

Task-shifting for cardiovascular risk factor management: lessons from the Global Alliance for Chronic Diseases

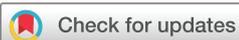
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ABSTRACT

Task-shifting to non-physician health workers (NPHWs) has been an effective model for managing infectious diseases and improving maternal and child health. There is inadequate evidence to show the effectiveness of NPHWs to manage cardiovascular diseases (CVDs). In 2012, the Global Alliance for Chronic Diseases funded eight studies which focused on task-shifting to NPHWs for the management of hypertension. We report the lessons learnt from the field. From each of the studies, we obtained information on the types of tasks shifted, the professional level from which the task was shifted, the training provided and the challenges faced. Additionally, we collected more granular data on 'lessons learnt' throughout the implementation process and 'design to implementation' changes that emerged in each project. The tasks shifted to NPHWs included screening of individuals, referral to physicians for diagnosis and management, patient education for lifestyle improvement, follow-up and reminders for medication adherence and appointments. In four studies, tasks were shifted from physicians to NPHWs and in four studies tasks were shared between two different levels of NPHWs. Training programmes ranged between 3 and 7 days with regular refresher training. Two studies used clinical decision support tools and mobile health components. Challenges faced included system level barriers such as inability to prescribe medicines, varying skill sets of NPHWs, high workload and staff turnover. With the acute shortage of the health workforce in low-income and middle-income countries (LMICs), achieving better health outcomes for the prevention and control of CVD is a major challenge. Task-shifting or sharing provides a practical model for the management of CVD in LMICs.

INTRODUCTION

According to the WHO, 60% of countries worldwide have insufficient skilled health professionals, defined as fewer than 59.4 physicians, nurses or midwives per 10 000 population.¹ The majority of countries with the lowest per capita skilled workforce (fewer

Summary box

- Task-shifting is an effective implementation strategy for infectious disease management and maternal-child healthcare.
- Literature describing 'what works' for implementing task-shifting strategies for non-communicable disease (NCD) management is limited.
- Tasks that can be shifted to non-physician health worker (NPHW) in hypertension management include: screening/monitoring, patient education, follow-up, adherence management and triaging referral/case management to physicians.
- Hypertension training programmes for NPHW ranged from 3 to 7 days with most including components of refresher training and 'on the job' clinical decision support through training manuals or mHealth tools/platforms.
- Task-shifting to NPHWs is a feasible, scalable model for addressing the burden of NCDs in low-income and middle-income countries where health human resources are limited.

than 22.8 per 10 000) are located in Africa and South East Asia,¹ regions which are currently facing the largest burden of communicable and non-communicable diseases (NCDs) and injuries.²

Task-shifting to non-physician health workers (NPHWs) such as community health workers^{3,4} and nurses has been shown to be effective in managing infectious diseases and improving maternal and child health⁵ in low-income and middle-income countries (LMICs). Task-shifting is defined as shifting specific tasks, usually undertaken by physicians, to non-physicians with different level of education or to people specifically trained to perform a limited set of tasks.⁶ Task-shifting may be facilitated by medical technology, such as standardised diagnostic equipment

linked to electronic decision support, which standardises the performance and interpretation of certain tasks. Task-sharing involves a team of healthcare providers working together to deliver a service. Similar models of care are being trialled for NCDs such as cardiovascular disease (CVD),⁷⁻⁹ diabetes^{10 11} and depressive disorders.¹² However, there is still inadequate evidence to show the effectiveness of task-shifting to manage CVD.^{8 13}

In light of the increasing burden of NCDs and lack of operational research in LMICs, the Global Alliance for Chronic Disease (GACD) was established with a goal to fund research in LMICs and disadvantaged populations in high-income countries. In 2012, the GACD funded 15 studies for the prevention and management of hypertension of which 8 were focused on shifting simple health-care-related tasks from physicians to NPHWs. These implementation studies from LMICs highlight the main challenges and facilitators for task-shifting for prevention and management of CVD. We report the lessons learnt from the field and the implementation challenges faced by the research teams.

Research investigators for all eight GACD studies were invited to participate in a working group which met online and face to face at annual meetings hosted by the GACD. Data were collated using three steps. First, a matrix was created to collect details of the critical variables relating to task-shifting. This included reviewing the study protocol to understand the study aim, methods, primary outcome, types of tasks shifted, professional level from which the task was shifted, qualifications of the NPHWs, training provided and the challenges faced. The second step involved asking the research teams to complete a two page 'mini-case study' addressing the following aspects of their projects: research context, research question, outcomes, status and details of the tasks that were shifted or shared. Researchers were asked to approach these 'mini-case studies' by detailing the original proposed approach. Finally, when the studies were near completion, the researchers were asked to reflect on what was ultimately implemented. Our goal was to (1) identify and share the lessons learnt through iteratively modifying interventions from conception to implementation to fit within the relevant health system and (2) understand the barriers and enablers to implementing successful (or unsuccessful) interventions.

The quantitative data were collated and mapped for analysis using Microsoft excel and SPSS V.20.0. Structured case studies from each study (except Argentina) were analysed qualitatively to identify and elucidate 'lessons learnt' themes. Data from the protocol review and contact with the researchers substantiated the analysis of the case studies. While no ethics approval was required for this synthesis, ethics approval was obtained for the conduct of each study mentioned in this report.

Which tasks were shifted and to whom?

Among the 15 studies funded by the GACD, 8 incorporated task-shifting from physicians to other cadres of the

health workforce to manage hypertension. These studies were conducted in Argentina,¹⁴ Canada,¹⁵ Colombia, Ghana,¹⁶ India,^{17 18} Kenya,¹⁹ Malaysia, South Africa²⁰ and Tanzania.¹⁵ All studies were randomised controlled trials, with one being a randomised controlled feasibility study. The cadres of NPHWs included nurses, community health workers,⁴ accredited social health activists (ASHAs)²¹ and community health extension workers (CHW supervisors). The NPHWs had between 8 and 14 years of education, while the nurses were graduates from formal nursing programmes. In four studies, tasks were shifted from physicians to NPHWs and in four studies, tasks were shared between two different levels of NPHWs (table 1).

The tasks shifted to NPHWs included screening of individuals, referral to physicians for diagnosis and management, patient education for improving lifestyle, titrating the dose of medications, follow-up and patient reminders for adherence to medications and appointments. Screening was undertaken by NPHWs in Colombia, Malaysia, India and Ghana (table 1). Three studies involved the use of mobile applications with clinical decision support tools to enable NPHWs to screen, manage and refer patients to physicians. In the SmartHealth India study, the mobile device also enabled blood pressure (BP) readings to be automatically wirelessly uploaded and included a treatment advice page that provided the 10-year CVD risk of the participant as well as guidance for ASHAs on providing, lifestyle advice and recommendations for referral.¹⁷ In the LARK study (Linkage And Retention to hypertension care in rural Kenya), community health workers were trained in a 'tailored behavioural communication strategy' and their mobile application had audiovisual tools such as illustrations/video¹⁹ to enable CHWs to link patients with hypertension to the health system and provide appropriate support. Decision support for the HOPE-4 (Heart Outcomes Prevention and Evaluation Colombia and Malaysia) study included, included diagnosis, guidance on initiating and providing appropriate combinations of CVD medications (statin and BP lowering agents) and counselling. The other tasks shifted to non-physicians included assisting in filing medical records, prepacking medications and reminding patients about their appointments using text-messages, telephone calls or personal visits (South Africa).²⁰ Some interventions included delivery of medications¹⁴ and ongoing monitoring of BP.^{14 18} In Tanzania, a programme of cost-sharing through a mobile money platform and a health insurance scheme for low-income earners was introduced with the aim of increasing patient compliance with refilling antihypertensive medications and reducing cost to patients (as drug access through the government-funded health centre was unreliable).¹⁵ In the HOPE-4 study, CHWs in Columbia and Malaysia were able to initiate appropriate CVD medications as well as follow up patients at regular intervals. Trained community nurses in Ghana used the WHO PEN tool to titrate medications.¹⁶



Table 1 Characteristics of studies using task-shifting to manage hypertension

Project	Country	Aim	Tasks-shifted	Task-sharing team	Qualifications of NPHWs
DREAM-Global ¹⁵	Tanzania and indigenous communities in Canada	To develop and implement a programme of training for community health workers and community nurses to diagnose and manage HTN among rural dwelling people with HTN. At the core of this intervention is education regarding HTN delivered to patients' mobile phones and improved access to antihypertensive medications through an SMS (eVoucher) programme in partnership with the private, informal pharmacy sector	Diagnosis of hypertension by community health workers Management by community nurses based at government health centres	Clinical officer at health centre supervises nurses who manage hypertension. CHWs work independently in the communities to diagnose hypertension and follow-up	Clinical officer (trained at CO school) Nurse—diploma nursing programme CHW has primary school education and 1–3 years of high school. CHWs trained informally by government
HOPE-4	Colombia and Malaysia	Screening and identification of participants with hypertension and moderate CVD risk, initiation of appropriate CVD combination medications (appropriate to local policy—statin and antihypertensives), lifestyle counselling and follow-up of participants	Screening and identification of participants with high CVD risk, initiation of appropriate CVD medications, lifestyle counselling and follow-up. Assisted by mobile tablets with decision support and data collection	Study physician and NPHW	Minimum high school education Combination of CHWs trained in other areas of healthcare—repurposed for CVD care Current research assistants trained as CHWs
Nkateko Trial ²⁰	South Africa	To improve the functioning of clinics by providing support to nurses	Patient reminders, BP measurements, Booking appointments, Pulling files and refilling. Health education, tracking defaulters. Assist with prepacking of medicines	Nurse and CHW. Manager—professional nurse	CHWs (lay)—10 years of education. Experience as a CHW (identification from local NGOs, they are not part of the government)
CHIRI ¹⁸	India	Develop and pilot a group led education intervention strategy to improve the control of hypertension	Facilitating group meetings, BP measurement, Education and information about the management of hypertension	Tasks shared between doctors and ASHAs	8 years of education
SmartHealth India: A smart phone based clinical decision support system for primary healthcare workers in rural India ^{25, 26}	India	To develop and evaluate a multifaceted clinic decision support tool	Screening and identification of patients with high CVD risk, risk communication and referral to doctors, follow-up of patients and counselling. Smartphone for decision making and health records	Physician, ASHA	8 years of education
Task-shifting and BP control in Ghana ¹⁶	Ghana	To evaluate the comparative effectiveness of the implementation of the WHO Package targeted at CV risk assessment vs provision of health insurance coverage, on BP reduction.	Screening and identification of patients with hypertension, CVD risk assessment, BP measurement, medication adjustment based on a prespecified algorithm, lifestyle behavioural counselling and patient referral for specialist care	Physician, community health nurses	14 years of education (6 years primary, 6 years high school, 2 years nursing training)
Optimising linkage and retention to hypertension care in rural Kenya ¹⁹	Kenya	To use a multidisciplinary implementation research approach to address the challenge of linking and retaining hypertensive individuals to a hypertension management programme	Linkage and Retention of patients by CHWs by equipping them with behavioural assessment tools, communication strategies, motivational interviewing. Smartphone for decision making and health records, and audiovisual tools such as images and videos	Nurses, CHEWs and CHW	At the minimum, they are literate, most have attained O level/Grade 12 education, with experience of more than 5 years
Comprehensive approach to hypertension control in Argentina ¹⁴	Argentina	To test whether a comprehensive intervention programme within a national public primary healthcare system will improve hypertension control among uninsured hypertensive patients and their families in Argentina	Education and counselling (lifestyle, risk factors) in the community. Teach participants to control BP, use BP machines	Physicians, nurses and CHWs 20 in all. Nurses were supervisors	At the minimum primary school education, about 50% high school. MCH training from government.

ASHAs, accredited social health activists; BP, blood pressure; CHEW, community health extension workers; CHIRI, Control of Hypertension in Rural India; CHWs, community health workers; CVD, cardiovascular disease; HTN, hypertension; NPHW, non-physician health workers.

There were some differences in the sites of care across the studies. The study in Argentina incorporated home-based care to patients and their families and included delivery of medications.¹⁴ In Tanzania, a combined approach was used, with CHWs measuring BP in the community, and non-physicians in the clinic accessing these readings, via smartphone, when the patient visited the clinic. Both the studies in India (SMARThealth and Control of Hypertension In Rural India (CHIRI)) were community-based with referrals to doctors based at local primary health centres. All of the studies included an education component either delivered by the NPHW of via text messages. The education included details about hypertension, its risk factors and how to manage it using lifestyle changes and adherence to medications.

Training of non-physician health workers

The training programmes ranged between 2 and 7 days in length with refresher training offered at 6 months in two studies, at yearly intervals (two studies), while in three studies, there was no defined time point for retraining. In the CHIRI study (India), ASHAs were trained to facilitate community groups and educate individuals to self-manage their BP.¹⁸ In South Africa, lay health workers were trained to assist nurses in educating patients about their condition.²⁰ In the HOPE-4 study, CHWs in Columbia and Malaysia were trained with a curriculum developed by the study team and now adopted by the WHO Hearts Implementation Package.²² This curriculum involves CHWs using their mobile application to help provide lifestyle counselling at regular intervals following screening. The WHO PEN decision support tool for CVD management was used by trained nurses in Ghana to provide appropriate lifestyle counselling.¹⁶ The training programme was evaluated in five of the eight studies using pretraining and post-training tests and an objective practical clinical examination. In the other three studies, a framework was used to evaluate the knowledge and skills gained during the training (table 2).

NPHWs were already part of the health system in all except one study, Nkateko Trial (South Africa), where they were recruited specifically for research purposes.²⁰ NPHWs received a salary for their role in three studies, a performance-based incentive in two studies and in three studies a combination of a salary and an incentive. All the research studies had a training programme that was developed specifically for NPHWs (table 2).

Enablers and barriers of task-shifting

The main challenges faced by the researchers included health system-related barriers, such as inability of NPHWs to prescribe evidence-based medications,²³ availability and affordability of medications and high workload of the staff and NPHWs. The varying capacity, skill-sets and confidence of NPHWs also provided some challenges in providing standardised training. When this occurred, research teams had to offer on the job training and close supervision to ensure high quality and fidelity of the

health intervention offered. In South Africa (Nkateko trial), where tasks were shared between nurses and CHWs, nurses were found to give CHWs additional tasks which were beyond their job description and hence difficult to perform. In some studies, there was a role conflict with other senior NPHWs who viewed the new role of newly trained junior NPHWs as a threat to their jobs. Other challenges included high staff turnover²⁴ and vacancies in government sponsored NPHW positions. Prioritising work was also a major problem for NPHWs, many of whom had many other routine demanding activities. This barrier was further exacerbated by the lack of remuneration for NPHWs for the new tasks assigned and transition of trained nurses to new roles/locations of employment within the government system. The lack of understanding of research posed another major challenge. As examples, there were challenges to maintaining confidentiality of study participants by NPHWs, while researchers in one study had to ensure that the health promotion intervention was not delivered to the control communities. Unavailability or inconsistent supply of antihypertensive and other medications was yet another health system related barrier which several studies faced during the roll out of the intervention (see table 3 for further details).

The common enablers for task-shifting across all the studies was the enthusiasm of NPHWs to learn new skill sets and take on a new role. The community accepted their new role and reported that they had better access to healthcare as interventions were delivered in the community rather than the health centres, largely because health centres were difficult to access.²⁵ In studies which involved the use of technology, there was an initial period of anxiety regarding the use of technology, but later NPHWs felt confident and described the tablet as a tool to help facilitate communications and engage with patients regarding lifestyle modification for CVD prevention.²⁶ When remuneration, standardised to the country's practices, was provided to the NPHWs for the additional tasks, this was reported to be a major enabler in implementing the intervention.

Prior to implementing the intervention, several investigators conducted audits of the health system, qualitative research with stakeholders and feasibility studies to better understand the main challenges in rolling out the main study. In five of the studies, there was some form of a pilot study, mainly to pilot and train NPHWs. The pilot studies were reported to be critical in making minor, and in some cases substantive, changes to the study and/or intervention design. In projects where there was no pilot study, investigators reported that a pilot would have avoided significant challenges in implementation and success of the programme. In addition, detailed process evaluation studies are planned in six studies, aimed at better understanding the moderators and mediators of the intervention (see online supplementary file 1 for additional details).

Table 2 Training and evaluation of knowledge change

Project	Training	Training assessment	Remuneration of NPHWs
DREAM-Global	5-day training Content: CVD screening, hypertension diagnosis and management	Observed Standardised Clinical Examination Pre and post test	Paid by a base salary, then additional payment paid based on results
HOPE-4	5-day training Content: A brief overview of cardiovascular physiology and pathology, an understanding of cardiovascular risk assessment, and implementing management and prevention strategies using the algorithms adapted from the WHO.	Pre and post test Observed Standardised Clinical Examination	Paid an hourly rate as determined by National Leaders
Nkateko Trial	7-day training Content: Hypertension screening, diagnosis, follow-up. Medical record keeping.	Pre and Post-test Ongoing assessment Post-test was used as a selection criteria	Paid a salary by the project in line with other organisations
Cluster randomised feasibility trial to improve the CHIRI	5-day training Content: Overview of study, hypertension content, facilitation of group meetings, SMART goal setting.	Pre and Post-test Kirkpatrick framework for evaluation	An incentive was paid in line with the Government of India pay scales
A smart phone-based clinical decision support system for primary healthcare workers in rural India	7-day training Content: Overview of study, CVD content, smartphone technology	Pretest and Post-test Kirkpatrick framework for evaluation	An incentive is paid to the ASHA
Task-shifting and blood pressure control in Ghana ³⁴	3-day training Content: Hypertension screening and diagnosis, hypertension and CVD content, management of low to medium risk of CVD and patient referral	Pretest and Post-test	Receive stipend monthly during recruitment and follow-up.
Optimising linkage and retention to hypertension care in rural Kenya	5 days Content: Overview of study, Hypertension Content, Behavioural Assessment, Motivational Interviewing and Communication Strategy smartphone technology	Observed Standardised Clinical Examination Written test	Receive stipend for field engagement and training, incentive-based stipend
Comprehensive approach to hypertension control in Argentina	2 days Content: Educate and counsel participants for CVD care Materials developed by NHLBI in Spanish and then translated and customised/adapted. Online platform—virtual learning	Observed Standardised Clinical Examination	Salary from government, incentive for home visits

ASHAs, accredited social health activists; CHIRI, Control of Hypertension in Rural India; CVD, cardiovascular disease; NPHW, non-physician health workers.

Table 3 How to implement an intervention involving task-shifting?

Process	Why?
Audit the health system	To understand the various factors which need to be considered in the implementation of the intervention from a health system's perspective. For example, are medicines available in the health centre?
Understand the regulatory framework	To ensure that the intervention is in accordance to the country's policy/regulation. For example, can NPHWs prescribe essential medicines?
Conduct qualitative assessment of key stakeholders	To gain a better understanding of the perception of key stakeholders. For example, will the community members accept the new role of the NPHW?
Pilot the intervention	To better understand enablers and barriers to the implementation of the intervention.
Train the NPHWs and assess training using a broad framework	To ensure NPHWs have gained the knowledge and skills required of them
Supervise/monitor the implementation*	To ensure good quality healthcare to the community
Check fidelity of intervention	To ensure that the intervention is being implemented in accordance to the protocol
Conduct a process evaluation	To get a better understanding of what worked and why

NPHW, non-physician health workers.

One of the targets of the United Nation's Sustainable Development Goals is to reduce NCDs by 30% by 2030.²⁵ In order to achieve this goal, there is a need to address the shortage of health human resources (including physicians, nurses and midwives). The shortage in human resources is currently estimated at 17.3 million, with the largest being in South-East Asia (6.9 million) and Africa (4.2 million).²⁴ In these regions, the experience of the health system in using NPHWs is limited to infectious diseases and involves either short-term or curative care. In this manuscript, we have highlighted the critical lessons learnt from the field about task-shifting for management of hypertension from eight LMICs. These studies will contribute towards building the evidence required to understand the role of task-shifting for chronic disease management.

Policy and regulatory environment

Task-shifting requires engagement with policy-makers, health professionals and community members.²⁷ At the health system level, it is essential to establish clear roles with detailed job descriptions and adequate remuneration for the tasks performed.²⁸ In some countries NPHWs have a large workload, and adding management of NCD may compromise their productivity and the quality of their current services.²⁹ Having structured training curriculums with evaluation, on the job training and supportive supervision would improve competencies, thereby contributing to better health outcomes in the communities.³⁰ The current models of reimbursement are tailored for short-term and mostly curative care such as incentives given to the directly observed treatment (DOTs) provider on the successful completion of an individual's DOTs programme or remuneration paid after complete immunisation of a child. Attractive incentive packages that will help motivate and retain NPHWs in the work force need to be devised and evaluated. These incentives could either be financial or non-financial, including enabling pathways for career progression.

During the peak of the HIV/AIDS epidemic, several countries in the African continent adopted changes in their legislation allowing ART initiation to clinical officers, medical assistants or nurses even as early as 2004, before the WHO recommended guidelines around task-shifting.³¹ A similar strategy is now needed for CVD management, where evidence-based decision support aided by technology can guide NPHWs to screen individuals in the community, and refer and manage individuals who do not have access to physicians. In Colombia, for example, trained nurses are allowed to prescribe from a list of essential medicines, an approach which facilitated the implementation of the HOPE-4 intervention. In Ghana, while there is no clear policy that allows nurses to prescribe medicines for BP management, nurses in the Task Shifting and Blood Pressure Control trial (TAASH) were trained to follow the WHO CVD package. In the TAASH study, the ability of the nurse to prescribe BP lowering medicines was a crucial enabler. Evaluation of these programmes, including compliance to study processes, will provide important details about the safety and efficacy of this approach for managing hypertension.

While task-shifting was the main aspect of managing hypertension in all studies, the effectiveness of the model does depend on the health work force and is reliant on a number of health system-related factors which are beyond the control of a research study and dependent on country-specific regulations on task-shifting. In order to address the global work force crises, the WHO recommends task-shifting as a viable option, but without country-specific policies that enable task-shifting and adequate physician oversight, it will be challenging to translate research into practice.

Recommendations for future research involving task-shifting

There are many lessons learnt from the investigations undertaken with the GACD projects (online supplementary file 1), including identification of the steps researchers should take while designing a study that

involves task-shifting. Since task-shifting is just one component of the larger health system, it is important to audit the health system to better understand the external factors that may impact the successful implementation of the intervention. For example, if one of the aims of the task-shifting interventions is to improve adherence to medicines, the audit will help researchers understand whether medicines or a pharmacist is available at the health centre. Supporting this approach, surveillance of 596 communities in 18 countries in the Prospective Urban Rural Epidemiology (PURE) study provided evidence that medicines for preventing cardiovascular disease were both unavailable and unaffordable in most LMICs surveyed.³²

Another lesson learnt was to engage with key stakeholders early and often, and well before implementing the intervention to better understand the perceptions of the community and policy-makers, for example, can reduced costs and improved access to culturally appropriate care overcome potential concerns over safety? This is essential because these perspectives influence the implementation and long-term sustainability of these programmes into real world settings.^{23 33} Stakeholders can also help by providing valuable feedback on the design of interventions from the outset, reducing the number of changes that need to be made during implementation.

Pilot studies were found to be an essential step prior to large-scale implementation. This helped researchers understand some of the challenges and resolve them before rolling out the intervention.^{26 33} Since task-shifting for managing hypertension is a new concept for NPHWs in LMICs, all the researchers involved had to ensure that NPHWs had gained appropriate knowledge and skills to provide quality care to the communities. This was often monitored by a research supervisor and sometimes supported by technology such as clinical decision support tools and blue tooth enabled BP monitors.

CONCLUSION

With the acute shortage and maldistribution of the health workforce in LMIC, achieving better health outcomes for the prevention and control of CVD is a major challenge. Task-shifting provides a practical model for managing CVD in LMICs. Task-shifting of certain tasks to NPHWs for preventing and controlling hypertension presents a great opportunity that could increase access to care, free up physician time and increase system efficiency in the long-term. Task-shifting has the potential to reduce premature mortality and morbidity due to CVD by improving early detection of risk factors, referral and linkage to care and support for adherence and life-style modifications.

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