

Thinking outside the box to meet health workforce needs

The health workforce landscape is changing as task shifting takes root. Peter Ngatia looks at the implications and the training needs.

The (true) story is told of an orthopaedic surgeon, one of very few who practised in Kenya in the 1970s who, although a brilliant surgeon, had a major weakness for alcoholic beverages that often caused him to fall asleep in the middle of an operation. Nevertheless, his patients were always wheeled out of the theatre with the operations having been done perfectly. It turned out that his assistant, an old man called Karuri who had for many years watched the surgeon at work, handing him scalpels and forceps and sutures, took over whenever his boss nodded off, doing everything exactly as he had seen the surgeon do countless times.

Not only did Karuri save the lives of those patients, but he also filled a critical gap for a service for which there was great demand but not enough providers. While this story is certainly not meant to encourage every theatre assistant to grab a scalpel and start slicing up the next patient that is wheeled into theatre, it illustrates an innovative and practical solution to the desperate shortage of health workers globally, and in Africa in particular. Four million health workers are needed worldwide to save lives and meet health-related Millennium Development Goals; Africa alone needs one million. The urgency for a solution is fuelled by the HIV epidemic, which not only puts great pressure on already overburdened health systems, but has taken a heavy toll on health workers, thousands of whom have died or are too ill to work. Faced with this crisis, and neither the time nor resources to fill this gap any time soon, we must begin to think outside the box.

Task shifting – described as ‘the rational redistribution of tasks among health workforce teams’ – has been touted as an effective and sustainable way of harnessing and focusing existing financial and human resources to ensure that all people have access to healthcare. Though not a new phenomenon, task shifting is only recently receiving recognition as a means to expand the capacities of health systems to provide essential health services. Examples of successful use of the concept abound. Many midwives are adept at setting up intravenous drips, which they are legally not allowed to do,

but which they have had to anyway because there was no-one else to do it, and a life was at stake. Nor is it unheard of for a midwife or nurse to perform a caesarian section when presented with obstructed labour and there is no doctor around. Indeed this has become common practice for clinical officers in Tanzania and midwives in Mozambique.

Successful implementation of task-shifting requires training, as well as changes in laws and policies to accommodate such ‘skilled up’ cadres of workers. Health workers of any cadre must be trained to perform professionally and procedurally if they are to save lives, not endanger them. In Malawi, nurses and midwives have been trained to set up intravenous drips and perform caesarian sections, enabling them to save the lives of thousands of mothers and babies. In Southern Sudan, the African Medical and Research Foundation (AMREF) provides intense 3-year training for clinical officers that equips them to handle anything from surgery, psychiatry and paediatrics, to ophthalmology, orthopaedics, and obstetrics.

In 2005, after 21 years of civil war, the Government of Khartoum and the Sudan People’s Liberation Movement/Army (SPLM/A) signed a peace agreement, whereupon the Government of Southern Sudan (GOSS) embarked on strategic development initiatives for political and socio-economic recovery and development. In the health sector, with the shortage of qualified personnel to provide much-needed services, innovative approaches were required to tackle the heavy burden of disease. The breakdown in the education system during the conflict had resulted in not only a shortage of trained personnel, but limited numbers of candidates for training. The Government prioritised the need to fill this human resource gap with clinical officers who can perform 70% of physicians’ work and be trained in a shorter time.

The Maridi National Health Training Institute, a government facility run by AMREF, is the only institution in Southern Sudan that trains clinical officers. Since its inception in 1988, the institute has trained 269, forming over 70% of all clinical officers in the country. The training takes 3 years, with a 1-year internship period, at a fifth of the cost of training doctors for 6 to 7 years. The impact of the shortage of physicians in the country is

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thus minimised by a more efficient and productive use of this available cadre of health workers. The clinical officers have been christened ‘the doctors of Southern Sudan’. They carry out tasks that would normally be done by highly qualified health professionals and they are known to do them well. They are the exemplification of task shifting.

Another cadre of health worker that has proved effective in filling the human resource gap in healthcare is that of Community Health Workers. Across Africa and other parts of the developing world, there is a clear consensus that Community Health Workers are essential to efficient and effective provision of primary healthcare, necessitating increased investment in their training and remuneration, and establishment of concrete policies to regulate how they work within supportive health systems. Community Health Workers are trained to deliver basic healthcare in the communities where they live. They are selected by those communities and are answerable to them, and should, ideally, be supported by the health system.

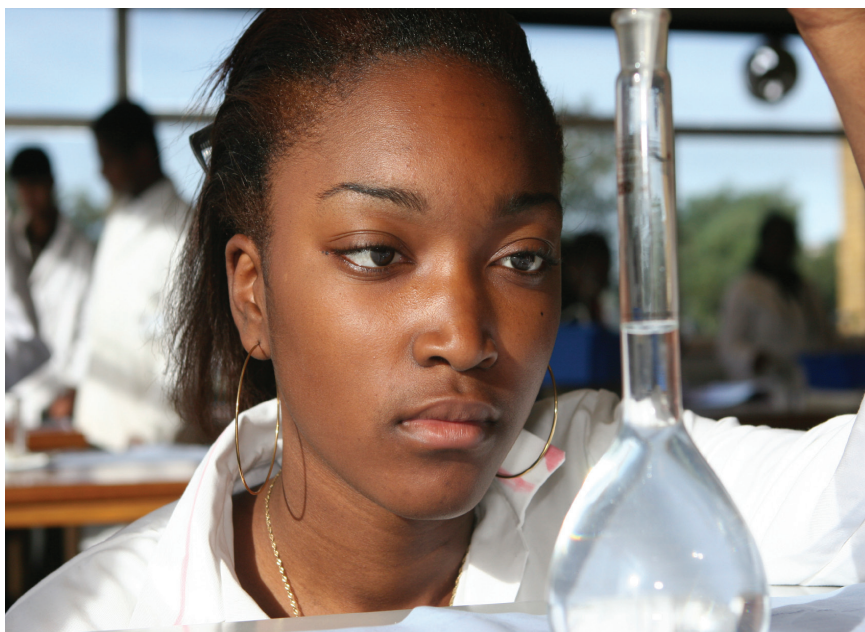
A few African countries, including Kenya, Southern Sudan, Ethiopia, and South Africa, have actually developed strategies for the formal inclusion of Community Health Workers in the health system. In Kenya, these health workers have traditionally been trained and employed by non-governmental organisations without clear regulatory guidelines scope of work, remuneration, or training. The government is now implementing the new Community-Based Kenya Essential Package for Health strategy that stipulates key issues, including recruitment, training, performance, supervision, and monitoring and evaluation.

There are several reasons for the shortage of health workers in Africa, including lack of training capacity and poor remuneration, discouraging many who would otherwise have entered the profession and forcing many others who do to relocate to countries where

they are paid more for their services – perpetuating the ‘brain drain’ phenomenon. One issue that is rarely ever highlighted, though, is the limited budget allocated to health in most governments, and in particular to the development of human resources for health. African governments are guilty of contributing to the crisis by failing to allocate enough money to train, absorb and retain health workers. In 2001, heads of state from the continent pledged in Abuja, Nigeria, to spend at least 15% of national budgets on health. So far, only Botswana and the Gambia met that target. Besides, the AU strategy is very clear about human resources for health, as, indeed, are the strategies of several many Ministries of Health. But most countries are long on commitment and short on implementation. Southern Sudan has set a good example for the rest of the continent with the creation of a full-fledged directorate dedicated to planning development of human resources for health. Most other countries have only small units that deal with personnel issues such as salaries and transfers, but not with strategic planning and expansion of capacities to provide basic healthcare.

Equally guilty is the donor community, which has been paying a lot of lip service but not doing enough to correct the situation. Take the World Bank’s structural adjustment programmes, which put a freeze on employment of civil servants in several countries, including Kenya, ensuring that thousands of trained health workers were unable to work despite shortages in hospitals and clinics across the country. And even those who have been absorbed do not operate at their maximum, due to lack of motivation as a result of low pay and poor working conditions. Moreover, the health institutions themselves do not operate as efficiently as they should for lack of strategic leadership and management.

So where do we go from here? Not only must civil society continue to lobby for human resources for health, it is, in many cases better placed than the government to put into action the plans and strategies of Ministries of Health. In Southern Sudan, AMREF is providing technical support for some of the activities spelt out in the Ministry’s strategic plan, such as training of midwives and clinical officers to meet the specific needs of that country. Similarly, successful production of adequate health workers across the continent will require innovation, and committed partnerships between governments, civil society, donors and communities to ensure provision of health services that are accessible, equitable and of good quality. Together, we can ensure that no African child, woman, or man goes without healthcare for lack of trained and skilled health service providers.



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