Policy dialogue

Task Shifting for Health Workers in Maternal and Child Healthcare

Kampala, Uganda
27 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:
  - Task shifting has already been taking place in the Ugandan health system with health cadres such as nurses and clinical officers taking on roles that were not meant for them originally. The need now is to develop a policy to regulate what is already happening anyway.
  - Before shifting tasks, Uganda should make use of its redundant health professionals who have ended up engaging in other commercial activities other than performing the roles for which they were trained; such as doctors working in pharmacies.
  - It is not clear whether enough health professionals are being trained, even if we were able to employ all the health cadres that have been trained so far.

- Conflicting views were also expressed regarding the roles of nursing aides and traditional birth attendants (TBAs):
  - It is not clear why nursing aides are being discontinued. Nursing aides have been in the system for a long time although they are not recognized professionally.
  - TBAs should be part of Village Health Teams to provide information so that the community can access health services. A problem associated with TBAs is reluctance to refer mothers who need more specialised care under skilled birth attendants.
  - TBAs should not be part of the solution in task shifting because the World Health Organisation has advised that they be phased out of national health systems. Nursing aides should also be removed from the system.
  - Less specialised cadres such as nurse aides take on the burden of health care provision in public health facilities in rural areas. So support should be given to these cadres.

- Terms such as ‘less specialised health workers’ need to be avoided as they might imply that poor quality services will be provided by these less skilled health workers.

- Incentives must be adequate to motivate health workers. At the same time, attention must be paid to corruption. There have been issues of fraud, with some health professionals registering in two neighbouring districts to access the government payroll for two full-time positions because of the low salaries.

- There is need for development and implementation of standard operating procedures to help those to whom tasks have been shifted.

- Curricula for health workers should be revised to reflect the current needs for training.
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Background

The Director General of the Uganda National Health Research Organisation, Dr Sam Okware welcomed the participants especially the Honourable members of the Parliament of Uganda.

A lot of research has been conducted in Uganda but it has not been translated into practice or policy. There is a need to change this. Uganda is behind in the millennium development goals and one of the contributing factors is the acute shortage for human resources for health.

Only 17% of the Ugandan population goes to public health facilities as first point of healthcare, the majority of the population first seeks help with other providers of care including traditional healers.

Dr Okware invited the participants to introduce themselves, after which he introduced the moderator, Dr Faustine Maiso who would be facilitating the proceedings. Dr Okware made an especial welcome to the Acting Permanent Secretary and Director General of Health Services, Ministry of Health, Dr Kenya Mugisha.

Dr Maiso explained that the reason for meeting today is to discuss the policy brief on task shifting for health workers in maternal and child healthcare. Maternal mortality and child mortality in Uganda is very high. A systematic review of research studies was conducted to produce an evidence-based policy brief on task shifting. This document assesses our health system problems, discusses viable options for addressing these problems and implementation strategies for implementing these options. This policy brief was prepared to support decision makers in the Ministry of Health, the Legislature and others who make decisions regarding policy for health. This document does not make recommendations as to which policy option should be adopted. 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 participant.

General discussion surrounding task shifting in Uganda

The maternal and child health sector is underfunded and there is need to step up funding for the health sector in general. Some development partners have stepped in this gap, but a lot more needs to be done.
We need sound research evidence to make informed decisions for good health policy. There is need to bring together all the stakeholders, researchers, policymakers, the community such as farmers to implement beneficial policies such as the DDT policy for internal residual spraying to protect against malaria. This policy has not been so successful perhaps because some stakeholders such as the farming community were left out of discussions.

Task shifting has already been taking place in the Ugandan health system with health cadres such as nurses and clinical officers taking on roles that were not meant for them originally. Nurses are giving intravenous fluids and clinical officers are performing surgeries. The need now is to develop a policy to regulate what is already happening anyway.

Uganda has taken part in international dialogues on task shifting in the health services as this is a global phenomenon, some of which have been hosted here in our country. We need to develop further the decisions that were taken at the various international dialogues.

We want Traditional Birth Attendants (TBAs) to be part of Village Health Teams (VHTs) to provide information so that the community can access health services. Some of the problems associated with TBAs is reluctance to refer mothers who need more specialised care under skilled birth attendants.

Task shifting has worked in Mozambique, clinical officers are able to perform surgical operations. The same thing has happened in Malawi. In Ethiopia, all paramedical schools have been converted into medical schools to deal with the acute Human Resource for Health (HRH) crisis.

In Cuba, every 200 homes have 1 doctor. The infant mortality rate as a result is very negligible. However, should Uganda formalize task shifting? Uganda has 156 health centre IVs, which need 2 doctors each. This is a total of 312 doctors for health centre IVs alone. Each year Uganda puts out 200 doctors. So does Uganda really need task shifting? We need to take up all the unused and unemployed HRH before we can consider task shifting. For countries such as Malawi, Mozambique with critical shortages of HRH, task shifting is a viable solution. However, Uganda should make use of its redundant HRH who have ended up engaging in other commercial activities other than performing the roles for which they were trained; such as doctors working in pharmacies.

Why doesn’t Uganda have a policy on task shifting, even in the presence of so much role extension already in the health sector? It is not easy to pass policy. This is a very extensive process. Perhaps the present members of the legislature can respond to this. A lot of policy proposals are pending in parliament. Task shifting is not yet clear to some of the senior decision makers. Skills and knowledge should be provided to the less specialised cadre before a role can be shifted to them. Quality should not be compromised in this. Also the less specialised cadre should not be overwhelmed in the roles extended to them.

The issue now, why remove nursing aides? Nursing aides have been in the system for a long time although they are not recognized professionally.
Nursing aides received a one off training for 3 months, several years ago. With attrition over time, the trained nurse aides left government facilities. Thereafter, nurse aide schools opened illegally, which were not permitted by government. The government is trying to replace nurse aides with enrolled comprehensive nurses, whose curricula have been developed and many of these cadres have now been passed out. A member of parliament demanded to know why we are training comprehensive nurses if we cannot employ all of them.

The only shortcoming for this health cadre is that there is not enough hands-on training in reproductive health for enrolled comprehensive nurses. Hence they cannot take on maternal and child health (MCH) care activities.

Many of our mothers cannot tell the difference between skilled healthcare providers and unskilled providers like TBAs. Many times the people in our constituencies demand for increased access to health services when they mean traditional practitioners like TBAs.

The problem

The problems are known that bring about high infant and maternal mortality. The issue of HRH is mismanagement of our HRH. How can we produce so many doctors and nurses and fail to employ them? The issues are financial motivation and other incentives, poor support, etc. Uganda collects a lot of money through taxation enough to meet our basic needs, but use of these revenues is not prioritized appropriately.

Poor political will and poor prioritization are part of the problem. This coming financial year in June, the cut of the national budget for health will be reduced. 47% of public positions in the health sector are vacant; is this a problem of inadequate numbers or no funding from government to fill these positions? Some time ago, the ministry of public service advertised for health care positions to be filled, but there was very little response from the unemployed HRH. Is it because they earn better in the private sector?

Why should we expect health workers to work in rural areas where infrastructure and social services are very poor? Uganda cannot pay these HRH well enough to meet their personal and family needs. What we need to do is provide re-training for nursing aides who are already working in our health facilities. In these rural locations, it is the less specialised cadres such as nurse aides who take on the burden of health care provision in public health facilities. So support should be given to these cadres. The government makes some bad decisions such as scrapping housing for HRH, which worked against government efforts to recruit HRH. The technical personnel working in government ministries should be able to advise the executive on what works and what does not work based on research evidence so policy mistakes like this are avoided in future.

Terms such as ‘less specialised health workers’ need to be avoided as they might imply that poor quality services will be provided by these less skilled healthworkers.

Some funding might be available such as the incoming World Bank loan to the health sector; there is strong need for prioritization on how to use this. There was a time when government imposed a ban on public recruitment for several years. Why should we be
surprised that trained HRH are not employed and are on the streets? Why does government train HRH and then put a ban on recruitment of the same? It means the public resources that went into training were wasted and this should not be tolerated. Taking care of our HRH on the job means that better care will be taken of health consumers seeking services.

Why should we get lower cadres to do the work of higher cadres when the higher cadres themselves are not employed? Is it because we want to exploit the lower cadres because we shall pay them less for the same tasks performed? How will these lower cadres feel? 85% of mothers deliver normally; it is the 15% who get complications. The mothers with complications require doctors to intervene. Task shifting does not mean doctors should be removed from the system. There are tasks that can only be performed by doctors.

### Policy options

We should not compromise the quality of health service provision in task shifting. We should identify those tasks that can be shifted safely from one health cadre to another.

The government is committed to provide skilled HRH for the health sector. Task shifting is already in existence at an informal level despite the fact that there are unemployed qualified HRH in Uganda. There are reasons for this dilemma and perhaps task shifting should be undertaken as a temporary medium term solution until such a time when government can recruit and retain adequate HRH.

TBAs should not be part of the solution in task shifting because the World Health Organisation (WHO) has advised that they be phased out of national health systems. Nursing aides should also be removed from the system.

Perhaps this agenda for task shifting is being pushed by donors who are willing to fund this program while this may not be a solution for Ugandas’ health service problems. Why don’t we revise the curricula of the lower health cadres to include these new tasks we expect them to take on in the field? Why should we wait for these health cadres to be posted at their stations and then they are told that they must now take on tasks normally performed by higher cadres such as doctors?

### Implementation considerations

Incentives must be adequate to motivate HRH; otherwise we shall not be able to solve this crisis. There have been issues of fraud, with some HRH registering in two neighbouring districts to access the government payroll for two full-time positions because of the low salaries.

Government has made good plans in the Health Policy and Strategic Plan for the health sector; but if we fail to implement these plans; we fail in our duties to the population. Government should revise its policies such as the ban on recruitment for HRH, why should government train health workers and fail to employ them? There is need for
development and implementation of standard operating procedures to help those to whom tasks have been shifted.
We shall take this policy brief and champion it in parliament; except for the issue on nursing assistants. We should close down nursing aide schools.
Patient education materials should be translated into local languages. If we educate our communities into demanding for health services; are we really ready to take on this increased demand?
We should re-instate user fees in the health system. Our constituencies have communicated that they would rather pay additional fees to the health facilities if this means there will be adequate drugs and personnel in government health facilities.
Employ the trained comprehensive nurses who can take on tasks in nursing, midwifery, community service, etc. Our constituencies are giving under the table payments to HRH in government facilities. Why don’t we make these payments ‘formal’ as user fees? The only downside is that there are some members of the population who are too poor to afford these and they could potentially be mistreated at the health facilities for failing to make a financial contribution.
Comprehensive nurse training has been halted because of the poor quality of training. Government is considering review of this policy to reverse to single training programs for either nursing or midwifery, with double training from one programme to another still possible. In-service training is going to be organized to upgrade skills.
The government policy now on TBAs is to be part of the Village Health Teams to do health promotion, community mobilization but not actually deliver pregnant mothers. The Uganda government decided to terminate training of TBAs and does not supply them with kits.
If nursing aides were phased out last year, how come they are still working in government health facilities? If these were removed, public health services will collapse. There is no money to employ the higher health cadres.

Next steps

Prof Nelson Sewankambo thanked the participants for their spirited discussion. He reflected on the various views that had been presented at the dialogue, such as controversies surrounding DDT. The dialogue on task shifting is an on-going issue.

If there are deficiencies in the curricula of our HRH; curricula are not static and should be revised to reflect the current needs for training HRH without necessarily eliminating particular health cadres from the system. Are we training enough HRH, even if we were able to employ all the health cadres that have been trained so far? This is something to consider.

Dr Sam Okware thanked the SURE team and Task Shifting working group that developed the policy brief.
Appendix 1: Agenda

Agenda

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

Kabira Country Club, Thursday, 27th May 2010

8.30 – 9.00 AM  Registration

9.00 - 9.10 AM  Remarks by the Chairperson
                Dr Sam Okware

9.10 - 9.20 AM  Introduction of participants and Moderator
                Dr Sam Okware

                Dr Faustine Maiso

9.30 – 10.00 AM Problem Section of the Policy Brief
                Discussion

10.00 – 10.30 AM TEA/COFFEE BREAK

10.30 – 11.30 AM Policy Options Section of the Policy Brief
                Discussion

11.30 – 12.30 PM Implementation Strategies of the Policy Brief
                Discussion

12.30 – 1.00 PM  Evaluation of the policy dialogue
                Dr Harriet Nabudere

1.00 – 1.15 PM  Closing Remarks
                Prof Nelson Sewankambo

1.15 PM  LUNCH

Departure
Appendix 2: Participants

Ssinabulya Sylvia, Member of Parliament
Kubeketerya James, Member of Parliament
Nansubuga Sarah Nyombi, Member of Parliament
Angufiru Margaret, Member of Parliament, Ayivu
Kenya Mugisha N., Ag. Director General Health Services / Permanent Secretary, Ministry of Health
Emmanuel M. Kaijuka, Professor, Makerere University, School of Public Health
Faustine Maiso, National Professional Officer, World Health Organisation
Charles Isabirye, Principal Health Training Officer, Ministry of Health
Nabatanzi Lillian, Network Coordinator, Parliament of Uganda
Anne Mugisa, Journalist, The New Vision Newspaper
Alisemera Babiiha Jane, Member of Parliament
Sam Okware, Director General, Uganda National Health Research Organization
Anthony K. Mbonye, Commissioner Health Services, Ministry of Health
Kavuma Jenifer Ute, General Secretary, Uganda Medical Association
Violet Nabatanzi, Journalist, Vision Voice Radio
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Competing interests

None known.

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