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Oral Abstract Session
WEAB02 - Task Shifting and Decentralising Care

WEAB0202 - Task-shifting and decentralisation of HIV/AIDS care in a rural district of Malawi: some successes and lessons learnt from Thyolo district

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Issues: Lack of qualified health staff seriously challenges health systems in Malawi to scale up HIV/AIDS care. First-line care dependends on few trained staff; services in district hospitals and HC are provided by clinical officers, nurses and other health workers. Malawi has nurse vacancy rates of 55% and only 1.7 doctors per 100,000 population. In an innovative approach in Malawi, lower cadre staff was used for defined tasks. Task shifting is a gap filling strategy for staff shortages.
Description: In line with the national ART scale up plan, MSF adapted the doctor driven approach towards a strategy with multiple patient tracks (according to patient profile) and with specific tasks in care provided by less qualified cadres. This was first applied in the hospital based ART-clinic of Thyolo and from June 2006 to December 2007, initiation of ART was done also in 3 HC. By end 2007, a total of 11,555 persons have ever started ART in Thyolo district.
Lessons learned: 1837 patients were initiated in the HC on standard first line regimen (Stavudine/Lamivudine/ Nevirapine), among which 1587 were in WHO stage 3 and 253 in WHO stage 4. Also 1127 patients on ARVs previously receiving care in the hospitals were referred to the HC. Overall, by 31/12/2007, 2706 (91%) of them were are alive and on ARVs. ART initiation increased up to an average of 450 patients enrolled per month. Thyolo experience shows that in spite of serious lack of qualified staff, expansion of ART-capacity to HC and good programme outcomes are possible.
Next steps: Task shifting can contribute significantly to overcome the HR-hurdle to ART scale up. However, task shifting cannot replace and should not be an excuse for failing to address health worker shortages; retaining and attracting sufficient numbers of trained staff remains crucial.
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