Mid-level providers online forum

Digest of day 4 (potential to improve distribution of health workers and access to care)

Responses by Barbara McPake, Institute for International Health and Development, Queen Margaret University, Edinburgh

Last week we posed the following questions, responses to which are summarized and commented on below each. Many thanks to everyone who contributed to this rich discussion.

1. Are there better data available that would help establish the current situation with regard to numbers, and location (public vs. private sector; urban vs. rural) of these cadres?

Respondents point out that some countries do produce reliable data whereas others do not. Some called for an internationally supported effort to improve data collection, but perhaps the liveliest debate over the past week has concerned the question of defining mid-level providers which would seem to be needed first. If we are going to count something, we had better know what it is we are counting. It may be helpful to define workers according to their length of training but this would not solve problems of discriminating between what they are trained to do, and what starting point is required in terms of years of schooling or further education, or success in those. Without resolution to this, ad hoc data collected from national systems that happen to count something, are likely to remain the only source of information and we are likely to remain unclear as to the importance and role of these cadres beyond specific country narratives.

2. What measures would support the role of mid-level cadres in improving distribution specifically?

Respondents make well supported points. If mid-level cadres are drawn from local under-served populations and if they are trained there, they are more likely to remain. Bonding schemes have been suggested and these have been shown to work in some places, to constrain international nurse migration. However, constraining internal migration is probably more complex. Would the bonded worker be required to stay in a particular job, at a particular facility, in a particular district, or in rural areas more generally? At the extreme end of that continuum, human rights issues loom large - the situation approaches indentured labour (slavery) and the worker would have little protection from exploitation and abuse. If employment were restricted to a district or to designated hard-to-fill posts, there are more practical difficulties – tracking the individual, defining and enforcing penalties. In the end, there is probably no short cut around the third category of recommendation on this point. Mid-level cadres need to be retained in post by adequate pay and conditions and career opportunities.

This raises a new discussion point – how can career opportunities be structured that also retain skilled and experienced workers in hard-to-fill posts? Often there are limited staffing numbers in total in remote facilities and the shallow hierarchy pyramids are
characterised by hierarchies among cadres rather than within cadres. Professional rivalries constrain the ability to advance of members of each specific cadre.

3. Can mid-level cadres be adequately supported in posts where more qualified staff are absent or in severe shortage? What roles can and do they play in these circumstances?

Given the imbalances that result from the inability to fill posts in hard-to-staff facilities, it is probably inevitable that all cadres end up undertaking roles for which they have not been trained. This argues for the broadest orientation in training all cadres and against the increasing specialisation that all professional groups see as the route to advancement for their members.

The need for supportive supervision is recognised. Perhaps, rather than emphasising the hierarchy across cadres and expecting that mid-level cadres will be supervised by high-level cadres who are in short supply at district (and sub-district) level as well as at individual facility level, career advancement and supervision goals could be jointly met by promoting more experienced mid-level cadres to more centralised supervisory roles. Perhaps this happens in some contexts but my impression is that this is the exception rather than the rule.

Really, as you can see, I would like to continue the conversation and throw out more points for discussion. I’m sure there will be opportunities for that in the future.
Summary of postings by participants.

Sarasivathy Eddiah (Malaysia) reports that in Malaysia statistics on MLP distribution are available from the MoH. Eddiah recommends improved availability and use of information and training curricula that allow MLP to operate autonomously as two of the key strategies that could specifically improve distribution. Making reference to the Malaysian experience of nursing aides and medical assistants, Eddiah thinks that MLP can effectively operate autonomously in areas lacking more qualified staff, as long as adequate training is provided and there are possibilities of referral.

Mwangi Johnson (Clinical Officer, Kenya) comments that MLP are, according to the initial statement provided, more numerous than doctors, cautioning against characterizing their number as "small". He suggests that prioritizing recruitment from communities where they will serve, and improving remuneration and professional development opportunities are strategies that could specifically improve distribution. Johnson worries that in under-served areas MLP often end up delivering also services for which they have not been adequately trained.

Kumar Gopal (India) explains that better data would be possible only if governments routinely collected statistics also for these cadres, and calls upon WHO to "support the definition of global standards and support countries in collecting these vital statistics". Gopal concurs with the idea of prioritizing recruitment of MLP from the same ethnic and linguistic group of populations where they are supposed to be deployed, and agrees also with improving remuneration and promotion opportunities. But, in addition, another option worth exploring is that of bonding schemes, i.e. requesting MLP trained with public funds to serve in rural areas. The role of MLP in under-served areas depends on the local health system context, including the disease burden and referral possibilities.

Hela Kochbati (Researcher; Afard, Tunisia) worries that if MLP are only seen as a stop gap measure their important contribution to improving equity in service delivery can be lost when sufficient numbers of traditional cadres become available. Kochbati recommends that appropriate training programs, adequate communication, fair and reliable compensation, sufficient resources, infrastructure, supportive supervision, evaluation, and feedback systems are needed to improve MLP distribution, and suggests that successful approaches should be disseminated for learning and wider adoption.

Abdurahman Ali (Chief Executive Officer; Ethiopian Nurses Association, Ethiopia) reports that in his country "access to HR data is not easy and in most cases incomplete or not available at all levels of the health system", with limited linkages between the MoH and its regional health offices. Ali recommends that in order to retain MLP and eventually improve their distribution, it is necessary to provide a fair remuneration package, continuing education opportunities, and improving the work environment and management systems in which they practice. Furthermore he suggests to empower them with key skills (such as strategic planning, leadership, policy and advocacy, M&E) to be able to operate more strategically and effectively at their level.
1 Am sorry for the late reply.

1. Are there better data available that would help establish the current situation with regard to numbers, and location (public vs. private sector; urban vs. rural) of these cadres?
Data can be gathered through a global data collection from the Ministry of Health in each country. The Ministry of Health in Malaysia has the data needed, whether in the public vs private sector or the urban vs rural areas.

2. What measures would support the role of mid-level cadres in improving distribution specifically?
In improving distribution of mid-level cadres specifically, there must be sufficient data on the population of the public vs private sector and the urban vs rural areas. Distribution must also be more where there is less access to big hospitals compared to the city. Sufficient training must also be given so that these mid-level cadres can work independently, in the absense of doctors or physicians.

3. Can mid-level cadres be adequately supported in posts where more qualified staff are absent or in severe shortage? What roles can and do they play in these circumstances?
They can, provided training is given. But scheduled evaluation must be done to evaluate their competency. In Malaysia, school leavers are recruited and given minimal training (mostly first aid) and used as nursing aides. These nursing aides, with expereince, then in turn go for certificate training and come out as assistants. The lucky ones, go for upgrading courses and become staff nurses.

With the shortage of doctors in the rural areas, the Ministry of Health has also opened One Malaysia Clinics solely run by Medical Assistants (now known by the name of Assistant Medical Officers). The patients are referred to the doctors if there are any serious problems.

The staff nurses in the rural areas also play the same role with regards to ante-natal cases. Theses nurses must have mid-wife courses and the clinics are solely run by them, and cases referred to the doctors only for the first visit check-up and ultrasounds.

The Ward Attendants on the other hand, have also been given training by attending upgrading course form Level 1 to Level 3. In Level one they are taught how to do Sponging, Mouth toilet and Bed Making and other simple task. They are then given a log book to achieve competency. They are subsequently allowed to do theses simple task under minimal supervision. This has minimize the burden of the staff nurses in the ward.

Sarasivathy Eddiah, Malaysia
I have a comment on the initial statement before giving an answer to the questions.

the statement says that "numbers are small", but from the statistics in the table it looks like in most African countries clinical officers and medical assistants are more than doctors, so "small" is relative. and as Kenya shows, clinical officers are also less likely than doctors to go to private sector. But these are data from 2004, isn't there new information?

on the questions.

1. Are there better data available that would help establish the current situation with regard to numbers, and location (public vs. private sector; urban vs. rural) of these cadres?

I wonder the same

2. What measures would support the role of mid-level cadres in improving distribution specifically?

1) recruiting from communities; 2) better salary; 3) more training and promotion opportunities

3. Can mid-level cadres be adequately supported in posts where more qualified staff are absent or in severe shortage? What roles can and do they play in these circumstances?

they end up doing everything, even if they might not be sufficiently trained

Mwangi Johnson
Clinical officer, Kenya

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1) better data would only be possible if statistics were routinely collected also for these cadres. given that in most cases they are not adequately categorised or even defined it is difficult to get hold of good information. governments maintain records through payrolls but these are not necessarily accurate or update regularly. WHO should support the definition of global standards and support countries in collecting these vital statistics. There is truth in the saying that "you cannot manage what you cannot measure".

2) I agree with previous intervention: recruitment from local communities, or if this is not possible at least same ethnic and language group. In addition improved remuneration and career ladders are also important. But I would also add bonding schemes: if the government invests in training health workers, it is right to expect something in return, and a minimum of, say 10 years of rural service following the 3 years of training.

3) this depends on circumstances, possibility of referral, and disease burden. there is no "one size fits all".
1. Are there better data available that would help establish the current situation with regard to numbers, and location (public vs. private sector; urban vs. rural) of these cadres?

Cadres who raise ethical arguments based on notions of equality and different situation between urban and rural locations in Tunisia show that - that the new cadre is a result in standard care for the rural population should understand that one of the principles of healthcare ethics is the principle of justice and an important expression of justice is equity. The provision of a primary level of healthcare to all sections of society according to their needs is crucial in achieving equity in healthcare provision. Nevertheless, there is a danger if we approach the present initiative in health human resources as a stop in a gap arrangement which can be reversed when enough of the present cadre of medical personnel are trained and made available for the rural areas. Our health system would only benefit if we approach them as an important type of healthcare provider and use their potential in providing universal primary level of healthcare.

2. What measures would support the role of mid-level cadres in improving distribution specifically?

Measures like careful selection of programs for training, communication, formation, fair and reliable compensation, resources, infrastructure, supportive supervision and evaluation, and feedback systems must be in place to allow implementation of good practices in services. There must be opportunities for career advancement in tandem with professional and academic development. Lifelong learning must be inculcated and accessible to ensure continued better quality distributed and shared of care that can be achieved by health system management.

Information on creative strategies, success stories, and lessons learnt should be assembled and dispersed. Distribution of roles and Evaluation and research about improving workforce effectiveness, planning, policy, and programmes is needed. An international collaborative networking and research agenda, coordinated, and aligned with other initiatives on health systems research, will avoid wasting time and resources and can also provide opportunities to develop capability of scientists and medical cadres. Ministries of Health and international organisations should be encouraged to help translate research results into action. A link across training and education, health care systems, and labour markets will assist in developing a system that will address these synergistically. This is an eye care for their education will be, how they fit into an eye care team, and if and how much they are paid by government will vary from country to country.

3. Can mid-level cadres be adequately supported in posts where more qualified staff are absent or in severe shortage? What roles can and do they play in these circumstances?

A strong human resource management and mid-level cadres can have function and operating at the local level and their roles are likely to improve by care team adequation for the enhancement of their competence, qualification, workforce motivation and performance.
1. Are there better data available that would help establish the current situation with regard to numbers, and location (public vs. private sector; urban vs. rural) of these cadres? Access to HR data base is not easy and in most cases incomplete or not available at all levels of the health system in public or private. The MOH health indicator is one of the existing reference available as far as Ethiopia is concerned. The data was captured on the bases of the yearly output of the training institutions and deployment mainly in the public sector. There are no networking system, between the MOH and regional health offices electronically as far as HRH is concerned. The HMIS is quite generic for Ethiopia, but I do not have evidence the HR is part of the data base.

2. What measures would support the role of mid-level cadres in improving distribution specifically? The migration of health workers from rural to urban from the public to private is quite evident due to economic reason and lack of positive practice environment. Fair enumeration package, salary, incentive, continuing education opportunity in any form, regular or distance would helps to retain them and eventually improving the distribution. The policy makers should aware of the impact of positive practice environment on HRH crisis and strategize the health policy in consideration of this critical factor.

3. Can mid-level cadres be adequately supported in posts where more qualified staff are absent or in severe shortage? What roles can and do they play in these circumstances? Empowering them with all sorts of leadership skills in the form of training or opportunity to exercise leadership at their level is essential. They have to be involved in strategic planning and policy dialogue to build their capacity to lead the health care with confidence. I feel MLP lack skills on strategic plan, leadership, policy and advocacy and on M&E. Other wise MLP like nurses are the backbone of the system, but the accumulated wisdom of these professionals is not utilized with full capacity to strengthen the health system in most countries including in my country.

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Ethiopian Nurses Association