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African Health Community

TASK SHIFTING IN SWAZILAND: CASE STUDY

FEBRUARY 2010

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EXECUTIVE SUMMARY

Countries in the East, Central and Southern Africa (ECSA) region realize that attaining universal access to HIV prevention, treatment, care, and support by 2010 and achieving the Millennium Development Goals by 2015 require radical changes in human resource policies and manpower development and retention strategies. At the same time, country health officials must use effective task shifting to help alleviate shortages of skilled manpower. Task shifting already is being implemented in the ECSA region to varying degrees. Administrators at the East, Central and Southern Africa College of Nurses (ECSACON) realize the importance of understanding country-specific policies, regulations on task shifting, health worker attitudes, preferences, required skills, and possibly using new types of workers who can help to reduce health manpower deficiencies, as well as the budgetary implications. All of these factors will affect scale-up of task shifting.

As a result, the East, Central and Southern African Health Community (ECSA-HC) commissioned and the USAID | Health Policy Initiative, Task Order 1 funded a case study on task shifting in the health sector in Swaziland. The objectives were to (1) understand the policy and programmatic implications of task shifting in relation to the current roles, responsibilities, and workloads of health workers (especially nurses) within the context of providing high-quality HIV care, treatment, and support services; (2) understand the policy and programmatic implications of task shifting related to using community-based health workers and/or people living with HIV to provide HIV peer counseling and related services; and (3) assess the attitudes and perceptions of health workers regarding task shifting.

The ECSA-HC consultant used a qualitative methodology for the situational analysis. The main part of the case study involved structured interviews with key informants relevant to the health sector, including policymakers and development partners and those from professional associations and regulatory bodies. The consultant also collected data through focus group discussions (FGDs) with health workers at health institutions; 86 health workers participated in these discussions. The group comprised samplings from all six Swaziland hospitals and three of the country's health centers. The ECSA-HC consultant collated and analyzed information from all sources. A summary is provided in this report.

Key Findings

Although Swaziland has not formalized task shifting through an official policy framework, it is occurring at both the institutional and community levels. Existing policies, guidelines, and strategic plans provide for task shifting at both levels as part of their guiding principles; these include the National Multisectoral HIV and AIDS Policy (MOHSW, 2006b), the National Multisectoral Strategic Framework for HIV and AIDS (MOHSW, 2009a), Prevention of Mother-to-Child Transmission of HIV–Operational Plan (2007–2011) (MOHSW, 2006c), HIV Testing and Counseling National Guidelines (MOHSW, 2006a), and the National Tuberculosis Strategic Plan (MOHSW, 2009b). For example, the HIV national policy calls for the inclusion of people living with HIV and other vulnerable groups in all aspects of HIV prevention, treatment, and care, while the HIV strategic plan supports strengthening the capacity of community-based care providers. While these documents provide some guidance about shifting certain job functions, there is no official policy framework to create an enabling and supportive environment for task shifting.

Findings show that the concept of task shifting is well understood by the Ministry of Health and Social Welfare (MOHSW), as demonstrated by the health system's spontaneous shifting of some tasks from one category to another in response to the workload created by the HIV epidemic and the high co-infection rates of HIV and tuberculosis (TB). The limited number of doctors at health institutions (1 doctor to 10,000 people) (MOHSW, 2008) often leaves nurses with no choice but to carry out tasks that normally would be done by a medical doctor. Yet, as doctors have shifted tasks to nurses, nurses have been unable to shift to lower levels of staff because there are no guidelines available. As a result, nurses find

themselves overloaded as they perform tasks in their original job descriptions as well as those shifted to them by doctors.

In the discussions, most health workers expressed appreciation of the role community workers play in community mobilizing for the prevention of mother-to-child transmission (PMTCT), HIV education, treatment adherence, nutrition support, tracing TB defaulters, TB directly observed treatment short-course (DOTS), home-based care, the expanded program for immunization (EPI) activities, and family planning. As these workers are part of the communities they serve, they are accepted and are available locally to respond to problems that may arise. Health workers interviewed, including doctors and nurses, expressed willingness to shift some health activities to community workers if these workers were well trained and supervised for the services they provided. The types of community workers mentioned included rural health motivators, expert clients, and lay counselors.

Most health workers acknowledged that task shifting can enhance the quality of patient care as professionals are able to shift tasks that otherwise can be done by non-health workers, leaving the professionals with those tasks that bring about the most desired patient care outcomes. Such shifting allows for supervision, training, mentoring, and monitoring of junior staff. In addition, accountability is improved when officials create clear job descriptions, also reducing the burnout and stress that result from huge workloads, especially for nurses. However, health workers recognized the need to plan and implement task shifting carefully. Also, to track quality along the continuum of care provided through task shifting, officials need to institute quality assurance frameworks, including standardized training, supportive supervision, certification, and regular assessments.

Summary and Lessons Learned

The following lessons were learned about the informal task shifting activities in the Swaziland health sector:

- To date, task shifting is occurring informally in this country due to shortages in human resources for health (HRH).
- Where there has been a structured introduction of task shifting to staff and community workers, they are well prepared, supervised, and mentored and monitored. Those interviewed mentioned that as a result of mobilization by community workers, communities have reported positive results, including increased uptake of PMTCT services, increased EPI coverage, and a reduction in the number of TB treatment defaulters.
- Without formal quality assurance frameworks—standardized training, supervision, certification, and regular assessment—officials cannot clearly assess the quality of care being provided through task shifting. Conflicts arise and tasks are neglected in cases where there is continued overlap between job descriptions due to lack of communication among the health workers whose job descriptions overlap.
- Key informants and FGD participants mentioned that where community health workers have been very active in carrying out their duties of advocacy, motivation, promotion, and care, the link between clinics and communities has been strengthened, resulting in clear upward and downward referrals of patients.
- For the majority of healthcare services, nurses continue to be overloaded. With fewer medical doctors at health institutions, nurses must carry out their own tasks as well as those normally performed by doctors. In addition, while doctors have managed to shift certain tasks to nurses so as to reduce their own workloads, nurses have shifted only a few tasks to others.

Recommendations

Based on discussions with stakeholders during key informant interviews and focus group discussions, the following recommendations for moving the task shifting process forward in Swaziland were identified:

- The MOHSW should identify a focal senior manager to provide leadership for the task shifting process in-country. Such leadership would include developing a concept paper on task shifting, conducting sensitization and consensus building with stakeholders in support of task shifting, and leading efforts to draft a task-shifting strategy.
- To assist with these efforts, the MOHSW should establish a working group or task force to help it think through task shifting; the group or task force could include representatives of regulatory bodies, facility managers, health professional associations, training institutions, and other implementing partners. The task force should design policies and regulations to foster an enabling environment for task shifting, including developing a time-bound implementation plan.
- Coordination, planning, implementation, and monitoring of task shifting activities need to be strengthened at all levels. The capacity of clinics for coordinating, supervising, and monitoring task shifting activities at the community level should be strengthened as clinics form links between the healthcare system and the community.
- An assessment to determine the HRH staffing needs for particular health services should be undertaken. One way of determining this information is through the use of a computer-based model, such as the Staffing Needs Module of the Goals Model.
- The MOHSW should recruit qualified human resource personnel in all regions to attend to human resource staff issues promptly. Addressing these issues is especially important given the growing demands on personnel officers as more health workers are recruited into the service.
- The MOHSW needs to facilitate the improvement of recruitment processes and procedures for nurses graduating from nursing colleges—which will help to reduce the time between the points when nurses complete their courses and when they enter the health service. Recruitment can also be accelerated by instituting practicums and placements before nursing students graduate, so that they can become familiar with the facility at which they will be working, and the facility can accelerate the recruitment process while the nurse is completing training.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ART	antiretroviral treatment
DOTS	directly observed treatment short-course
ECSA	East, Central and Southern Africa
ECSACON	East, Central and Southern Africa College of Nurses
ECSA-HC	East, Central and Southern Africa-Health Community
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EPI	expanded program of immunization
FGD	focus group discussion
GNI	gross national income
HIV	human immunodeficiency virus
HRH	human resources for health
HRIS	human resource information system
MDG	Millennium Development Goal
MOHSW	Ministry of Health and Social Welfare
MSF	Medicines San Frontières (Doctors without Borders)
NGO	nongovernmental organization
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
RHM	rural health motivator
TA	technical assistance
TB	tuberculosis
TTR	Treat, Train, and Retain
UNAIDS	United Nations Joint Program on HIV/AIDS
USAID	United States Agency for International Development
WHO	World Health Organization

INTRODUCTION

Most African countries face considerable human resource constraints within their health systems. This challenges a country's ability to address the HIV epidemic effectively and reach global and national universal access targets for HIV prevention, treatment, care, and support by 2010. Many countries also have recognized that universal access to HIV services will not be attainable without strengthened health systems, including a significant expansion of the health workforce. Most countries in Africa have lost a huge number of health professionals—through internal and external migration as these professionals seek better employment opportunities and as a result of AIDS-related deaths among health workers.

In 2006, the World Health Organization (WHO), in collaboration with health development partners and national authorities, developed a plan to tackle the health workforce problems through a new initiative, commonly known as "Treat, Train, Retain" (TTR). TTR is based on the following three principles: (1) preventing and treating HIV infection among health workers; (2) training and expanding the health workforce; and (3) developing retention strategies to reduce exit rates from health services (WHO, 2007b).

Box 1. Definition of task shifting

"Task shifting is the name given to a process of delegation whereby tasks are moved, where appropriate, to less specialized health workers. By reorganizing the workforce in this way, task shifting presents a viable solution for improving healthcare coverage by making more efficient use of the human resources already available and by quickly increasing capacity while training and retention programs are expanded."

—WHO/PEPFAR/UNAIDS, 2008

Task shifting (Box 1) occurs when specific tasks are shifted from highly qualified health professionals to health workers who require less training and fewer qualifications so they can fill in the critical manpower shortages that prevail in most resource-constrained countries. Although TTR is a new concept, some of its elements, such as task shifting, already are operational in a number of countries in the region, particularly to retain health workers (WHO/PEPFAR/UNAIDS, 2008).

Countries in the East, Central and Southern African (ECSA) region realize that attaining universal access to HIV prevention, treatment, care, and support by 2010 and the Millennium Development Goals (MDGs) by 2015 require radical changes in human resource policies and manpower development and retention strategies. At the same time, health officials must use effective task shifting in those countries most affected by the loss of health professionals. Task shifting already is being implemented in the ECSA region in varying degrees. The USAID | Health Policy Initiative, Task Order 1 and the ECSA-Health Community (ECSA-HC) with the ECSA College of Nursing (ECSACON) collaborated to conduct case studies on task shifting in Swaziland and Uganda to better understand country-specific policies, regulations on task shifting, health worker attitudes, preferences, required skills, what new types of workers can be brought into the workforce to reduce health manpower deficiencies, and budgetary implications.

Country Selection: Swaziland and Uganda

Swaziland and Uganda[1] were selected for in-depth case studies on task shifting for several reasons. Many ECSA human resources for health (HRH) activities are ongoing in Swaziland through the Southern African Human Capacity Development Coalition, which provides a good entryway for task shifting. As a country, Swaziland is ready to adopt task shifting. Swaziland health officials attended the meeting for the Adaptation of Task Shifting Guidelines, convened by WHO in Harare, Zimbabwe, on November 4–7, 2008. The ECSA region was represented by ECSACON. At this meeting, the Swaziland participants

[1] See East, Central, and Southern African Health Community (ECSA-HC). 2010. *Task Shifting in Uganda*: *Case Study*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

developed a Plan of Action for task shifting, as reflected in Annex C. However, when the interviews for this case study were conducted in April 2009, implementation of this plan had not yet begun.

Task shifting already has begun in Uganda and its experience informed the WHO/U.S. President's Emergency Plan for AIDS Relief (PEPFAR)/Joint United Nations Program on HIV/AIDS (UNAIDS) global recommendations and guidelines on the topic (WHO/PEPFAR/UNAIDS, 2008). In addition, the U.S. Agency for International Development (USAID) supports other related activities in Uganda, such as the development of human resource information systems (HRIS) through the Capacity Project, which has synergies with task shifting.

Geography also played a part in country selection. To obtain as much information as possible about task shifting in the ECSA region, one country was selected from the northern part of the region (Uganda) and another from the south (Swaziland). Officials from both countries were able to identify ECSACON focal points that played a vital role in implementing the studies. The information and lessons learned from the case studies are expected to guide the scale-up of the task shifting strategies in other countries in the ECSA region where applicable.

BACKGROUND

Country Profile

Swaziland is a landlocked country, with an estimated land area of 17,364 km² (approximately the size of New Jersey). It shares borders with South Africa in the south, north, and west, and Mozambique in the east. Its estimated population is 1.1 million (World Bank, 2006), with the majority of the population residing in rural areas and only 23 percent residing in urban areas. The population is also relatively young; an estimated 69 percent of the population is under 25 years of age. Infant, child, and maternal mortality remain high, and few people have access to a trained health professional (see Table 1). The country is divided into four administrative regions—Hhohho, Manzini, Lubombo, and Shiselweni—and is further subdivided into 55 constituencies (or *Inkhundla*) for political purposes, with each *Inkhundla* having its own administrative center. The country is facing acute and increasing levels of poverty, persistent drought, and food insecurity. Unemployment is also high, with almost one-third of the economically active population unemployed. Official figures place the unemployment rate at 29 percent (MOHSW, 2006b), while some anecdotal sources estimate the rate to be as high as 40 percent (Thompson, 2005). Youth are the hardest hit, with an unemployment rate of 60 percent (MOHSW, 2006a). Swaziland faces a severe shortage in HRH. In 2004, 44 percent of posts for physicians, 19 percent of posts for nurses, and 17 percent of posts for nursing assistants were vacant (Kober and Van Damme, 2006). This situation may be worse today due to emigration and attrition of health workers, as well as AIDS-related deaths in the health sector.

Table 1: Swaziland demographic and health profile

Total population	1.1 million
Population growth (annual)	0.6%
Life expectancy at birth	40.8 years
Youth female literacy rate (females ages 15–24 years)	89.8%
Gross national income (GNI)	US$2.8 billion
GNI per capita, Atlas method	US$2,450
HIV prevalence (population ages 15–49 years)	26.1%
Total fertility rate (lifetime births)	3.8
Contraceptive prevalence	50.6%
Contraceptive prevalence—modern methods (married women ages 15–49)	47.7%
Infant mortality rate	85 per 1,000 live births
Under-5 mortality rate	120 per 1,000 live births
Maternal mortality ratio	482 per 100,000 live births
Population with access to improved sources of water (rural and urban areas)	75.5%
Rural population with no toilet facilities	25.6%
Doctor population ratio	10 per 100,000 population
Nurse population ratio	56 per 100,000 population
Midwife population ratio	64 per 100,000 population

Sources: World Development Indicators 2006 for demographic indicators. Swaziland Demographic and Health Survey 2006–2007 and the National Health Sector Strategic Plan 2008–2013: Final Draft.

The Burden of HIV in Swaziland

Swaziland has the world's highest adult HIV prevalence rates (26.1% among those ages 15–49) (see Table 2) and one of the highest TB/HIV co-infection rates (80%) (Médecins Sans Frontières, 2008). The Government of Swaziland has demonstrated a high level of political commitment to addressing the HIV epidemic. The Swaziland National AIDS Program was established in 1987. In 1999, the King of Swaziland declared HIV to be a national disaster and established an HIV and AIDS Cabinet Committee to coordinate the country's response to the epidemic. In view of the need to involve all stakeholders in the national response to HIV, in 2006, the government developed the National Multisectoral HIV and AIDS Policy to provide the framework, direction, and general principles for interventions and also established the National Emergency Response Council on HIV and AIDS to coordinate and facilitate the national multisectoral response to the epidemic.

Table 2: Swaziland HIV and AIDS indicators

Number of people living with HIV by the end of 2007	170,000
Adults (ages 15–49 years) living with HIV by the end of 2007	26.7%
HIV cases among women ages 15–49 years by the end of 2007	59%
Number of children (0–5 years) living with HIV by the end of 2007	15,000
Number of AIDS-related deaths in 2007	10,000

Source: UNAIDS 2008. *Report on the Global AIDS Epidemic.*

Study Objectives

The main objectives of the case study were to increase the understanding of

- The policy and programmatic implications of task shifting in relation to the roles, responsibilities, and workload of health workers (especially nurses) within the context of providing high-quality HIV treatment, care, and support services;
- The policy and programmatic implications of task shifting in the utilization of community-based health workers and/or people living with HIV (PLHIV) to provide HIV peer counseling and related services; and
- The attitudes and perceived needs of health workers about task shifting.

Methodology

This case study used a primarily qualitative methodology, comprising a literature review, interviews with key informants, and focus group discussions (FGDs) with health workers. Interviews for the case study were conducted in May 2009.

Study Sample

Of the 154 total health facilities in Swaziland, nine were selected for this study: the central hospital, the five regional hospitals, and three health centers (see Table 3). The five regional hospitals included three government and two mission hospitals. The health centers were selected using a convenience sample because they offered HIV prevention, treatment, care, and support.

Table 3: Health institutions where FGDs were conducted

Hospitals	Health Centers
Piggs Peak Government Hospital	Dvokolwako
RFM Mission Hospital	Sithobelweni
Good Shepherd Mission Hospital	Nhlangano
Mankanyane Government Hospital	
Hlatikhulu Government Hospital	
Mbabane Government Hospital	

Focus Group Discussions

In addition, the consultant facilitated FGDs with teams of health workers (e.g., doctors, nurses, laboratory technologists, and others) to find out whether officials were implementing task shifting in health institutions and at the community level and to determine health workers' views on task shifting. FGDs were not conducted by cadre type, as it was not possible to pull groups of nurses, doctors, or other health workers aside for the duration of the FGD. As such, FGDs included teams of various health workers from a given health facility. A total of 85 health workers, including doctors, matrons, nurses, pharmacists, laboratory technicians/technologists, facility administrators, physiotherapists, and dental hygienists, participated in nine FGDs held at the selected facilities (see Table 4). Annex B presents the full list of FGD participants by facility.

Table 4: Categories of FGD participants

Doctors	9
Nurses (including matrons)	64
Pharmacists	3
Laboratory technologists	3
Hospital administrators	2
Physiotherapists, anesthetists, radiotherapists, and dental hygienists	4
Total	**85**

Key Informant Interviews

In consultation with the Ministry of Health and Social Welfare (MOHSW), the consultant chose key informants from groups of MOHSW policymakers, development partners, professional organizations, and regulatory bodies. The consultant interviewed 21 key informants to obtain their views on task shifting in the health sector (see Annex A).

Study Limitations

This study used a convenience sample and so cannot be considered representative of health facilities in Swaziland—though the findings can help illuminate the challenges faced by health personnel. The study collected information on the attitudes and perceptions of healthcare providers. While PLHIV have important roles to play in task shifting, the consultant did not include either PLHIV or community workers, as the MOHSW did not allow for them to be interviewed as key informants or as FGD participants.

CASE STUDY FINDINGS

Understanding Task Shifting

While the term "task shifting" was not used by many health workers in Swaziland, the concept was well understood, as demonstrated by the health system's spontaneous shifting of some tasks from one category of workers to another in response to the workload created by the HIV epidemic and the high co-infection rates of TB and HIV. The MOHSW reports that medical doctors in Swaziland have been migrating to neighboring countries, including South Africa, or beyond in search of better working conditions. Some doctors are reported to have left for training but decide not to return to Swaziland. This migration has been taking place for many years but has increased in recent years. The reduced number of doctors at health institutions has left nurses with no option but to carry out tasks that normally would have been performed by a doctor. Yet, as doctors have shifted tasks to nurses, nurses have been unable to shift tasks to lower levels of staff because no guidelines are available. As a result, nurses find themselves overloaded as they perform tasks in their original job descriptions as well as those shifted to them from doctors.

Most respondents felt that the task shifting currently taking place informally is not reversible because health manpower shortages cannot be resolved overnight. Key informants and participants in FGDs indicated that task shifting should be formalized and institutionalized. The respondents also felt that officials should develop parallel strategies to address health worker shortages. Suggestions from the respondents for addressing human resource shortages included the following:

- Recruiting, training, and retaining more professionals, including those trained in-country (i.e., nurses) and those trained outside of the country (i.e., doctors, technologists, and pharmacists)
- Offering attractive remuneration packages to lure professionals who have left the country to pursue better offers
- Attracting retired professionals in-country, as they have a great deal of experience and are familiar with the systems
- Accelerating civil service recruitment
- Improving working conditions (i.e., opportunities for recognition, continuing education, etc.) for all staff, which would lead to better staff retention

Respondents said that, for task shifting to be effective, categories of workers to whom new tasks will be shifted will need supervision, mentoring, and monitoring by professionals. Nurses, who usually will be expected to supervise any new personnel, already are over-burdened due to human resource shortages. Introduction of new cadres (see Box 2) into the health system to alleviate manpower shortages is ongoing and they receive brief training. All of these new cadres are on stipends or salary from either the government or partners. Box 3 describes the experiences of an HIV-positive woman who became a lay counselor, or "expert client."

Box 2. Examples of new cadres of staff being introduced into the health system

- Lay counselors trained for six weeks in rapid HIV testing and counseling
- TB treatment support buddies (i.e., former TB patients recruited and trained on community TB management and support)
- TB defaulter tracers
- Malaria and TB microscopists also trained as phlebotomists
- Cough monitors (i.e., pick up possible cases in queues to isolate them and minimize transmission)
- PLHIV selected as "expert clients" (i.e., enrolled in and have shown good adherence to treatment and care services) by health teams to follow up with PLHIV in the community
- HIV-positive mothers who have benefited from PMTCT programs to support new HIV-positive mothers

Box 3. Experience of a PLHIV expert client

Sibusisiwe (not her real name) is an expert client who has volunteered at a government hospital-based voluntary counseling and testing program for five years. She believes that she has made a great impact in encouraging treatment adherence among patients and encouraging people to be tested for HIV. Sibusisiwe is an outspoken mother of four and grandmother of one and she is HIV positive. She believes that she is in a better position to counsel and reassure patients as someone who has had similar experiences. She explained that people are motivated by listening to someone like her who openly shares her HIV status and is living positively because this person becomes a role model. In this way, others can see first hand that those living with HIV can still lead positive and fruitful lives. In Sibusisiwe's opinion, using expert clients is very effective, because there is better understanding between "us and patients because we are both in the same boat." Sibusisiwe is proud that of all the people she has counseled who tested HIV positive, none have ever come out crying. She attributes this to the fact that she shares practical experiences with them and makes them feel that there is life after testing positive.

Facilitators of Task Shifting

Respondents identified the following as facilitating factors for task shifting.

At the policy level

- Developing policies and regulations to support a conducive and enabling environment for task shifting.
- Establishing a task shifting working group or task force to assist the MOHSW in developing a time-bound implementation plan for the task shifting process.
- Identifying a focal senior manager in the MOHSW to provide leadership for the Task Shifting Strategy. The focal person will be expected to keep the process moving forward and share relevant information with stakeholders.
- Sensitizing and consensus building with all stakeholders, policymakers, employees and their regulatory bodies, professional associations and partners, and communities at all levels is paramount to foster ownership and cultivate a feeling of belonging.
- Conducting targeted assessments to collect information to inform the process.
- Developing the coordination and planning strategy necessary to move the task shifting process forward with the involvement of all relevant stakeholders.

At the operational level

- Revising job descriptions as the current ones become obsolete. Many roles have been added and others have been transferred to other levels, yet these changes have not been reflected in current job descriptions.
- Developing and standardizing criteria to select new cadres of health workers; training curricula; and supervision, mentoring, and monitoring and evaluation tools (including creating quality assurance standards to monitor the quality of services provided).
- Training new and retraining existing health workers to prepare them for additional responsibilities.
- Carefully selecting the tasks to be shifted; it is important to avoid shifting tasks in such a way that the new health worker cadres receiving the tasks will be placed in roles beyond their capacity. Overloading health workers through task shifting should be avoided, as this is likely to render them ineffective.

- Developing clearly defined coordination and referral systems at the regional level to improve patient care by ensuring that less qualified cadres can refer patients or cases they cannot manage to a higher level of care.

Barriers to Task Shifting

Respondents identified the following as potential barriers to task shifting.

At the policy level

- The absence of policies and regulations on task shifting means that health-related tasks are being shifted without official policies or regulations.
- Lack of government preparedness for financially supporting task shifting, even though officials view the strategy as necessary.
- Lack of coordination and planning involving all of the departments and partners key to supporting the new strategy.
- Undefined career paths, compensation, and recognition of new cadres and standardization/certification of these cadres, especially home- and community-based healthcare workers or any newly developed cadres.

At the operational level

- Clarity in tasks to be shifted—often tasks are shifted beyond the capacity of the cadre delegated to the work.
- Preparedness—no formal training or certification plans are in place.
- Management—poor supervision, mentoring, and monitoring could result in poor performance by the service providers, which could in turn discredit the entire task shifting strategy.
- Fairness/transparency—some barriers to delegating acceptable tasks may stem from employees lacking confidence and trust in the health system to remain fair to them; this is especially true for nurses, who are in the majority. They may see their profession as being trivialized when many others claim to do their work. In other words, people are protecting their own turfs.

> "I have little understanding of what is meant by task shifting. My understanding of task shifting is passing on activities to others. This scares me, as the more we pass on our activities to others, the less we will have on our job descriptions. We may lose our jobs and strength as a profession when most of our duties are now done by community health workers who have less training and earn less money. Maybe there is a need for more sensitization and giving us adequate information on task shifting."
>
> ***—Junior Nurse, Health Center, Swaziland***

> "Task shifting could bring about good benefits if it is properly planned, personnel are trained and supervised, and personnel are mentored and monitored. However, extensive consultation/engagement with nurses is needed, as some nurses believe that task shifting will lower the nursing profession and standard of patient care. Task shifting is not going to be cheap, as funds will be needed for recruitment of new cadres, development of training guidelines for the new cadres or those taking on the new roles, remuneration and compensation for those getting added roles of supervision, mentoring and monitoring. Formalizing task shifting will assist the [Ministry of Health and Social Welfare] to define job descriptions which are appropriate and clear."
>
> ***—Matron, Government Hospital, Swaziland***

At the community level

- Strong stigma and discrimination directed toward PLHIV in communities could reduce the acceptability of community health workers as caregivers; fellow community members might not be able to access tests or treatment from a community worker without a loss of confidentiality.
- Community members who expect to be seen by a doctor whenever they visit health institutions may resist being treated by less qualified personnel.

Task Shifting Process to Date in Swaziland

FGD participants identified core functions for nurses and doctors (see Boxes 4 and 5).

Box 4. Nurses' core functions

- Birth deliveries
- Taking vital signs
- HIV testing and counseling
- Administering injections
- Prescribing and administering routine drugs
- Dressing surgical wounds
- Inserting nasogastric tubes

Box 5. Doctors' core functions

- Major surgical procedures
- Prescribing opioid and narcotic drugs
- Deciding on patient admissions and discharges
- Assessing critical patients
- Authorizing critical medical investigations
- Changing antiretroviral treatment regimens as necessary

During FGDs, participants identified some tasks as having been shifted from doctors to nurses (see Table 5).

Table 5: Tasks shifted from doctors to nurses

Routine Tasks (i.e., tasks performed frequently)	**Occasional Tasks** (i.e., tasks performed infrequently)
Administering intravenous fluids	Refilling TB drugs and following up with patients at the institutional level
Drawing blood and checking hemoglobin and blood glucose	Suturing minor wounds
Requesting diagnostic tests for TB and reading chest X-rays	Applying plaster of Paris to set bones
Initiating antiretroviral and TB treatment	
Catheterizing patients	

Discussion participants also identified several tasks that potentially could be shifted from nurses to nursing assistants or orderlies (see Table 6).

Table 6: Example of nurses' tasks that could be shifted

To Nursing Assistants	To Orderlies
Making beds	Routine transporting of patients from ward to laboratory and from X-ray department for diagnosis
Dispensing and administering drugs	Transporting corpses to the mortuary
Checking vital signs (including weighing patients)	Completing admission forms
Testing urine for glucose to test for diabetes	Making beds
Completing information in registers	Feeding conscious patients
	Bathing patients
	Washing linen
	Offering bedpans

Long-term Effects of Task Shifting on Health Professionals

Most respondents said that task shifting could contribute positively to staff retention by reducing stressful workloads that increase staff burnout and attrition. They also felt that it could build positive attitudes among health workers as they begin to value each other's contributions to service delivery. However, they also noted that task shifting could create complacency among staff members that have received inadequate training from the MOHSW. This could result in unskilled workers taking on tasks for which they have not received adequate training, potentially leading to patient complications and/or death if health authorities fail to implement strategies to enhance professional development.

Effects of Task Shifting on Quality of Patient Care

Most respondents agreed that, if carefully planned and implemented, task shifting can enhance the quality of patient care. By passing certain tasks to other health professionals, medical doctors can concentrate on using their specialized skills and still have some time for supervising, training, mentoring, and monitoring the junior staff. Respondents felt that task shifting could reduce the burnout and stress that result from huge workloads, especially for nurses. This reduction in workload would most likely improve healthcare providers' motivation to provide high-quality services.

However, respondents acknowledged the necessity of tracking the quality of care being provided following task shifting. Health authorities must institute a quality assurance framework that includes standardized training, supervision, certification, and regular assessments. Health workers need clear job descriptions for improved accountability and professional monitoring/supervision. Some job descriptions currently overlap, so that some tasks become the responsibility of many people. As a result, these tasks could be neglected if there is no clear communication, and workers could find themselves in conflict with others when job descriptions are not clear and specific.

Views on Shifting Tasks to Community Workers

Most respondents appreciated the role that community workers play in community mobilization for prevention of mother-to-child (PMTCT), HIV, and AIDS education; treatment adherence; nutrition support; tracing of TB defaulters in TB DOTS; home-based care; mobilization for expanded program of immunization (EPI) activities; and family planning. Because they are part of the communities they serve, community workers often are more acceptable and accessible to the community and so are able to respond to issues that arise. Health professionals expressed willingness to shift complementary tasks to community workers if they are trained and supervised. Nurses said that they could shift certain tasks to

rural health motivators (RHMs), expert patients, and lay counselors, as well as PLHIV mothers (to deal directly with their newly diagnosed peers) (see Box 6).

Box 6. Rural health motivators

RHMs are MOHSW-supported multipurpose community-based volunteers selected by community leaders. They include married men and women who reside in the community. They receive a 12-week training course and are charged with looking after 15–20 households. Among the chiefdoms of Swaziland, there are currently 4,000 RHMs with whom MOHSW program managers work to reach communities.

These cadres of health workers are seen as doing valuable work at the community level. However, there are reports that they are overwhelmed as a result of taking on too many roles from different programs and nongovernmental organizations (NGOs). Thus, checks and balances are necessary to ensure that these community workers are not rendered inefficient by being overloaded with many tasks.

The RHM program has a coordinator based at MOHSW headquarters who facilitates the development and review of training material for RHMs, conducts pre- and in-service RHM training, and is supported by two trainers in each of the four regions of the country.

Health workers identified several tasks that could be shifted to community workers, provided they are well trained, supervised, mentored, and monitored. Some of these tasks include nutrition support, treatment literacy, and palliative care (see Box 7).

Box 7. Example of tasks that could potentially be shifted to community health workers

- Nutrition support
- Provision of medications for PMTCT
- HIV treatment literacy (including drug interactions)
- Family planning counseling for HIV-positive men and women
- Sexual and reproductive health information and referrals
- Monitoring ART side effects
- Advocacy for community treatment, stigma reduction, rights of women
- Referral to social and economic services, including advising PLHIV on income-generating projects
- Palliative care
- Emergency first aid

Health workers had reservations about delegating HIV counseling and testing to community workers because communities are still battling stigma and discrimination; the result is that many people delay seeking testing and PLHIV wait a long time to access antiretroviral treatment (ART). Participants focused on confidentiality at the community level as an area of concern if community members provide HIV tests to their peers. Nurse participants also expressed discomfort about shifting the task of resupplying antiretroviral drugs to community health workers, due to fear of drug misuse. They explained that many community members reported sharing drugs with relatives who did not want to visit the clinic because of possible stigma. Also, they thought that monitoring ART drug interactions should remain a function of health professionals but that community health workers could play a role in the recognition of symptoms and referral to medical professionals for additional problems.

> "There is definitely a need for formal training and supervision for any shifted tasks. Swaziland has not yet conducted any training in this area … The quality of service provided by less qualified personnel can be good if they are well trained and supervised."
>
> ***—Chief Nursing Officer, Swaziland***

FGD participants indicated a need for clinics to strengthen their supervision and coordination of community programs. For example, RHMs attend meetings and trainings at regional offices, bypassing the community clinics and health centers.

As a result, the relationship between RHMs and clinics/health centers needs to be improved. Moving the training for RHMs to local clinics or health centers would reduce the workload of regional trainers, who are located far from the communities.

FGD participants said that lay persons could be awarded certificates for the training they have received if their various roles are clear and distinct from those of health professionals. Conflicts as to roles and job descriptions already have been reported between non-health and professional health staff. In some cases, non-health staff members feel they can provide the same services as professionals and should be paid accordingly.

Political Commitment

Most respondents indicated that they had not heard any politicians or MOHSW leaders discuss task shifting. MOHSW staff explained that health workers and politicians had not yet begun engaging in discussions on task shifting. Respondents believed that politicians usually were supportive once engaged in discussions related to health. For example, politicians were involved in and provided support for the decision to involve RHMs in health activities. Politicians had great respect for these community workers and often spoke during community meetings about the contributions of RHMs.

National Policies

Many health workers interviewed were not aware of MOHSW national policies related to task shifting. However, several existing documents were identified that support task shifting at both institutional and community levels:

- National Multisectoral HIV and AIDS Policy (MOHSW, 2006b)
  - Calls for the full, meaningful involvement and participation of PLHIV and other vulnerable groups in aspects of HIV prevention, treatment, care and support.
  - Supports community-owned and driven HIV initiatives, using existing structures and applying local solutions.
  - Recognizes that communities should be partners in the fight against HIV. This recognition allows for some health-related tasks to be shifted to PLHIV, community health workers, and other non-health professional individuals.
- National Multisectoral Strategic Framework for HIV and AIDS (MOHSW, 2009a)
  - Encourages the involvement of PLHIV and the community in HIV interventions: "…communities will be supported, empowered and their systems strengthened to ensure that interventions at the community level are driven and owned by the communities themselves. The capacity of community-based care providers will be strengthened not only to improve the provision of medical, psychosocial, and material support, but also to scale up palliative care."
  - Supports the shifting of tasks from medical doctors to nurses: "Given the shortages of skilled manpower, task shifting will be promoted to allow some services being provided by medical doctors to be provided by qualified nurses. The shift will require [a] Policy Directive to institutionalize task shifting."
- Prevention of Mother-to-Child Transmission of HIV–Operational Plan 2007–2011 (MOHSW, 2006c)
  - Encourages training community-based organizations, traditional birth attendants, RHMs, lay counselors, and other community caregivers.
- HIV Testing and Counseling National Guidelines June (MOHSW, 2006a)

- Provides for both client- and service provider-initiated counseling and testing at all levels of contact with the patient, including integrated services, stand-alone services, and in the private sector.
    - Provides national standards to which all institutions, organizations, individuals, and communities must adhere when providing testing and counseling.
- National TB Strategic Plan (MOHSW, 2009b) and National Health Sector Strategic Plan 2008–2013 (MOHSW, 2008)
    - Encourages using trained non-health cadres to perform specific activities, including TB treatment support buddies (i.e., former TB patients who are recruited and trained on community TB management, support, and treatment adherence) and TB defaulter trackers.
    - Encourages malaria and TB microscopists to also be trained as phlebotomists and cough monitors (i.e., identify possible TB cases from queues at the health facility).

Although these documents have incorporated aspects of task shifting, they are not sufficient to move the task shifting agenda forward. There is need for a national dialogue on policy development to create a conducive and supportive environment for task shifting in Swaziland.

WHO Task Shifting Guidelines

Few of the respondents had seen or heard of the WHO/PEPFAR/UNAIDS Task Shifting Global Recommendations and Guidelines. It was determined that MOHSW senior managers had copies of the WHO Guidelines and Recommendations but had not yet shared them with stakeholders. This may be an indication that documents are not being shared adequately among programs and staff. Several respondents were aware of guidelines regarding training lay persons (i.e., the National Guidelines on Community-Based Care and Support Manual) and lay counselors (i.e., the Manual for Training Rural Health Motivators).

Funding for Task Shifting

The Abuja Declaration of Commitment states that at least 15 percent of a country's total budget should be allocated to health (Organization of African Unity, 2001). The Government of Swaziland currently allocates 17.5 percent of its total budget to the MOHSW. This increased percentage (up from 10.9% during the years since 2002) (MOHSW, 2008) offers better opportunities for the health sector and exceeds the Abuja Declaration, despite the fact that the health and social work entities within the ministry share this portion of the budget. Task shifting has not yet been formally adopted by the MOHSW, so funds to support it have not yet been discussed. Officials posited that funds for task shifting would be added as a component within the MOHSW budget when needed.

Although to date there are no specific funds for task shifting, several programs—including the HIV and TB programs and RHM activities—are providing funds to support salaries, stipends, training, and supervision of new cadres of staff (i.e., community health workers) as they are introduced into the health service. Development partners [i.e., the Global Fund, Médecins Sans Frontières (MSF), Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), WHO, and the Southern Africa Human Capacity Development Coalition] also have been supporting task shifting activities within the programs they run.

Health worker interviewees supported the inclusion of task shifting as a line item within the MOHSW budget. Respondents said that a task shifting policy and strategy should be developed and costed to create a separate funding allocation. They identified numerous activities to support implementation once task shifting has been adopted formally by the MOHSW, including sensitizing stakeholders, conducting a needs assessment, reviewing job descriptions, developing criteria for recruiting new cadres, developing

curricula and training, developing supervision and monitoring frameworks, and providing compensation and incentives to relevant staff.

Staffing and Human Resources Capacity Building

The health sector faces severe human resource shortages, as demonstrated by a doctor-to-population ratio of 1 to 10,000 and a nurse-to-population ratio of 56 to 100,000 (MOHSW, 2008). WHO estimates that, to provide adequate health services coverage, countries, at a minimum, should build a ratio of 2.5 health workers per 1,000 (WHO, 2007a). Skilled health workers from the public service are leaving Swaziland for neighboring countries and beyond in search of better work conditions. Many public health providers also take up new careers in the private sector, NGOs, and the United Nations, either in-country or outside of Swaziland. The attrition rate of skilled health workers from the public sector is attributed mainly to a lack of career progression, unsatisfactory working conditions, inadequate working environments, lack of incentives (including promotions), and excessive workloads. The skewed distribution of manpower between urban and rural areas also exacerbates health workers' discontent, particularly those in rural areas, where the workload is heavier due to larger populations. More than 50 percent of the health workforce is deployed at hospitals—mainly located in urban areas—which serve only 20 percent of the population (MOHSW, 2008).

Swaziland has only three institutions for training health professionals. The Faculty of Health Sciences of the University of Swaziland is responsible for training about 70 percent of professional nursing cadres in the community, as well as medical and surgical nurses. Nazarene College accounts for the remaining 30 percent of the professional registered nurses. Nazarene College staff indicated they had started scaling down the number of students because the school could not cope with the very large numbers needing training. As such, they have switched from training 90 students per year to 60. The Good Shepherd Nursing School trains nursing assistants and accepts 40 students per year.

Respondents believed that one of the main reasons Swaziland was losing newly qualified nurses from training schools was the long waiting period to be recruited into the public health service. Some nurses have had to wait for as long as a year to be recruited. This is an area that urgently needs to be fixed, so that by the time nurses graduate, they are already assured of a job in-country. Otherwise, Swaziland will remain a training ground for nurses, while other countries benefit.

There are no training schools for other health cadres, including doctors, pharmacists, laboratory technicians, rehabilitation therapists, and radiographers. These health professionals all receive their training and certification in neighboring countries or abroad. However, the Faculty of Health Sciences plans to reestablish training for clinical officers, pharmacy technicians, and dental therapists. In-country training is likely to keep health workers in the country longer, especially if they are bound by MOHSW contracts.

The Human Resource Policy was in draft form at the time of this case study and the contents of the draft were not yet ready for sharing. The current health worker supply does not meet the demands of the healthcare service. The MOHSW has made requests to the Ministry of Public Service for increases in staffing across all levels of health services, including the Human Resource Department, but the Ministry of Public Service has responded that there is no money available to support this request. The MOHSW's Human Resource Department is reported to be too small to respond to all of the ministry's human resources needs. Qualified human resources personnel are not available at regional offices, resulting in all staff issues being referred to the MOHSW head office, which has only one trained person, who has a large workload.

The results of this study indicate that it would be ideal to have trained human resources personnel in each region, so that they could handle staff issues immediately. The number of human resource personnel should match the needs and budget. When task shifting becomes formalized, the demand on human

resource personnel will most likely increase. Currently, conditions of service for the health workers are regulated by the Public Service Commission, which deals with staffing issues and conditions of service for all government employees. The MOHSW hopes to improve the conditions of service for the health workforce through the establishment of the National Health Service Commission, in accordance with the Constitution of Swaziland. This Commission will deal with service conditions only for the health workforce. The Health Service Bill will determine the operational aspects of the Commission and establish a code of conduct applicable to all health workers. Some of the delays experienced in recruiting nurses trained by the country's institutions were attributed to the Public Service Commission's failure to respond promptly to staff issues.

CONCLUSIONS

Respondents had positive views on task shifting—many had experienced its benefits within their current projects—and could see benefits at both the professional and community levels. Task shifting has brought services closer to the people at the community level and is said to have reduced waiting time for some patients at health institutions. With the current professional health manpower shortages, it will not be possible for Swaziland to achieve the MDGs by 2015 and attain universal access to HIV treatment, care, and support by 2010. The process of delegating or shifting tasks to less specialized health workers can play a valuable role in the provision of HIV services. Task shifting can provide an opportunity for Swaziland to efficiently use existing health professionals, while increasing capacity by training and retaining other health workers.

Although there is support for task shifting, respondents agreed that it must move from being an informal to a formal process. This will require adequate preparation for task shifting to be effective and avoid unintended negative outcomes. Respondents stressed that the MOHSW should undertake the leadership and coordination of implementing the national task shifting strategy. In addition, the ministry needs to create an enabling environment and enact supportive policies, regulations, and guidelines. The MOHSW also should prepare for training both the new and existing cadres that will be taking on new tasks. Respondents saw supervision, mentoring, monitoring and evaluation, and regular assessments as crucial steps to the development of a task shifting strategy. They also believed that the task shifting process should be clear and transparent.

Key Findings About Task Shifting

- While task shifting has not yet been formalized in an official policy in Swaziland, it is taking place informally at both institutional and community levels. Swaziland also has numerous existing policies, guidelines, and strategic plans that provide an entryway for task shifting.
- The concept of task shifting is well understood, and is already occurring spontaneously as a result of increased workloads due to HIV and HIV/TB co-infection rates. However, nurses are bearing the burden of increased workloads because they have been forced to accept tasks shifted to them by medical doctors yet have not been able to shift their own tasks to other cadres.
- Health professionals acknowledged the key role that community workers play in community mobilization and stated a willingness to shift certain tasks to these workers.
- Health professionals acknowledged that, when done properly, task shifting can enhance the quality of patient care; allow for supervision, training, mentoring, and monitoring of junior staff; and improve accountability, while also reducing worker burnout.

Lessons Learned from Informal Task Shifting Activities

The case study identified the following lessons from informal task shifting activities taking place in Swaziland:

- Positive results occur when task shifting is introduced, managed, and monitored effectively, and staff and community workers are well prepared, supervised, mentored, and monitored. Such results include increased use of services due to increased access within communities.
- Those interviewed appreciated the role community workers play in community mobilization, especially with regard to increased uptake of PMTCT services, increased EPI coverage, and improved follow-up with TB defaulters.
- FGDs and key informant interviews revealed that when community health workers are actively carrying out their duties of advocacy, motivation, promotion, and care, clinics and communities see strengthened links, resulting in upward and downward client referrals.

Opportunities for Scaling Up Task Shifting

Because task shifting is already taking place in Swaziland, there are several opportunities for it to be strengthened, formalized, and institutionalized to prepare for scale-up:

- Several partners (i.e., the Global Fund, MSF, EGPAF, WHO, and the Southern Africa Human Capacity Development Coalition) already support task shifting activities in Swaziland. It is important that these organizations and many others be harnessed to provide technical and financial support.
- Health workers expressed their readiness to move the process forward, as they already are shifting tasks.
- Community health workers and other volunteers offer various services in the community already. Officials should harness these human resources to make a difference in community health outcomes.
- The MOHSW has been allocated 17.5 percent of the total government budget as its portion. This percentage exceeds the Abuja Budget Declaration goals of a 15 percent allocation for health. While financial resources are never large enough, this budget allocation is an increase from the 10.9 percent allocated in the years since 2002 and offers the MOHSW an opportunity to accomplish new and significant work.

Recommendations

Task shifting should be one component of a package of complementary short- and long-term strategies that can be enacted to help alleviate Swaziland's HRH crisis. Following the WHO model, this package should focus on treating the health conditions of health workers, training new and existing cadres of staff, and recruiting and retaining health professionals through a range of financial and non-financial incentives. Swaziland is carrying out promising approaches, such as developing an HRIS and establishing a Wellness Center for Health Care Workers. The MOHSW is also leading a process to prepare a Human Resource Policy, which will inform the design of a Human Resource Strategy. In addition, there needs to be stronger linkages between training/academic institutions and health facilities. These institutions play an important role by setting norms, building practical experiences, and opening up rosters to accommodate higher numbers of students.

To move the task-shifting process forward, the MOHSW should develop a strategy to create a conducive and supportive policy environment for task shifting, which already is being implemented in the country. Based on discussions with stakeholders during key informant interviews and focus group discussions, the following recommendations for moving the task shifting process forward in Swaziland were identified:

- The MOHSW should identify a focal senior manager to provide leadership for the task shifting process in-country. Such leadership would include developing a concept paper on task shifting, conducting sensitization and consensus building with stakeholders in support of task shifting, and leading efforts to draft a task-shifting strategy.

- To assist in these efforts, the MOHSW should establish a working group or task force to help it think through task shifting; the group or task force could include representatives of regulatory bodies, facility managers, health professional associations, training institutions, and other implementing partners. The task force should design policies and regulations to foster an enabling environment for task shifting, including developing a time-bound implementation plan. This team may need to review the plan developed in November 2008 (see Annex C) by workshop participants and assess its current relevance.

- Coordination, planning, implementation, and monitoring of task-shifting activities need to be strengthened at all levels. The capacity of clinics for coordinating, supervising, and monitoring

task-shifting activities at the community level should be strengthened as clinics form links between the healthcare system and the community.

- An assessment to determine the HRH staffing needs for particular health services should be undertaken. One way of determining this information is through the use of a computer-based model, such as the Staffing Needs Module of the Goals Model.[2]
- The MOHSW should recruit qualified human resource personnel in all regions to attend to human resource staff issues promptly. Addressing these issues is especially important given the growing demands on personnel officers as more health workers are recruited into the service.
- The MOHSW needs to facilitate the improvement of recruitment processes and procedures for nurses graduating from nursing colleges, which will help to reduce the time between the points when nurses complete their courses and when they enter the health service. Recruitment can also be accelerated by instituting practicums and placements before nursing students graduate, so that they can become familiar with the facility at which they will be working, and the facility can accelerate the recruitment process while the nurse is completing training.

[2] The Staffing Needs Module is a component of the Goals Model and is used to estimate the human resources required to implement a variety of HIV prevention, care, and treatment, and mitigation interventions in order to effectively reach a specified number of individuals with each intervention.

ANNEX A. KEY INFORMANTS INTERVIEWED

Title	Organization
Chief Nursing Officer	MOHSW
Registrar	Swaziland Nursing Council
President	Swaziland Nursing Association
HIV and AIDS Officer	World Health Organization
Program Manager	Reproductive Health Unit
Deputy Nursing Officer	MOHSW
Country Director	Southern Africa Human Capacity Development
Human Resources Advisor	Southern Africa Human Capacity Development
Monitoring and Evaluation Specialist	Southern Africa Human Capacity Development
Senior Lecturer	Nazarene Center Nursing College
Head of Mission	MSF
EPI Program Manager	MOHSW
Regional Program Director	EGPAF
Program Manager	National AIDS Program
Coordinator	PEPFAR/USAID
Malaria Program Manager	MOHSW
Principal Personnel Officer	MOHSW
TB Program Director	MOHSW
Deputy Director	MOHSW
Principal Secretary	MOHSW

ANNEX B. FGD PARTICIPANT LIST

Institution	Title
RFM Hospital	Medical Laboratory Technologist
	Nursing Sister
	Nursing Sister
	Nursing Sister
	Nursing Sister
	Physiotherapist
	Matron
	Community Health Matron
	Matron
	Medical Officer
	Pharmacist
	Nursing Sister
	Nursing Sister
	Nursing Sister
Mbabane Government Hospital	Nursing Sister
	Nursing Sister
	Nursing Sister
	Nursing Sister
	Nursing Sister
	Nursing Sister
Dvokolawako Health Center	Nursing Sister
	Nursing Sister
	Nursing Sister
	Nursing Sister
	Nursing Assistant
	Catering Officer
	Laboratory Technologist
Mankanyane Government Hospital	Dental Officer
	Anesthetist
	Laboratory Technologist
	Medical Officer
	Pharmacist
	Surgeon
	Community Health Nurse
	Community Health Nurse

	Matron
	Nursing Sister
	Nursing Sister
	Administrator
Hlathikulu Government Hospital	Nursing Sister
	Nursing Sister
	Nursing Sister
	Nursing Sister
	Nursing Sister
	Nursing sister
	Nursing Sister
	Nursing Sister
	Nursing Sister
	Nursing Sister
	Medical Officer
Sithobelweni Health Center	Nursing Sister
	Nursing Sister
	Nursing Sister
	Nursing Assistant
	Laboratory Technologist
	Nursing Sister
Good Shepherd Mission Hospital	Nursing Sister
	Nursing Sister
	Nursing Sister
	Nursing Sister
	Matron
	Matron
	Medical Officer
	Nursing Sister
	Nursing Sister
	Nursing Sister
	Pharmacy Technician
	Nursing Sister
	Nursing Assistant
Hlangano Health Center	Matron
	Nursing Sister
	Nursing Assistant
	Nursing Sister
	Nursing Sister

	Nursing Sister
	Nursing Sister
	Nursing Assistant
Piggs Peak Government Hospital	Acting Senior Medical Officer
	Matron
	Nursing Sister
	Nursing Sister
	Administrator
	Medical Technologist
	Nursing Assistant
	Radiographer
	Dental Hygienist

ANNEX C. KEY STEPS ON TASK SHIFTING IN SWAZILAND FOLLOWING THE MEETING IN HARARE, ZIMBABWE, NOVEMBER 4–7, 2008

Activity	Timeframe	Technical Assistance (TA) needed	Sources of TA
1. Sensitization and advocacy to MOHSW senior management on concept and the WHO Global Recommendations and Guidelines	November (19/11/08)		
1.1 Sensitization and advocacy to MOH managers (RHMs and program managers), regulatory bodies, training institutions on concept and the WHO Global Recommendations and Guidelines	November 27, 2008		
2. Establish a task team/working group for task-shifting building on existing structures in the MOHSW	December 2008		
3. Develop a concept note on task shifting and a proposed process to take it forward	December 2008–January 2009		
4. Situation analysis on HRH and task shifting	December 2008–January 2009	Yes	WHO
5. National consultative meeting with healthcare providers on the concept, guidelines, and proposed process	February 2009	Yes	WHO
6. National stakeholders on the task-shifting concept, guidelines, proposed process, and implications for different stakeholders	February 2009	Yes	WHO
7. Develop a national costed plan and/or include in HRH strategy and plan with a monitoring and evaluation component, including relevant task-shifting indicators	February–March 2009	Yes	WHO

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