

Task shifting: why the controversy?

Shima Gyoh reminds us that task shifting is by no means a new phenomenon. Once again we must adapt or leave people to die because there was no-one to care for them.



Although I have never hesitated from joining the popular bandwagon of heaping blame for our national woes on our colonial history, thinking health has cultivated in me a healthy respect for the British. The real motive of colonisers was plain trade, and treaties were signed to give them dominance over certain areas. To define the areas, they had to organise governments, and that led them to also organise other services including health. Despite our frightening health indicators now, they were more ghastly then. Can you imagine the total absence of trained professional staff? No doctors, nurses, pharmacists, or laboratory technicians. No infrastructure: roads, water supply, power, you name it!

My birth was not supervised by a trained midwife, and you could say my mother and I were lucky to get away with this seventh pregnancy. Out of eight pregnancies, three of us survived to adult life, a good record then. While I was growing up in the 1940s, the British had done much to alleviate the suffering of the public. State-certified midwives and nurses were at work. They trained numerous injectors that used to line us up in scores and give us injections of penicillin in the fight against yaws that affected every child. They built dispensaries all over the land and trained numerous dispensers that were our doctors, making diagnoses, giving us medicine, washing and dressing our sores. Harmful practices were thus avoided, giving us better chances of survival and minimising all manner of disability. Hospitals were few and far between, and doctors even fewer. People with little education were trained to examine specimens and look down microscopes. Others felt our necks for glands and treated us for sleeping sickness which was very rampant. This was a world in which, in modern parlance, health was implemented by 'task shifting,' training lower grades of staff to manage conditions including some usually handled by highly educated professionals.

They did much good. Teaching of hygiene was intro-

duced in primary schools. Books about the flying doctor service in East Africa became interesting advocacy for us to go to hospital early with our health problems. They even managed to practically eradicate some diseases like yaws, smallpox, and sleeping sickness.

But then we became educated and the professional class arrived. At this time, the tasks shifted were done by even better educated staff, as most now had at least primary school education. However, we made regulations, with excellent intentions, dividing up the performance in the health sector among professionals, and forbidding anyone who did not have the benefit of higher education and training to practise those skills – the way it is done in developed countries. We succeeded in stopping the training and blocked official support for low- or middle-grade health workers carrying out functions normally assigned to higher levels. This happened at the time when very little had changed in the quality of life of the public – the standard of living which, more than anything else, defines the state of health and improves the health indicators of a nation. OK, a few diseases had been eradicated, but others like river blindness and guinea worm were resisting, while malaria and the new disease of AIDS were still killing and maiming people at 'unacceptable' levels.

There is a severe shortage of health professionals worldwide, but it is obviously worse in sub-Saharan Africa. International opinion is that we should seriously resort to task shifting even to achieve the millennium development goals, but the idea causes many of our professionals to think it is advocacy for inferior services for the public. They cannot see that the alternative to these 'inferior' services is no service at all, leaving the public in a condition worse than that of pre-colonial days.

The solution lies in the implementation of primary healthcare policies – they have task shifting already built in. Special efforts would be required in some areas, like rapid reduction of maternal mortality. Task shifting is not a replacement for, or a design to slow down the development of a professional training. It is merely an emergency measure necessary to ameliorate immediately the current awful suffering of our people.

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