Policy dialogue

Task Shifting for Health Workers in Maternal and Child Healthcare

Kampala, Uganda
25 May 2010

Report

This report was prepared by the Uganda country node of the Regional East African Community Health (REACH) Policy Initiative.

This policy dialogue was informed by the following policy brief: Nabudere H, Asiimwe D, Mijumbi R. Task shifting to optimise health workers’ roles to improve the delivery of maternal and child healthcare (SURE policy brief). Kampala, Uganda: College of Health Sciences, Makerere University, 2010.

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What is a policy dialogue?
A structured discussion focused on an evidence-based policy brief

The agenda from the policy dialogue is attached as Appendix 1

Who participated in the dialogue?
People with relevant expertise and perspectives, including policymakers, civil society and researchers

The complete list of participants is attached as Appendix 2

What was the aim of the policy dialogue?
That discussion and careful consideration should contribute to well-informed health policy decisions

The dialogue did not aim to reach a consensus or make decisions

What is included in this report?
Views, opinions and insights of individual participants reported without attribution

The opinions included in this report reflect the understanding (or misunderstanding) of individual participants in the dialogue

These opinions may or may not be consistent with or supported by the policy brief or other evidence

It should not be assumed that the opinions and insights in this report represent a consensus of the participants unless this is explicitly stated

Nor should it be assumed that they represent the views of the authors of this report
Key messages

The following statements represent views, opinions and insights of individual participants in the policy dialogue.

Conflicting views were expressed about the need for task shifting in Uganda:

- Factors affecting access to health workers were identified as governments’ ban on recruitment resulting in a redundant health workforce who could still be made use of, maldistribution of health workers seeking better remuneration thus favoring urban areas compared to rural areas, private sector employment compared to public sector employment.

- If task shifting were adopted, there should be adequate supervision by senior cadres over the lower cadres to whom tasks have been shifted

- Mechanisms should be adopted to increase HRH retention such as bonding of students to work in rural areas,

- Compensation should be commensurate with the tasks shifted. There should be additional remuneration for additional responsibility to avoid exploitation of the lower cadres

- Task shifting is already in existence in Uganda, e.g. radiography assistants conducting ultrasound scans. What we need is a regulatory framework and policy on task shifting

- There is no need for task shifting; training for HRH needs to be improved with adequate provision of incentives and education of mothers to improve the health system.

- Customer care training should be provided for HRH and training should focus on teams as opposed to individuals,

- Education curricula for HRH need to be revised to reflect the new tasks to be included in pre-service training
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Background

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.

The problem

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.

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.

**Implementation considerations**

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.

Next steps

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.
### Appendix 1: Agenda

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

Kabira Country Club, Thursday, 25th May 2010

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<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Speaker</th>
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<tbody>
<tr>
<td>8.30 – 9.00 AM</td>
<td>Registration</td>
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<tr>
<td>9.00 - 9.10AM</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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<tr>
<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  Discussion</td>
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<td>10.00 – 10.30 AM</td>
<td>TEA/COFFEE BREAK</td>
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<tr>
<td>10.30 – 11.30 AM</td>
<td>Policy Options Section of the Policy Brief  Discussion</td>
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<tr>
<td>11.30 – 12.30 PM</td>
<td>Implementation Strategies of the Policy Brief  Discussion</td>
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<td>12.30 – 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>LUNCH</td>
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<td>Departure</td>
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Appendix 2: Participants

Christine Rebecca Mubiru, Principal Policy Analyst, Ministry of Health

Mpiima Kibirango Patrick, Registrar, Allied Health Professionals Council, Ministry of Health

Musinguzi Henry, M&E – Programme Officer, STDIACP-MOH

Sentongo Miriam, Senior Medical Officer, Ministry of Health

Sakina Kiggundu, President, Uganda Private Midwives Association

Charles Isabirye, Principal Health Training Officer, Ministry of Health

Sam Luboga, Associate Professor, Makerere University College of Health Sciences

John C. Lule, Associate Professor, Dept. of OB/GYN, Makerere University College of Health Sciences

Isaac M. Kagimu, Human Resource Advisor, Uganda Catholic Medical Bureau

Emmanuel M. Kaijuka, Professor, Makerere University, School of Public Health

Kyakulaga Cranmer Francis, Lecturer, Uganda Christian University

Betty Kasanka, Senior Medical Officer, Ministry of Health

Faustine Maiso, National Professional Officer, World Health Organisation

Juliet Bataringaya, Country Advisor, Health Systems Development, World Health Organisation

Stella Neema, Senior Lecturer, Makerere University, Faculty of Social Sciences

Anne Mugisa, Journalist, The New Vision Newspaper

Patience Akumu, Journalist / Lawyer, Observer Media

Okwany Rogers, Journalist, The New Vision Newspaper

Violet Nabatanzi, Journalist, Vision Voice Radio

Shifa Mwesigye, Journalist, The Observer

Nabukeera Florence, Journalist, Bukedde FM

SURE Secretariat

Nelson K. Sewankambo, Principal, College of Health Sciences, Makerere University

Harriet Nabudere, Project Coordinator, College of Health Services, Makerere University

Delius Asiimwe, Research Scientist, Supporting Use of Research Evidence for Policy (SURE Project), College of Health Sciences, Makerere University

Rhona Mijumbi, Project Officer, Sure Project, Makerere University
Observers

Andy Oxman, Researcher, Norwegian Knowledge Centre for the Health Services

Goran Tomson, Professor, International Health Systems Research, Department of Public Health Sciences, Karolinska Institutet
Authors
Harriet Nabudere, MD, MPH *
Delius Asiimwe, MA *

*Regional East African Community Health (REACH) Policy Initiative, Uganda and Supporting the Use of Research Evidence (SURE) for policy in African Health Systems Project, College of Health Sciences, Makerere University, Kampala, Uganda

Address for correspondence
Dr Harriet Nabudere
SURE Project Coordinator
College of Health Sciences, Makerere University
P.O. Box 7072, Kampala
Kampala, Uganda
Email: hnabudere@gmail.com

Competing interests
None known.

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