Makerere University

COLLEGE OF HEALTH SCIENCES

Supporting the Use of Research Evidence (SURE) for Policy in African Health Systems

The Regional East African Community Health (REACH) Policy Initiative
Uganda Country Office

Policy Dialogue on Task Shifting for Health Workers In Maternal and Child Healthcare

Kabira Country Club
Kampala, Uganda:

Tuesday, 25th May 2010

REPORT

College Of Health Sciences
P.O. Box 7072 Kampala, Uganda
Tel: 256 414 530020/1, Fax: 256 414 532204
E-mail: principal@med.mak.ac.ug
Kampala, Uganda
1.1 Convening of the Meeting

A policy dialogue to discuss a policy brief on task shifting for health workers in maternal and child healthcare was organized by the Uganda Country Office of the REACH-Policy Initiative on the 25th May 2010 at Kabira Country Club, Kampala. The agenda is attached as Annex I.

1.2 Participation

Policymakers in health, health managers, researchers, civil society and the media participated in the meeting. The complete list of participants is attached as Annex II.

1.3 Opening of the Meeting

The Director General of the Uganda National Health Research Organisation (UNHRO), Dr Sam Okware welcomed the participants and apologized for the late start in the proceedings.

He reiterated to the participants that UNHRO is mandated to coordinate health research in the country, promote ethics and good practice in research, and ensure use of research evidence in health interventions and health policies. This dialogue to discuss the policy brief which outlines health policy options using the current research evidence is a fulfillment of one of UNHRO’s responsibilities of supporting evidence-based policy decisions. Dr Okware remarked that Uganda is lagging behind on the millennium development goals, particularly in the area of maternal and child health. How can task shifting help to solve this problem? He invited participants to introduce themselves.

He introduced the moderator, Dr Faustine Maiso, who stated that the main reason for meeting today was to discuss the policy brief on task shifting for health workers in maternal and child healthcare. Dr Maiso pointed out that the policy brief on task shifting outlines a health system problem or problems, discusses viable options for addressing the problem and implementation strategies for implementing these options. He echoed the chairperson’s call by inviting participants to give their views and comments freely on the document with mutual respect to one another. This dialogue does not aim for a consensus, it is an open discussion to enrich the policy making process. He pointed out that much as records would be kept, comments made would not be attributed to the identity or affiliation of the speaker. He requested the participants to adhere to the programme as much as possible to save time.
DISCUSSION:

2.0. Problem Section of the Policy Brief:

It was noted that there is an acute shortage of human resources for health in Africa and Uganda and slow progress towards meeting the MDGs. Uganda’s infant mortality is high at 82 per 1000 live births and maternal mortality is high at 440 per 100,000 live births compared to the USA, used as a gold standard of 12 per 100,000 live births. In addition, there is lack of access to surgical services for persons who suffer injury in road traffic accidents and persons who suffer debilitating, chronic conditions.

In Uganda, about 100 doctors are produced per medical school of the 3 medical schools per year. However, Uganda seems unable to employ the doctors it produces. The issue is not numbers, there are doctors and nurses on the streets and hospitals are empty. There is no recruitment. There is need for a policy on recruitment and retention of workers.

There is also maldistribution of healthworkers as a consequence of vertical planning. People prefer to work in urban areas because of the development there. So the issue is how we develop all the areas of Uganda. Put money in other sectors, roads, infrastructure, etc. Finances are only part of the solution, even with hardship allowance in the Ministry of Health, many personnel still resist to work upcountry. The same problem exists in the industrialized world, HRH are well paid but they still have inadequate numbers and are taking workers from the developing world.

There is a strategic direction in Uganda; government has made an effort to review its structure in view of decentralization of services so that the population could access skilled services from health workers. There have been efforts since 1996-1997, to develop a Human Resources for Health (HRH) policy, which was finalized to work towards reducing the ratio of HRH: population. The Health Strategic plan also addresses how to train and retain HRH; hence reference should be made to these documents which show efforts undertaken by government to address the problem. However, the problem is commitment to implement interventions that have been agreed upon by technocrats in government. In addition, the Mid-Term Expenditure Framework has shown zero growth in the budget, hence money for HRH cannot be increased.

3.0. Policy Options:

It would have been good to see a generic description of task shifting; the options discussed in the document are examples of how task shifting should be done. It is good to indicate which roles are task shifted from and to whom. Supervision should still be maintained by the senior cadre shifting the task. The aim should not be just to cut costs but also to increase access; hence this may entail paying more to the less specialized cadres which could actually result in higher financial
costs as their numbers are more than the specialised cadres but access to health services is improved. Monitoring and evaluation is needed if task shifting is to be implemented.

In medical training, HRH have to provide services to all including the population in rural areas and this has to be integrated in the training of HRH. HRH should be trained to be more empathetic and willing to work in rural areas. Perhaps training should include bonding of health students to hard to reach areas. Criteria for training at present are selecting students with the best marks for sciences whereas these students may not have an interest in healthcare. Students should be given career guidance early enough so they can make informed decisions.

There are concerns about the regulation of the less specialized cadres such as nursing assistants who do not fall under any professional council. The nursing council does not recognize them as professionals. The ministry of health directed to stop the training of nursing assistants.

We need to be very careful in shifting tasks to people who are ignorant. Patients should be protected from harm. What is the cost-benefit of task shifting? Traditional Birth Attendants were trained sometime back but were found to be doing more harm than good. Herbalists did a lot of harm in the early days of HIV/AIDS scourge. They mixed prescription drugs with herbs and used these to treat patients mainly for purposes of financial gain; which was both illegal and harmful.

The options presented are about tasks that are already being undertaken by these cadres. Perhaps care by less specialized cadres to improve access for all is better than high quality care for a few. What we need is a regulatory framework and a policy to oversee these activities which are already taking place anyway.

There are different levels of task shifting defined by World Health Organisation. What are the legal and regulatory frameworks, quality checks, what are the benefit-risks of task shifting? The options do not feel like we need to weigh one against the other, they are not comparable.

Most of our mothers get problems during antenatal care and delivery. Lay Health Workers (LHWs) when trained feel like they are ‘real doctors’ and overstep their limits in providing care. Drugs are actually poisons especially if in the wrong hands of poorly trained personnel. Traditional Birth Attendants (TBAs) have done more harm than good, if the govt cannot provide supplies, drugs in health facilities how can they provide these same things to LHWs?

In the Private Not for Profit sector, particularly in the rural areas we can train clinical officers better than doctors. However, the more tasks that are passed onto lower cadres, the more pay they demand otherwise we would be exploiting them.
A success story in task shifting in Uganda is extending cataract surgery to ophthalmic clinical officers from ophthalmic surgeons in some district hospitals.

4.0. Implementation Barriers and Solutions:

The College of health sciences is now using a problem based approach for training which requires students to train in rural areas. This has had some effect in encouraging students to work in the rural areas.

However, there should be additional remuneration for additional responsibility.

Task shifting may not reduce the problem but may bring about an overload of HRH with the increase in training institutions in the country.

There are health system issues that need to be addressed. Decentralisation was meant to bring health services closer to the people. Doctors cannot work in isolation, we need other support staff. It is time to revise our health system structure to attend to our current population needs.

In 1978, the Alma Ata declaration refocused training from a specialised to a more generalized health cadre. Task shifting has not just started, an example is ultrasound scanning (USS). The radiology fraternity saw it fit to extend the role of USS to lower cadres. Training was for a minimum of 6 months. However, film reporting, to interpret what is on the film, training takes 1 year. How can we get specialised roles down to the community? It needs to be taken into account whose task we are shifting, to whom it should be shifted to, and what resources and training are required.

The health system can be improved to deliver services without the issue of shifting tasks from cadre to cadre. Training of LHWs, provision of incentives, education of mothers all these are required to improve the health system.

The senior cadres should support, mentor and supervise the lower cadres. For example, if midwives are trained to do caesarian sections, the senior cadres may not be able to supervise the less specialised cadres adequately which may harm mothers.

Are mothers really comfortable with less specialised HRH? This statement needs to be repackaged. Cadres with less training tend to spend more time with patients than cadres with more specialised training. Mothers are simply more comfortable with cadres that show more care who are usually cadres with less training. A study done in Uganda showed that 83% of health seeking is outside the formal health facilities. Health workers are not good communicators. Many mothers seek care from TBAs because they handle their patients better and listen to them. Customer care should be incorporated in the training of HRH. The problem is that HRH are overworked and really do not have time for customer care. The health workers are not well facilitated to perform their duties.
There is need to rethink continuing professional development. There is need to train teams not train individuals. All members of a team should be recognized for their contribution towards care of the patient; including say cleaners working in surgical theatre. These health system problems have existed for a long time, answers should be sought from all stakeholders particularly from the community who are most affected by health system short-comings.

Our health system needs to be redesigned; hence pay-for-performance cannot work here at present. You cannot have two health cadres with similar qualifications and experience earning different compensation even if this is based on outputs. This could produce disgruntlement in the workplace. There is need to change attitudes towards work with clear performance targets and proper performance appraisal.

4.0. Closing:

Prof Nelson Sewankambo, the Principal of the College of Health Sciences thanked participants for making the effort to participate in the dialogue. He summed up the various participant views presented at the dialogue. He assured them that all views would be taken into consideration in revising the policy brief.

He thanked the chairperson and moderator of the meeting, the SURE team and Task Shifting working group that developed the policy brief. Special thanks to Dr Andy Oxman for his invaluable support to the team in producing this document.

The meeting was adjourned at 1.20 pm.
Annex I

AGENDA

Policy dialogue on Task Shifting for Health Workers in the delivery of Maternal and Child Healthcare

Supporting the Use of Research Evidence (SURE) for Policy in African Health Systems Project

Kabira Country Club, Tuesday, 25th May 2010

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<td>8.30 – 9.00 AM</td>
<td>Registration</td>
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<tr>
<td>9.00 – 9.10 AM</td>
<td>Remarks by the Chairperson</td>
<td>Dr Sam Okware</td>
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<tr>
<td>9.10 – 9.20 AM</td>
<td>Introduction of participants and Moderator</td>
<td>Dr Sam Okware</td>
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<td>9.20 – 9.30 AM</td>
<td>Procedures and Rules of the Dialogue</td>
<td>Dr Faustine Maiso</td>
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<td>9.30 – 10.00 AM</td>
<td>Problem Section of the Policy Brief</td>
<td>Discussion</td>
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<td>10.00 – 10.30 AM</td>
<td><strong>TEA/COFFEE BREAK</strong></td>
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<td>10.30 – 11.30 AM</td>
<td>Policy Options Section of the Policy Brief</td>
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<td>11.30 – 12.30 NOON</td>
<td>Implementation Strategies of the Policy Brief</td>
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<td>12.30 – 12.45 PM</td>
<td>Wrap up</td>
<td>Mr Delius Asiimwe</td>
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<td>12.45 – 1.00 PM</td>
<td>Evaluation of the policy dialogue</td>
<td>Dr Harriet Nabudere</td>
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<td>1.00 – 1.15 PM</td>
<td>Closing Remarks</td>
<td>Prof Nelson Sewankambo</td>
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<td>1.15 PM</td>
<td><strong>LUNCH</strong></td>
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<td>Departure</td>
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Annex II

List of Participants

Christine Rebecca Mubiru
Principal Policy Analyst
Ministry of Health
P.O.Box 14299, Kampala, Uganda
TELEPHONE (OFFICE): 0414 340 874
MOBILE NUMBER: 0712 974 587
EMAIL: crmubiru@hotmail.com

Mpiima Kibirango Patrick
Registrar, Allied Health Professionals Council
Ministry of Health
P.O.Box 7272, Kampala, Uganda
TELEPHONE (OFFICE): 0414 345 688
MOBILE NUMBER: 0772 503 126
EMAIL: mpiimap@yahoo.com

Dr. Musinguzi Henry
M&E – Programme Officer
STDIACP- MOH
P.O.Box 7272, Kampala, Uganda
MOBILE NUMBER: 0712 980436
EMAIL: h2musinguzi@gmail.com

Sentongo Miriam
Senior Medical Officer
Ministry of Health
P.O.Box 7272, Kampala, Uganda
TELEPHONE (OFFICE): 0414 340 874
FAX NO: 0414 321572
MOBILE NUMBER: 0772 413433
EMAIL: stogomir@hotmail.com

Sakina Kiggundu
President, Uganda Private Midwives Association
P.O.Box 71114, Kampala, Uganda
TELEPHONE (OFFICE): 0414 273943
MOBILE NUMBER: 0712 866940
EMAIL: upma@africaonline.co.ug

Charles Isabirye
Principal Health Training Officer
Ministry of Health
P.O.Box 7272, Kampala, Uganda
MOBILE NUMBER: 0772 893011
EMAIL: cisabirye@netscape.net
Sam Luboga
Associate Professor
Makerere University College of Health Sciences
P.O.Box 7072, Kampala, Uganda
MOBILE NUMBER: 0772 503275
EMAIL: lubogasam@gmail.com

Prof. John C. Lule
Associate Professor
Dept. of OB/GYN
Makerere University College of Health Sciences
P.O.Box 7072, Kampala, Uganda
MOBILE NUMBER: 0772 425104
EMAIL: luleje@yahoo.co.uk

Emmanuel M. Kaijuka
Professor
Makerere University, School of Public Health
TELEPHONE (OFFICE): 0772 503860
MOBILE NUMBER: 0772 503860
EMAIL: drkaijuka@yahoo.com

Isaac M. Kagimu
Human Resource Advisor
Uganda Catholic Medical Bureau
P.O.Box 2886, Kampala
TELEPHONE (OFFICE): 0414 269705
FAX NO: 0414 510575
MOBILE NUMBER: 0772 402965
EMAIL: impoza@ucmb.co.ug
sorach@ucmb.co.ug

Betty Kasanka
Senior Medical Officer
Ministry of Health
P.O.Box 7272, Kampala
MOBILE NUMBER: 0752 645532
EMAIL: abenakyobk@yahoo.com

Kyakulaga Cranmer Francis
Lecturer
Uganda Christian University
P.O.Box 4, Mukono
TELEPHONE (OFFICE): 0312 350800
MOBILE NUMBER: 0702 437310
EMAIL: fkyakulaga@ucu.ac.ug
Faustine Maiso
National Professional Officer
World Health Organisation
Plot 60, Prince Charles Drive, Kololo
TELEPHONE (OFFICE): +256 414 335500
FAX NO: +256 414 335569
MOBILE NUMBER: +256 754 401356
EMAIL: fmaiso@yahoo.co.uk
maisof@ug.afro.who.int

Dr. Stella Neema
Senior Lecturer
Makerere University, Faculty of Social Sciences
P.O.Box7062
TELEPHONE (OFFICE): 0414 540650
MOBILE NUMBER: 0772 457576
EMAIL: sheisim@yahoo.com

Dr. Juliet Bataringaya
Country Advisor, Health Systems Development
World Health Organisation
Plot 60, Prince Charles Drive, Kololo
P.O.Box 24578
TELEPHONE (OFFICE): +256 414 335500
FAX NO: +256 414 335569
MOBILE NUMBER: 0772440381
EMAIL: bataringayaj@ug.afro.who.int

Okwany Rogers
Journalist
The New Vision Newspaper
P.O.Box 9815, Kampala, Uganda
TELEPHONE (OFFICE): 0413 337 000
MOBILE NUMBER: 0772 479590
EMAIL: okwanyrogers@yahoo.com

Patience Akumu
Journalist / Lawyer
Observer Media
Plot 1, Tagore Crescent, Kamwokya
MOBILE NUMBER: 0712 821622
EMAIL: veroak2001@yahoo.com

Anne Mugisa
Journalist
The New Vision Newspaper
P.O.Box 9815, Kampala, Uganda
TELEPHONE (OFFICE): 0414 337000
MOBILE NUMBER: 0752 693912
EMAIL: amugisa@newvision.co.ug

Violet Nabatanzi
Journalist
Vision Voice Radio
The New Vision Publishing Co.
P.O.Box 9815, Kampala, Uganda
TELEPHONE (OFFICE): 0414 337000
MOBILE NUMBER: 0772 688797
EMAIL: nviolet@yahoo.com
vnabatanzi@newvision.co.ug

Nabukeera Florence
Journalist
Bukedde FM
P.O.Box 9815, Kampala, Uganda
TELEPHONE (OFFICE): 0312 337000
MOBILE NUMBER: 0772 976337
EMAIL: keeraflo@yahoo.com

Shifa Mwesigye
Journalist
The Observer
Plot 1A, Tagore Crescent, Kamwokya
TELEPHONE (OFFICE): 0414 230433
FAX NO: 0414 230440
MOBILE NUMBER: 0701 250805, 0754481505
EMAIL: smwesigye@observer.ug
shifahazel@yahoo.co.uk

SURE Secretariat:

Prof Nelson K. Sewankambo
Principal
College of Health Sciences
Makerere University
MOBILE NUMBER: 0782 366751
EMAIL: sewankam@infocom.co.ug

Dr. Harriet Nabudere
Project Coordinator
College of Health Services, Makerere University
P.O.Box 7072, Kampala, Uganda
TELEPHONE (OFFICE): 0414 530020/1
FAX NO: 0414 532204
MOBILE NUMBER: 0772 490096
EMAIL: hnabudere@gmail.com

Mr Delius Asiimwe
Research Scientist
Supporting Use of Research Evidence for Policy (SURE Project)
College of Health Sciences, Makerere University
New Mulago Hospital Complex, Administration Building, 2nd Floor
P.O Box 7072, Kampala, Uganda
Mobile: +256 (0)772 496 036
Email: deliusasiimwe@yahoo.com
Observers:
Andy Oxman
Researcher
Norwegian Knowledge Centre for the Health Services
Oslo, Norway
TELEPHONE (OFFICE): +47 4825 4924
EMAIL: oxman@online.no

Goran Tomson
Professor
International Health Systems Research
Department of Public Health Sciences
Karolinska Institutet
Tel: (Office): +46 8 524 833 59
Mobile: +46 70 618 62 98
Email: goran.tomson@ki.se