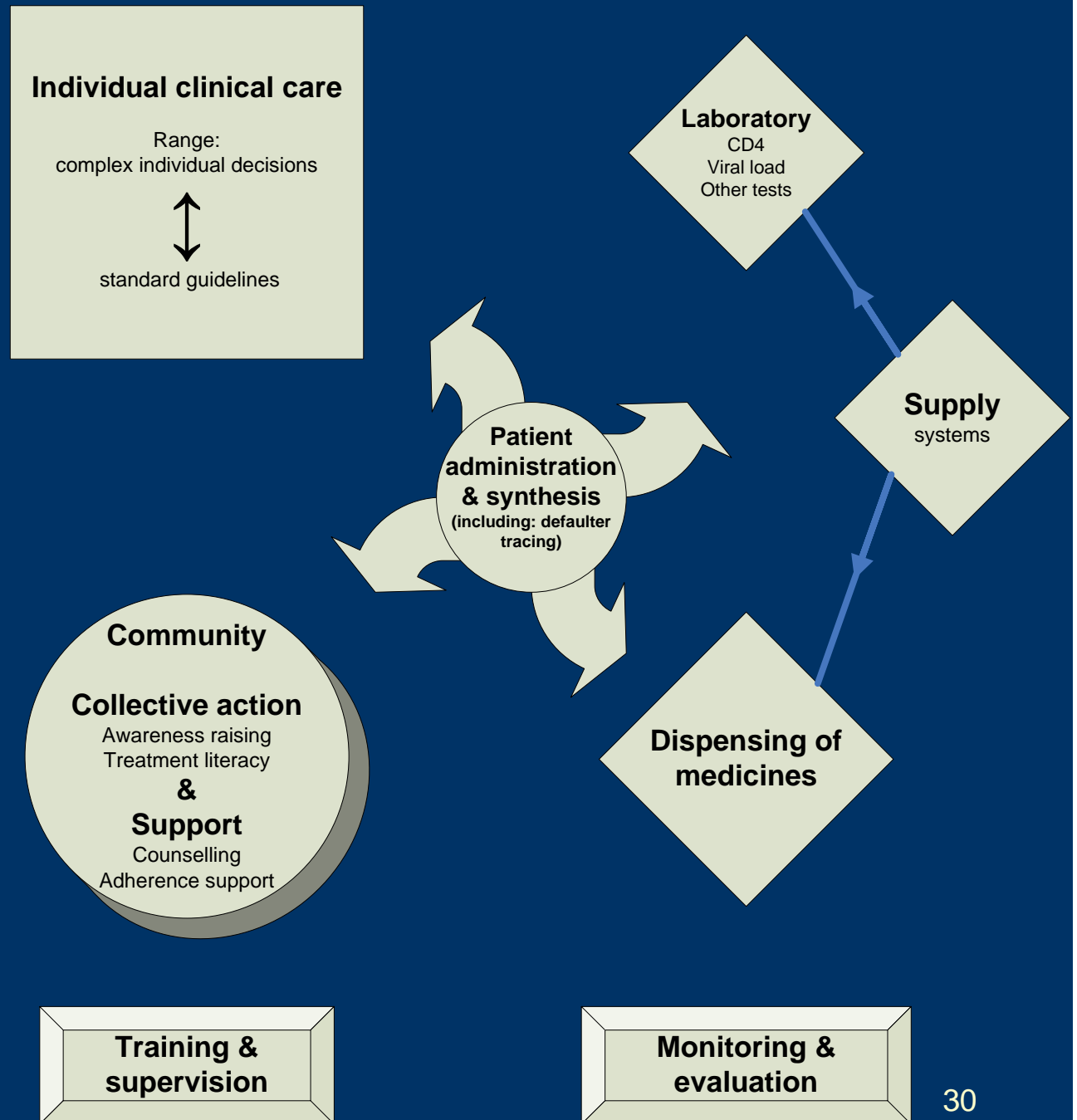
Testing, counselling

- counsellors, lay counsellors

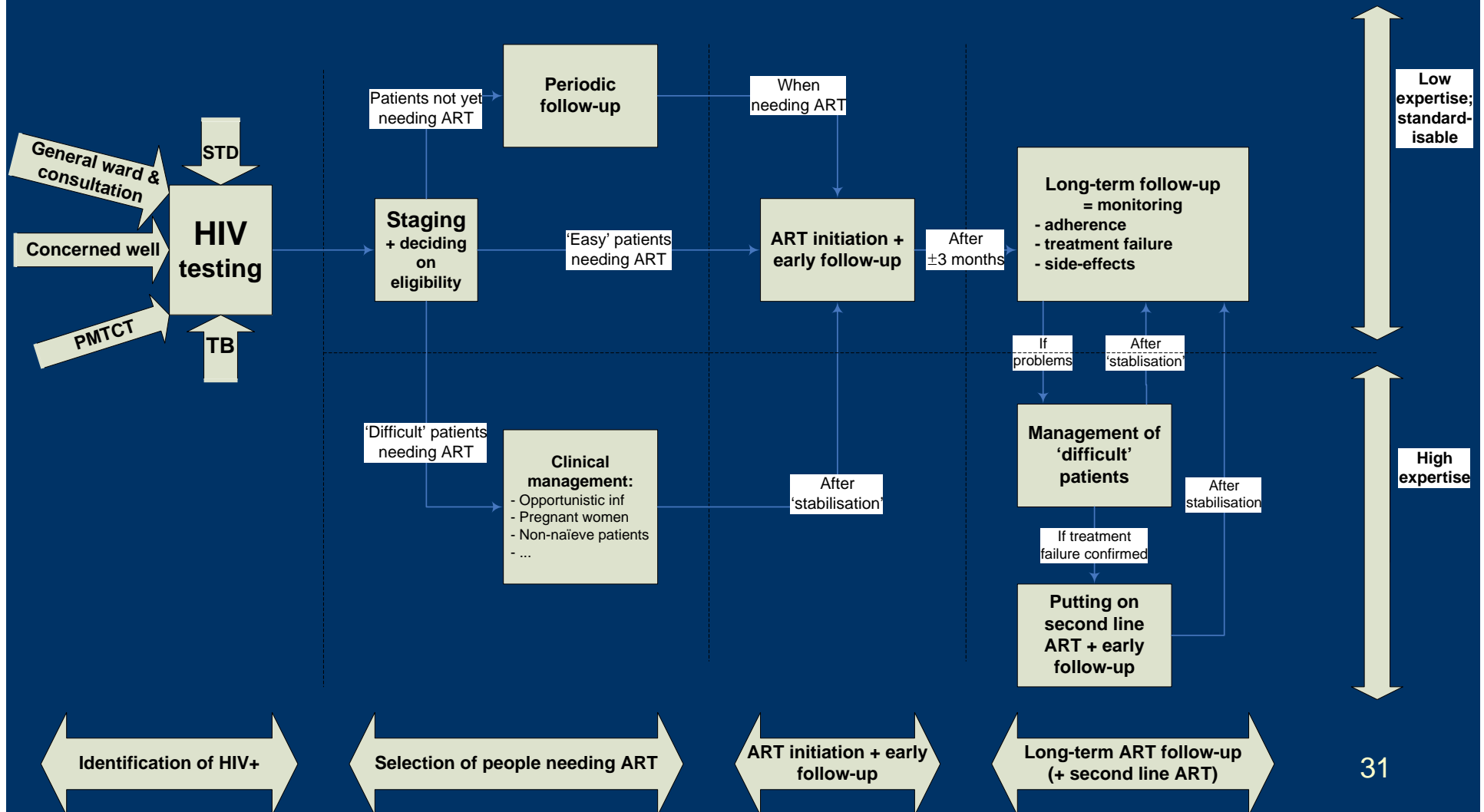
Special focus: patient-empowerment

- expert patients

ART functions



Clinical ART: phases & levels



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