

## THE ROLE OF MID-LEVEL AND COMMUNITY HEALTH WORKERS A SYSTEMIC APPROACH TO TASK SHIFTING

A briefing note by Health Workforce Advocacy Initiative (HWAI)  
and African Medical Research Foundation (AMREF)  
to the G8 Health Expert Group

*Confident that:*

- *the Health Expert Group will continue to provide a focus on the crisis of human resources for health in the frame of the G8 Summit 2009;*
- *the Group will take the occasion of the 2009 G8 Summit to strengthen both financial commitment and strategy development in this crucial area;*

*we submit the following briefing note on the role mid-level and community health workers can play in the frame of the health workforce crisis, with particular reference to a task shifting strategy. This briefing note contains a short presentation of our positions on the subject, as well as a proposed wording for G8 statements.*

In the context of the global crisis of human resources for health, mid-level and community health workers are critically needed, especially in resource constrained settings, as there is robust evidence that they “can improve access to and coverage of communities with basic health services.”<sup>1</sup> Involving mid-level and community health workers in a task-shifting approach to the organization of health personnel – i.e., rationally distributing tasks among health workforce teams<sup>2</sup> - accomplishes four important goals simultaneously:

- 1- strengthens and expands the health workforce to rapidly increase access to health services in under-served and disadvantaged communities, particularly to meet the needs of the poor;
- 2- shares and assigns 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;
- 3- takes advantage of simplified health promotion and treatment protocols that permit task-shifting to less intensively trained and specialized cadres of health workers; and
- 4- shifts more health promotion and treatment and care delivery to the community-level by introducing new or strengthening existing cadre of community health workers.

We believe that any G8 statement concerning mid-level and community health workers should be based on the following points:

**1- Task-shifting to mid-level and community health workers can only be successful in the presence of a budgeted expansion of human resources within the overall health care system.**

Community and mid-level health workers cannot be considered as a cheap substitute to health professionals, including doctors, nurses and midwives. Rather, in most circumstances *community and mid-level health workers need to be additional to other health professionals in terms of numbers*. A task-shifting approach could actually lead – in the short and medium term - to an increased demand on doctors, nurses and midwives themselves, to take up increased responsibilities as trainers and supervisors and to take care of the new patients generated by efficient community health worker programs. Any task-shifting plan should therefore be carefully planned, budgeted and funded, and implemented alongside other efforts to increase the numbers of more highly skilled health workers.

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<sup>1</sup> Community Health Workers: What do we know about them? The state of evidence on programmes, activities, costs and impact on health outcomes of using community health workers, WHO, 2007, [http://www.who.int/hrh/documents/community\\_health\\_workers.pdf](http://www.who.int/hrh/documents/community_health_workers.pdf)

<sup>2</sup> Global Recommendations and Guidelines on Task Shifting, WHO, 2007, [http://www.who.int/healthsystems/task\\_shifting/en/](http://www.who.int/healthsystems/task_shifting/en/)

From this perspective, while setting human resources targets, the G8 should explicitly refer to the *“WHO goal on minimum health worker density of at least 4.1 health workers per 1,000 population, including at least 2.3 doctors, nurses, and midwives per 1,000 population.”* The G8 would thus recognize that the 4.1/1,000 target does not undermine – but on the contrary, builds on – last year’s G8 2.3/1,000 commitment to be more inclusive of needed professional, paraprofessional, and auxiliary health workers, including specifically community and mid-level health workers, as well as managers and administrators.

## **2- Task-shifting to mid-level and community health workers can only be successful if the systems that support its implementation are strengthened**

In the shift to community-based health services there is a risk that countries and partners may neglect the educational pipeline and 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. This system would fail to meet the total health needs of the patient and would offer instead 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 poor motivation and high attrition rates for community health workers.

It is therefore essential to identify and support the ancillary systems that are essential to the success of task-shifting. The points below are particularly focused on community health workers, but are highly relevant to mid-level health workers as well. Mid-level health workers include such categories of health workers as clinical officers, assistant nurses, and pharmacy technicians. Among their many roles, in a number of countries mid-level health workers have a central role in expanding AIDS treatment, and they have largely untapped potential in improving maternal and newborn health care.

### **Planning and Regulatory Systems**

In the process of developing robust needs- and rights-based, comprehensive costed human resources for health and health system strengthening 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 investing in faculty to teach new and existing cadres of health workers, to consult with professional groups, civil society, community representatives, and other stakeholders to get their feedback and buy-in, to clearly define roles and the associated competencies, 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. Planning will also address selection criteria, pre and in-service training curricula, new supervisory relationships, and referral systems. Finally, it will add in a systems learning mechanism through a monitoring and evaluation component.

Regulatory processes may involve changes in legislation, policy development, and quality assurance mechanisms; they can take many forms, making it essential that an impact assessment is undertaken when introducing task-shifting.

### **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.

In order to identify prospective community health workers, task-shifting will need an effective, fair, equitable, and non-discriminatory/non-patronage system that produces the right candidates with the highest potential to serve community health needs. Recruitment can take place in educational settings or in community contexts, or through a hybrid approach. In some contexts, a certain level of education or pre-service training may be considered to be pre-requisites for selection, while in others selection will be mediated through community structures and the identification of trusted

community members, with high-quality training to follow selection.

In most settings, a strong pre-service training program for prospective community health workers will be needed to orient them both to the basic science of health promotion, disease prevention, treatment and care and to governing ethical standards including confidentiality, non-discrimination, and other patient rights. The pre-service training has to educate community health workers with respect to the priority interventions they will undertake, and in accordance with a community's epidemiological profile.

Because it will not be possible to pre-train community health workers on all their eventual tasks, and because priorities, strategies, and medical interventions will evolve over time, it will be necessary to have on-going in-service training systems specifically designed to improve their skills and service delivery.

It will also be important that training systems are designed to evaluate and credit the experience-based competencies of community members who have already learned valuable skills through their pragmatic responses to community needs.

### **Fair Compensation Systems**

As is uniformly agreed in principle, but often breached in practice, essential health services cannot be provided by people working on a voluntary basis if they are to be sustainable. While volunteers can make a valuable contribution on a short-term or part-time basis, trained health workers who are providing essential health services, including community health workers, should receive adequate wages and/or other appropriate and commensurate incentives. In fact community health workers are often women and among the poorest members of the community. They should not have to put their and their families' own well-being at risk to attend to people whom society and health systems have neglected.

### **Safety and Supply Systems**

Community health workers need to have access to health services for their own needs and safe working conditions. This includes having adequate supplies to ensure their own safety and to support the safety of home-care providers and of the community members whom they serve. 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 underserved rural and peri-urban communities must be strengthened.

### **Supportive 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 adequate supervision and other support services. Community health workers need supervisors who can answer their questions and help them problem-solve the inevitable barriers that arise to service delivery, and who can also help them survive burn-out from the stress arising when providing services to ill and dying people.

To provide such supervision and support, supervision capacity has to be built, credited, and rewarded. Task-shifting will impose additional supervisory tasks on existing health workers: many of them need to be trained to take on new supervisory responsibilities. The supervisors may 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 may need to be accompanied with appropriate increased compensation.

### **Referral Systems**

Despite the best training, community health workers will not be able to deliver all the health care that the sick require. Therefore, highly functional, transparent, and dependable referral systems must be established that permit community health workers to diagnose or triage health care needs. They must know how and to whom to refer patients promptly for appropriate care or for the needed social services.

Strong referral systems will require clear guidelines or standards for referral, good communication

and transportation systems and, critically, an expanded number of more highly trained health workers at the other end of the referral system: in the short and medium term, in fact, 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.

### **Task Shifting Across the Continuum of Care**

The discussion so far has focused primarily on mid-level and especially community health workers and the systems support that they will need. However, the same type of analysis of systems needs should be applied at other levels in continuum of care. For example, in some countries, it may be desirable to shift tasks so that well-established cadres of health workers, especially nurses, are trained and supported to take on upgraded clinical responsibilities. Task-shifting is therefore both a short-term response to critical human resource shortages and an appropriate strategy in a maturing health system where human resources are denser. Furthermore, along with increased domestic health financing, Northern countries should provide funding to increase the capacity of training institutions to produce the needed health workers and to enable countries to deploy and specifically retain them. Along with advancing other health-related commitments and obligations, this would help compensate countries for the benefits Northern countries have received from the migration of health professionals from the South caused in part by the policies and practices of Northern countries. This funding would help support adequate production and retention of a full continuum of health workers, including highly skilled health workers.

In planning the distribution of tasks, health policymakers must also consider the locus of services. They must decide which health services should be delivered at the community and district clinic and which at more specialized services at secondary and tertiary facilities. These determinations will affect what tasks will be performed by which workers, and what competencies they will require.

### **3- Task-shifting to mid-level and community health workers requires increased fiscal space for health spending.**

Task-shifting programmes demand – in most cases - increased financial resources to cover fair compensation and support systems, as outlined above. Alongside increased investments from development partners and developing countries, macroeconomic policies mediated through the International Monetary Fund and Ministries of Finance that limit overall public investment, including wage ceilings and unduly restrictive overall budget ceilings, and consequently constrain health budgets, should be changed.

*Based on the positions outlined above, we invite the G8 Health Expert Group to consider the following wording while drafting the Group's documents in preparation of the G8 Summit 2009. (Please note that the proposed wording is specific to the issues raised in this briefing, and does not intend to cover the whole debate on human resources for health. We refer the Health Experts to HWAI's overall set of recommendations, available from [http://www.healthworkforce.info/advocacy/G8\\_2009\\_HWAI.pdf](http://www.healthworkforce.info/advocacy/G8_2009_HWAI.pdf)):*

**“We will support developing countries in achieving, as soon as feasible as part of a comprehensive approach to health workforce and system strengthening, the WHO threshold on minimum health worker density of at least 4.1 health workers per 1,000 population, including at least 2.3 doctors, nurses, and midwives per 1,000 population.**

**We will encourage countries choosing to expand their health workforce through task-shifting programs involving mid-level and community health workers to take a systemic, needs-based, and sustainable approach. We commit to provide the needed financial and technical support to enable all countries that choose to adopt task-shifting strategies to develop and effectively implement them through a systemic approach within the framework of their national health plans. We will fully fund, by the end of 2009, in combination with domestic resources and as a sustained commitment, existing national task-shifting programmes that are part of a comprehensive plan to improve human resources for health within the overall health system plan, in order to help ensure the sustainability and systemic approaches of these programmes and to support their scale-up. We further**

**commit to support:**

- **developing consultation mechanisms that involve communities and health workers;**
- **carefully planning and budgeting the selection, training, supervisory, supply and referral systems that support the local delivery of health services by mid-level and community health workers;**
- **ensuring fair compensation for all cadres of health workers, as well as strengthening measures to ensure their own health and safety;**
- **planning and adequately resourcing task-shifting across the continuum of care, with due attention also to the need for expanding training and supervisory capacities of professional health workers within a task-shifting frame.**
- **Increased funding for the pre-service and in-service training, deployment, and retention of a full continuum of health workers, including highly skilled health workers, in part to compensate countries of origin for our own countries' benefits from the migration of health workers to our countries, and in recognition that our own policies and practices have contributed to this migration.**

**We commit to the long-term sustainability of our own funding, while also actively promoting macroeconomic policies, particularly as mediated by International Financing Institutions, that will increase fiscal space for health spending, as needed to enable the expansion of the overall health workforce, including of mid-level and community health workers”.**

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