Human Resources in Humanitarian Health Working Group Report

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Abbreviations:
ART = antiretroviral therapy
CHW = community health worker
GHWA = Global Health Workforce Alliance
HRHH = Human Resources in Humanitarian Health
NGO = non-governmental organization
NPC = non-physician clinician
TH = Tiyatien Health

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Abstract
Humanitarian responses to conflict and disasters due to natural hazards usually operate in contexts of resource scarcity and unmet demands for healthcare workers. Task shifting is one avenue for delivering needed health care in resource poor settings, and on-the-ground reports indicate that task shifting may be applicable in humanitarian contexts. However, a variety of obstacles currently restrict the ability to employ task shifting in these situations, including issues of regulation, accreditation, funding, and a lack of commonly agreed-upon core competencies for different categories of humanitarian health workers. The Human Resources in Humanitarian Health (HRHH) Working Group during the 2009 Humanitarian Action Summit evaluated the potential strengths and weaknesses of task shifting in humanitarian relief efforts, and proposed a range of strategies to constructively integrate task shifting into humanitarian response.

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Background

Human resources issues were identified in the inaugural year of the Humanitarian Conference series as critical to improving the field of humanitarian health services. During the 2006 Humanitarian Health Conference, the Human Resources in Humanitarian Health (HRHH) Working Group drafted a statement about human resource issues in humanitarian health, recognizing HRHH as a distinct body of knowledge.[1] During the 2007 Humanitarian Health Conference, the Working Group focused on the difficulties of recruiting and retaining health staff and proposed conducting a conference for donors to highlight HRHH needs.

The Global Health Workforce Crisis

An adequate health workforce is a necessary component of a functional and equitable health system, and is a major determinant of service delivery and health outcomes. The global health workforce shortage has risen to prominence as the rate-limiting step for achieving individual country health outcomes and Millennium Development Goals (MDGs) 4, 5, and 6, which deal with child, maternal, and infectious disease mortality respectively.

Globally, there is a shortfall of 4.2 million health workers, and as a result, one billion people currently lack access to health care. The health worker shortage inequitably affects the poorest countries, exacerbating the burden of disease already experienced by some of the world's most marginalized populations. Sub-Saharan Africa carries 25% of the global burden of disease, but is home to only 3% of the world's health workforce.[2]

Several underlying factors contribute to this health workforce shortage. Inadequate training rates of health professionals perpetuate limited domestic capacity. The 'brain drain' phenomenon has resulted in only one in four physi-

cians and one in 20 nurses trained in developing countries remaining in their home countries to work,[2] with many leaving because of poor working conditions and low pay. An urban service delivery bias further restricts the health workforce for rural populations. In addition, health workers themselves are affected by the same public health challenges as their communities, such as HIV/AIDS.

This global challenge requires a global response. In March 2008, the First Global Forum on Human Resources for Health endorsed the Kampala Declaration and Agenda for Global Action. It provided a roadmap for the next decade for coordinated international and national efforts to resolve the global health workforce crisis (Appendix). Stakeholders recognize the need for substantial scale-up of health human resources, including both highly trained professionals, and less highly trained workers, including community health workers (CHWs).

Human Resources for Health in Humanitarian Settings

The worldwide health worker shortage is not limited to countries at peace; scarcity of health workers acutely affects the delivery of health services in conflict, post-conflict, and disaster settings. Most of the countries at high risk for humanitarian crises also face the greatest burden of the global health workforce deficit. The World Health Organization (WHO) identified 57 countries as having an acute health workforce crisis,[2] and most countries affected by conflict are included in this group. In regions experiencing humanitarian disasters, well-defined health systems often are either absent or under major threat of collapse. Additionally, non-crisis countries that receive refugees typically suffer a disproportionate health worker shortage.

Issues in the Field of Human Resources for Humanitarian Health

Several inter-related human resource issues face the field of humanitarian health. Humanitarian agencies find it difficult to retain well-trained and experienced staff, especially to work in austere settings. They experience a rapid turnover of workers and often absorb health workers who were previously employed in the public sector, weakening the capacity of local ministries of health. After working for NGOs in these settings, many workers with high-level skills, migrate to developed countries to seek further employment. This turnover and lack of adequate support for local healthcare establishments precludes the build-up of resiliency and institutional memory of best practices. Additionally, many non-local health workers entering emergency situations are inadequately and/or inappropriately educated and trained in the necessary tasks of humanitarian health, and their skills often do not match local health needs.

Currently there are no universally accepted standards of competencies for humanitarian health workers, nor are there ways of certifying competencies possessed by humanitarian field health workers. This has led to an over-reliance on professional degrees, which often are used as surrogates for skill development and training. Many tasks required in the field do not require full medical or public health training, and an over-reliance on professional degrees overlooks the context-specific skill set required in a given humanitarian context. On the other hand, workers seeking to enter the humanitarian field lack a clear professional path, training guidelines, and opportunities for career advancement. Health practitioners desire a more coherent way to develop their skills and experiences into a lifetime portfolio, rather than a series of experiences or phases. This trend toward professionalization of humanitarian health is evidenced by initiatives such as the creation of the Sphere Standards and a number of other recognized training programs, such as the Red Cross Health Emergencies in Large Populations (HELP) course.

Another key issue is that the causes of humanitarian crises may contribute directly to local health worker shortages. For example, following the 2003 Bam earthquake, almost all of the local health facilities were severely damaged and 70% of the health workforce either was injured or killed.[3] Conflicts and emergencies can have extensive effects on the health system, including the collapse of management systems, destruction of working environments, and disruption of training facilities. In humanitarian and post-conflict settings, health workers often are expected to perform with increasing demands without institutional support or sufficient personnel. Frequently, health workers are personally affected by humanitarian crises through disabilities, psychosocial stresses, and unemployment, that reduce their ability to maximally contribute to their communities.

Because an adequate humanitarian response often entails a large influx of human resources in times of crisis, such a response could be an opportunity to expand the capacity of the local workforce in stressed health systems. Addressing the health worker shortage in humanitarian settings requires a two-pronged approach aimed at reinforcing the existing workforce and bringing in new workers. A potential strategy for both of these approaches is task shifting.

Task Shifting

(There has been controversy among different professional groups over the concept of task re-allocation and even the use of the term "task shifting". The use of this term is not intended to endorse a specific approach to this concept; rather it reflects the concept as presented in the professional literature.)

Task shifting is defined as shifting specific tasks from highly trained health workers to less highly trained health workers, including trained CHWs and expert patients, and can be divided into four types (Appendix):

Task Shifting I—The extension of the scope of practice of non-physician clinicians in order to enable them to assume some tasks previously undertaken by more senior cadres (e.g., medical doctors);[4]

Task Shifting II—The extension of the scope of practice of nurses and midwives in order to enable them to assume some tasks previously undertaken by senior cadres (e.g., non-physician clinicians and medical doctors);[4]

Task Shifting III—The extension of the scope of practice of CHWs, including people living with HIV/AIDS, in order to enable them to assume some tasks previously undertaken by senior cadres (e.g., nurses and midwives, non-physician clinicians and medical doctors);[4]

Task-Shifting IV—Patients are trained in self-management, assume some tasks related to their own care that would previously have been undertaken by health workers.[4]

Task shifting has been used in many resource-poor settings as a strategy to expand human resources capacity, utilizing the resources present in the local community. If aspects of healthcare delivery can be broken down into discrete tasks that are manageable by para-professionals, then many of the problems facing humanitarian health work may be alleviated when recruitment and training occurs from among the local population. Community health workers and other locally derived workers are endowed with local knowledge and cultural competency, and are more likely to stay in the communities in which they serve. Recruitment, retention, and local capacity all can be increased if health workers involved in the humanitarian response can be incorporated into the local health system for the long term.

Task shifting is based on the principle of optimization. This entails leveraging tasks such that health workers only are performing tasks for which their skills are absolutely necessary and, when appropriate, are mentoring and supervising lesser trained paramedical staff to carry out other responsibilities. Less demanding tasks are allocated to workers with appropriate levels of training, allowing more highly trained workers to optimize their time performing specialized tasks.

Task shifting is not a panacea, and cannot be incorporated as a stand-alone approach without concurrent training programs and health system development.[5,6] The Working Group agreed that no health professional's work can simply be broken down into component tasks while ignoring the scientific, managerial, and personal skills that also are parts of that work. Yet, task shifting may help to expand the number of people available to perform certain health tasks, to increase the health knowledge and awareness among affected groups, to improve capacity in places where human resources for humanitarian health are scarce, and to maintain the health and safety of both the beneficiaries and practitioners of humanitarian health projects.

Progress Prior to the 2009 Summit

Task-Shifting Literature Review

To inform their deliberations on task shifting before the 2009 Humanitarian Action Summit, the HRHH Working Group conducted a review of the published and grey literature on task shifting. The review yielded few resources relating specifically to task shifting in humanitarian health, but identified key aspects of task shifting in non-crisis situations that may be applicable in a humanitarian context. One study found that 25 of 47 countries in Sub-Saharan Africa utilize non-physician clinicians (NPCs), who have fewer clinical skills than physicians, yet have more than nurses.[7] Many NPCs were from, trained near, and worked in rural areas. Their training was not standardized, was usually run by Ministries of Education and Health, and tended to focus on "indigenous" disorders.

Task shifting has been effective in promoting immunizations and reducing mortality for some infectious diseases, such as respiratory infections in children,[8] but the majority of task shifting in the literature was implemented for scaling up prevention, diagnosis, and treatment capacities for HIV/AIDS.[5,6,9] Lay counselors, especially people living with HIV/AIDS, have taken on HIV testing and counseling, encouraging antiretroviral therapy (ART) adherence, and teaching treatment literacy, tasks previously performed by nurses.[6] A major advantage of this task-shifting is that patients often are able to be treated in their own homes and communities.[9] Doctors and nurses are tasked with inpatient care of severe opportunistic infections, management of ART side effects, and provision of care for special groups, such as children.[6]

There are few thorough analyses of how task shifting has been carried out in humanitarian health settings. Philosophically, many humanitarian agencies support concepts conducive to task shifting, though their implementation strategies differ. While some focus on rehabilitating and strengthening the pre-existing health workforce, others seek to develop novel, localized cadres of health professionals.[6,10–14] While the program type and degree of indigenous empowerment varies, the majority share a commitment to strengthening local capacity through training, scaling, and task shifting. Specific roles of new health workers include independently educating their communities, supporting the work of non-governmental organization (NGO) programs, functioning as counselors, mentors, and monitors of community health, performing research, and sitting on health governance boards.[10,12–16] Local health workers are utilized by humanitarian agencies to address a wide range of health and managerial needs, including public health education,[17] pre- and post-natal care;[10] distribution of contraceptives;[18] child health; and treatment and support for people living with HIV/AIDS.[19]

In 2008, the WHO published recommendations on task shifting based on HIV/AIDS treatment and services.[4] The recommendations include the need for consultation, situation analysis, national endorsement, and a regulatory framework. The recommendations are directed primarily at countries with functional governance capacities, so for humanitarian settings, the humanitarian community may need to create international standards for task shifting when such governance structures do not exist.

Survey

Prior to the 2009 Humanitarian Action Summit, the HRHH Working Group conducted a survey of humanitarian health workers to provide primary data and unique insights from humanitarian health workers employed by international NGOs, UN agencies, national NGOs, and Ministries of Health to frame their discussions (Appendix).The data from the survey were presented at the 2009 Conference and will be published in full in a separate report. Overall, the results confirm that task shifting can be an appropriate strategy in humanitarian settings, but that the dearth of "best practice" policies restricts its use in the humanitarian sphere.

Activities During the Summit

The objectives of the HRHH Working Group for the 2009 Humanitarian Action Summit were to:

1. Identify a process by which the main functions preformed by humanitarian health workers may be broken down into discrete health tasks for which less highly trained staff may be trained;

2. Target the main facilitators of and barriers to re-allocation;
3. Explore what sort of regulatory framework and/or quality assessment mechanisms need to be in place to ensure that such re-allocation is done appropriately and safely; and
4. Identify other key working groups in the broader human resources for health movement in order to ensure a broad consensus on how to move forward in further development of HRHH.

Findings, Discussions, and Deliberations

Presentations, discussions, and deliberations of the Human Resources for Humanitarian Health working group during the 2009 Humanitarian Action Summit covered a range of topics including core competencies, managerial staff, accreditation, regulation, and financing.[20]

Defining Tasks and Core Competencies

A necessary step toward planning and implementing task shifting in humanitarian settings is the development and definition of core competencies for humanitarian health workers. Competencies are overarching capacities, knowledge, or skills that allow humanitarian health workers to perform various necessary tasks in a range of settings. Definitions of core competencies in humanitarian health interventions would allow NGOs to better assess what capacities already exist on the ground, allowing them to focus on expanding local capacities. Internationally recognized competencies could be standardized across NGOs and can be used to frame career progression through lifelong learning.

The process for articulation of core competencies described in other disciplines provides guidance for humanitarian health human resources:

1. Define what we must know to be effective;
2. Review key documents;
3. Convene an expert panel to discuss findings;
4. Draft recommendations; and
5. Solicit feedback on recommendations from all stakeholders.

Managerial and Senior Staff

While much of the discussion around task shifting focuses on CHWs, cadres of highly trained health professionals also are important components of health systems that incorporate task shifting. Task shifting does not imply that responsibility is removed from higher-level workers. Rather, higher-level workers retain overall accountability and supervision of lower-level staff. Within a health system, there should be sufficient higher-level workers to select, train, and supervise the new cadres of workers including CHWs. This is a major challenge in emergency settings when there is a lack of higher-level staff. In the process of task shifting, the number of health workers will increase, and should be accompanied by appropriate scaling-up of higher-level staff. In humanitarian settings, and particularly early in emergencies, these workers often are expatriates who have worked globally in multiple countries.

Some health professionals seek career paths in humanitarian assistance, and the humanitarian community should create a clear career path for health workers who are successful in their roles. There should be opportunities for further education, status, and income. An appropriate curriculum and certification process should be developed to ensure that health workers in humanitarian settings are adequately trained in the core competencies required in their field. Overall human resource planning in humanitarian settings must provide opportunities for health workers trained in humanitarian settings to retain their skills and continue to work for the long-term.

Accreditation and Certification

Accreditation is less developed in the field of humanitarian health, where it faces some resistance. Professional associations frequently impose regulatory barriers, in part, because of concerns that new cadres may draw attention away from the necessary scale-up of highly qualified health professionals such as doctors and nurses. Some physicians resist Level-I task shifting out of concern that new workers will open private practices and create competition for physicians. There also are legitimate concerns about patient safety and quality of care, especially when task shifting is implemented in places underserved by the traditional medical establishment. For example, Level-II task shifting faces resistance and regulatory barriers because it involves shifting diagnostic and prescriptive privileges from physicians or non-physician clinicians to nurses, with the concern that nurses do not receive sufficient training to take on these tasks.[6] If task shifting is to be implemented, pre-service education must to be improved and expanded, and nurses must undertake further in-service training and continuing medical education to ensure the safety and quality of care. Strategic partnerships, especially with governments and professional associations, are important if new cadres are to be established and tasks shifted.[21] Steps also must be taken to adequately compensate workers for assumed additional workloads.

Some discussants suggested that local people trained by NGOs should have a standardized certification so that they can seek incorporation into the health system when the NGOs pull out or transition ownership to Ministries of Health. This certification can help the process of retaining skilled workers, and streamline re-training or refresher courses to ensure their continued utility to the needs of the population. If these certifications are internationally recognized, this also may allow these workers to apply their skills in other countries. A major question is who should or could set standards, accredit people, or credential programs for humanitarian health work. National bodies such as the National Board of Medical Examiners (NBME), the US Medical Licensing Examinations (USMLE), and the Accreditation Council for Graduate Medical Examination (ACGME) and their international counterparts may assist in this process and link humanitarian health to the larger world of assessment and discipline-building. Additional stages of professional field development might include regulation with international rather than state or national application.

Regulation

In order to guarantee the safety of both patients and staff, regulatory mechanisms must be developed to provide an

enabling and structuring environment for task shifting to occur. Regulation can be categorized into three levels:
Level I (Low)—This level includes cultural and social considerations, and often is driven by NGOs and other service providers. Usually, this level occurs when external regulation of expanded roles does not exist or when existing regulation is not enforced;
Level II (Moderate)—Government reacts to the absence or non-enforcement of regulation, and interacts with NGOs and service providers. While incremental changes occur, they are restricted to the internal operation of the Ministry of Health;
Level III (High)—The government takes a pre-emptive role in formulating regulatory policy, including key stakeholders such as the Ministry of Health, professional organizations, and other community interests.

Many potential approaches for regulation exist; however few governments have the capacity to support consistent, inclusive regulation, especially in conflict situations. While recognizing this limitation, the Working Group identified regulatory elements applicable to all levels, including supervision and mentoring, scope of practice competencies, standards of care, standard pre-service and in-service education and training, and licensing and certification.

Fair Compensation and Financing Issues
A critical component of the task shifting approach is the procurement of adequate financial support. Task shifting has effects on existing payment structures and cadres of health workers who should be fairly compensated for their work,[21,22] and the development of human resources in humanitarian settings requires substantial investment in salaries and compensation for health workers.

This applies particularly to the less trained CHWs, many of whom currently work on a voluntary basis. In humanitarian settings, these workers face tremendous personal and financial stress. By providing them with financial security, agencies can assist their workers in meeting their needs and responsibilities. Only with adequate compensation can workers reasonably be expected to take on the task of providing health services. Additionally, health workers require a safe workplace and adequate supplies to ensure their own safety and that of their patients. Also, as tasks are shifted to pre-existing health workers, financial considerations must be addressed. If workers develop an expanded repertoire of competencies, it should be expected that they receive appropriate compensation for their professional advancement.

At the systemic level, this requires the utilization of additional funding for human resources. International policies such as wage-bill caps by the International Monetary Fund (IMF) and World Bank (WB) that prevent Ministries of Health from recruiting and managing CHWs[5] must be changed. Ministries of Labor and Finance must be involved in the drafting of task shifting policies, since these policies will require major financial investments.

In many humanitarian settings, health services are dependent largely on foreign aid. Therefore, within the international donor community, support for human resource capacity building must be followed by funding commitments. Some mechanisms, such as the Global Fund, already are in place and should be used to bolster programs that require funding. Similarly, ensuring the continuation of funding streams for supporting human resources must be a major component of NGO exit strategies and long-term planning in post-conflict and post-disaster settings.

The development and maintenance of an effective health workforce exposes the false dichotomy between relief and long-term development. Task shifting provides a pertinent example of the potential for humanitarian initiatives to contribute to sustainable programs by not only allowing for the short-term scale-up of health capacities in emergency settings, but also fostering long-term improvements in health outcomes. A vast majority of humanitarian workers are indigenous to the communities in which they work. As NGOs train local health workers in humanitarian settings, they build local capacity for long-term improvements in health. Donor support for building task shifting mechanisms and human resource development in humanitarian settings could provide an attractive incentive for countries to adequately invest in their local capacity.

Thus, human resources in humanitarian settings provide an important opportunity for achieving objectives such as the MDGs—a fact that must not be overlooked by the donor community. Great progress can be made toward achieving the MDGs by prioritizing development in fragile states that are home to a substantial proportion of the world population and some of the most vulnerable people with the poorest health outcomes.

Examples of Task Shifting Programs in Humanitarian Settings
Little data exist on how task shifting currently is practiced in the field by humanitarian health organizations, and many questions still exist as to what extent task shifting should be employed; when it works; factors for success; and methods for scaling up. While the literature reveals few examples of task-shifting in humanitarian settings, several examples were raised and discussed at the Humanitarian Action Summit. These initiatives indicate that in humanitarian settings, health outcomes can be improved at lower cost through the use of new cadres of health professionals. These included the training of mid-level Medical Assistants in Southern Sudan, the creation of a new cadre of Lady Health Workers in Pakistan, and the extension of primary health initiatives in Ethiopia through Health Extension Workers. These programs demonstrate that non-physician clinician models can be feasibly implemented to increase access to complex health interventions in settings of extreme violence and poverty. Non-physicians and CHWs can extend the reach of healthcare, expanding social and economic protection for the poor and those displaced by violence.

The most prominent example discussed was that of Tiyatien Health (TH), an NGO operating in partnership with the Liberian government that provides free health services in post-conflict southeastern Liberia. Funded by the Global Fund, Tiyatien Health and the Liberian government initiated the HIV Equity Initiative (HEI) to delivery comprehensive HIV services in Tchien district. Prior to the HEI, ART only could be administered by physicians in Liberia. At that time, no rural health clinic was delivering

ART. Tiyatien Health trained the first Liberian non-physician clinicians to provide ART integrated within a Chronic Care Clinic, and focused on primary care for other complex diseases, such as hypertension, heart failure, and depression/substance abuse. They employed CHWs to provide directly observed ART, a constant link to the health center, and psychosocial support. The use of CHWs were associated with improved survival for patients on ART at 12 months, and programs utilizing task-shifting to CHWs have shown better outcomes than have other projects piloted in Liberia that do not use CHWs. Tiyatien Health demonstrates that in post-conflict settings, some of the known barriers to task shifting, such as government regulations and lack of trained staff, can be overcome.

Global Health Workforce Alliance

When considering the strategies for addressing the issues discussed thus far, it is important to consider how to engage the necessary national and international stakeholders. Humanitarian crises do not occur in vacuums, rather they take place in countries that have established rules, regulations, training schemes, and professional organizations, as well as a unique history of health care in that country. In order to effectively introduce new strategies for healthcare provision in times of emergency, humanitarian health agencies must work during peace-time with a wide array of stakeholders to come to a consensus on how such changes can be made and broadly accepted. Such stakeholders include governmental authorities, professional organizations representing various health professions, ministries of education, as well as international organizations and UN agencies. The HRHH Working Group has been exploring partnership with larger bodies that can influence high-level policy changes and engage with the wide range of stakeholders involved in human resource development.

The response to the global health worker crisis has been spearheaded by the Global Health Workforce Alliance,[20] launched in May 2006. The GHWA is hosted by the WHO under an independent governance body, bringing together groups of experts to develop a range of standards, opportunities, and policies to increase the capacity and professionalism of the global health workforce. The GHWA brings stakeholders together to enhance several approaches: advocacy efforts for mobilizing financial resources and promoting understanding of human resource issues; knowledge brokering by collecting and sharing evidence of good practice; and monitoring the effectiveness of interventions.

The Global Health Workforce Alliance provides an ideal forum to further explore the issue of human resources in humanitarian health. The HRHH Working Group is eager to marry its efforts with the Alliance, and investigate how best to assist the organization to ensuring that its vision to "advocate and catalyze global and country actions to resolve the human resources for health crisis"[20] is achieved in humanitarian crises.

Conclusions

Deliberations at the 2009 Humanitarian Action Summit led to several points of consensus and disagreement.

Overarching Themes

1. The human resources challenges facing the field of humanitarian health are part of a global health workforce crisis.
2. Addressing human resource challenges in humanitarian settings are critical for achieving the MDGs.

Task Shifting

1. Task shifting can be an appropriate strategy for addressing human resource limitations and building local capacity in humanitarian settings, and preliminary reports on the use of this strategy from post-conflict settings suggest that task shifting improves health outcomes.
2. Task shifting can have a fundamental role in building long-term local capacity for health services by connecting emergency humanitarian efforts with long-term development goals.
3. Several major challenges exist for implementing task shifting strategies, particularly policies of national governments and professional organizations that limit the tasks that certain health worker cadres can assume, and the lack of sufficient resources for compensating health workers.

Steps to be Taken

1. Steps should be taken toward developing core competencies for humanitarian health workers as an integral component to developing the humanitarian health professions and facilitating task shifting. This would begin by identifying the key tasks in humanitarian health settings.
2. Efforts should be made to clarify a career path for health professionals seeking careers in humanitarian health, including supervisors and international staff.
3. Task-shifting strategies must incorporate mechanisms for regulation.
4. Health workers at all levels of the health system, should be fairly compensated for their work.
5. Donors must scale-up their funding of health personnel in order to build local health capacities.

Key Points of Disagreement

1. There is disagreement on the level of accreditation or certification that should be implemented for humanitarian health workers. On one hand, developing credentialing systems would allow for standardization of skills and avoidance of unnecessary re-training. On the other hand, core competencies for humanitarian health workers have not yet been defined and credentialing systems may impose further barriers to short-term capacity building through task shifting.
2. There is disagreement over how NGOs and Ministries of Health should interact in humanitarian settings, in part due to the wide variation in capacities of these organizations in different situations. There is no clear agreement on when and how health services established by NGOs should be transferred to local governments, or whether other systems, including private health systems, should be incorporated into these efforts.

Recommendations

1. Task shifting should be considered by NGOs and governments involved in planning and coordinating health services in humanitarian settings.
2. Countries should seek to collect data on the skills and distribution of their health workforce.
3. Stakeholders should define core competencies of humanitarian health workers and guidelines for how these competencies can be adopted by different cadres.
4. Training programs for humanitarian health workers should reflect the core competencies required for their work.
5. Higher-level workers must be incorporated into health systems to provide support and supervision for the expanded workforce.
6. Wage-bill caps imposed by International Funding Institutions that prevent Ministries of Health from recruiting and using CHWs must be removed or modified to create an enabling environment for task shifting in settings in which health workers are civil servants.
7. Ministries of Health, Ministries of Finance, and Ministries of Labor all should be involved in the task-shifting planning processes.
8. Field-level workers also should be involved in the development of task shifting policies and processes.
9. The NGOs, Ministries of Health, and other actors should fairly compensate all health workers.
10. The NGOs should develop the mechanisms for drawing on local skills and expertise without removing practitioners from their existing positions and alienating them from their previous agencies. For instance, payroll should be conducted in a way to avoid drawing people out of the existing health system.
11. To increase donor support of task shifting and other human resource development strategies, the narratives of local health workers who have benefited from their incorporation into health systems and the patients who have benefited from their work should be provided by NGOs and other actors to funding organizations.
12. Feedback mechanisms should be created to ensure that knowledge gained from CHWs is incorporated into programming activities.

Suggested Strategies

In order to advance the recommendations listed above, create an enabling environment for the further development and refinement of task-shifting strategies, and promote the implementation of effective and appropriate task shifting practices, the HRHH Working Group commits itself to the following roadmap for action:

1. Attempt to estimate the overall size of the humanitarian workforce as well as the number of organizations, countries affected and the potential population served. This more clearly will identify the scope of the impact of any human resources intervention;
2. Explore partnerships with other key stakeholders, including international health professional organizations, the UN health cluster, and the Global Health Workforce Alliance;
3. Assess training curricula in the existing international training programs for humanitarian workers as well as the protocols of humanitarian health agencies in order to identify key tasks for which competencies can be developed;
4. Seek to identify donors willing to support pilot projects to expand HR capacity in humanitarian health programs and develop a proposal for such a pilot;
5. The findings of the recently conducted survey on task shifting conducted by the Working Group will be published to illustrate the state of current knowledge, attitudes, and practices regarding task-shifting in the humanitarian health community; and
6. While these objective data may provide support of the idea that task shifting can be a potentially beneficial human resources strategy for humanitarian health agencies, the Working Group also will seek compelling case studies of successful task shifting in humanitarian health settings both to develop best practices as well as highlight narratives that can better illustrate the benefits of such strategies to policy-makers.

2009 HR Working Group

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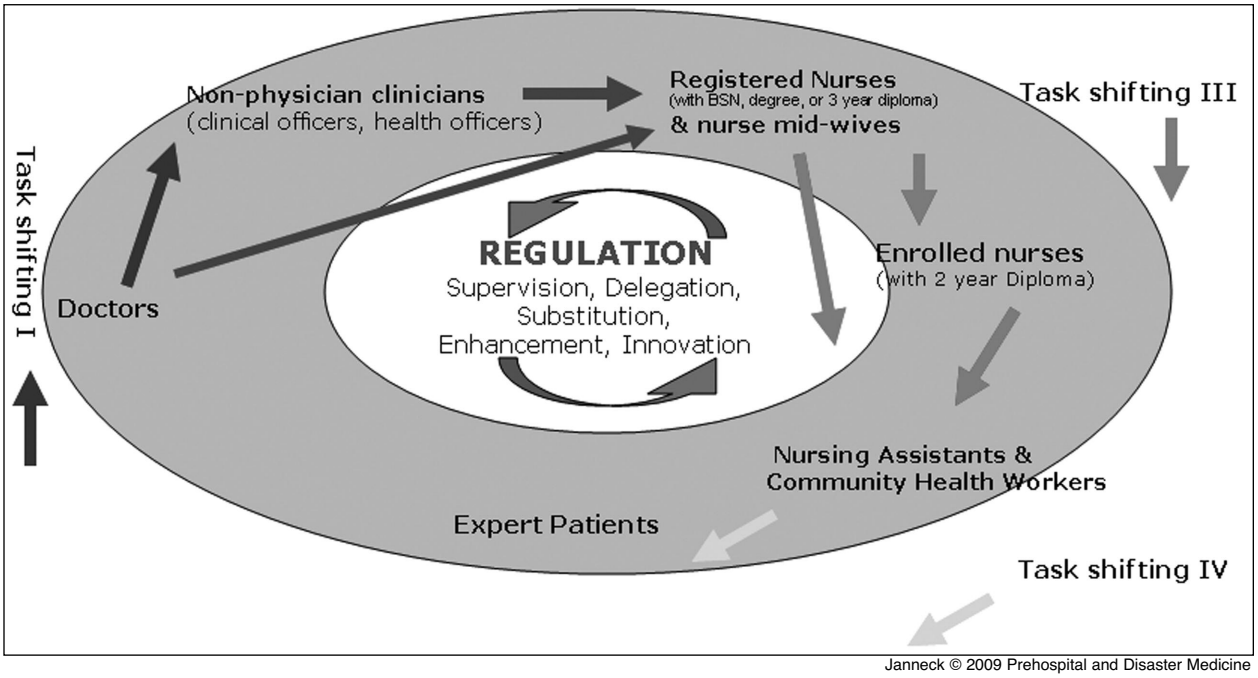
Appendix 1—Six main strategies of the Kampala Declaration

1. Building coherent national and global leadership;
2. Scaling up education and training;
3. Managing pressures of the international health workforce market and its impact on migration;
4. Retaining an effective, responsive and equitably distributed health workforce;
5. Securing additional and more productive investment in the health workforce; and
6. Ensuring capacity for an informed response based on evidence and joint learning.

Appendix 2—Types of task shifting



Appendix 3—Survey questionnaire (TB = tuberculosis)

1. Have you worked for or with a humanitarian health agency within the past 5 years (including consultancies)?
   Yes No

2. Are you over the age of 18 years?
   Yes No

3. For what type of organization do/did you work?
   Ministry of health/local government services National non-governmental organization
   International non-governmental organization Faith-based organization Other

4. Does/did your organization provide services in the following phases of health response to crisis? (Mark all that apply.)
   Emergency response (emergency or during conflict) Transitional response (immediate post-emergency)
   Post-emergency / post-conflict (long-term health response)

5. What is/was your position within the organization?
   Health officer Human resources officer (involved in hiring for health services) Program director
   Other

6. What type of services does/did your organization primarily provide? (Mark all that apply.)
   Maternal child health Reproductive health Nutrition
   Disease specific services (HIV/AIDS, TB, Malaria, other communicable diseases) Mental health services
   Medical supplies and logistics Primary emergency response Other

7. For the above services, which type of worker is/was primarily used for service provision?
   Types of workers:
   Physicians Clinical health officer Nurses or Nurse Midwives Community Health Workers
   Other Non-Health Trained Personnel
   Services:
   Maternal child health Reproductive health Nutrition
   Disease specific services (HIV/AIDS, TB, malaria, other communicable diseases) Mental health services
   Medical supplies and logistics Primary emergency response Other

8. Does/did your organization currently employ a strategy of task shifting to increase the number of available health workers?
   Yes No

9. Which of the following services do you feel is most amenable to task-reallocation/task shifting?
   Maternal child health Reproductive health Nutrition
   Disease specific services (HIV/AIDS, TB, malaria, other communicable diseases) Mental health services
   Medical supplies and logistics Emergency health services

10. What do you believe is the greatest obstacle to using task-reallocation/task-shifting in your organization?
    Insufficient number of trained personnel to which tasks can be shifted (e.g., paramedical staff, community health workers, expert patients)
    Insufficient number of trainers who can train other staff to do health tasks
    No structured curriculum or training manual for task shifting
    Government regulations do not currently permit task shifting
    Our organization has no policy or plan for task shifting
    Lack of funding for task shifting
    Perception that task shifting will result in compromised quality safety of care
    Stigma associated with task shifting

11. Have you observed "informal" [without policy in place] task shifting in health emergencies?
    Yes No

12. If quality and safety of care could be ensured and necessary funds were put in place, would you want to see task shifting developed and implemented for your organization as a means of increasing access to health services?
    Yes No