What do we know from the literature on MLWs

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The Task Force on Health Systems Research 2005

- Interventions to reduce mortality and morbidity are well established but are “being implemented at disappointingly low rates and inequitably, at the cost of preventable suffering and millions of lives”.
- Fragile health institutions, skills drain, weak professional governance, lack of political accountability and poverty, all contribute to deterioration of health in Africa

Global policy recommendations 2010

- B1 Introduce and regulate the enhanced scope of practice in rural and remote areas to increase the potential for job satisfaction
- B2 Introduce different types of health workers with appropriate training and regulation for rural practice in order to increase the number of health workers practicing in rural and remote areas

Do we just need more of everyone?

- Estimated need - 2.5 hws for every 1000 people to provide basic healthcare
- Human resource shortage of 720 000 physicians and 670 000 nurses in SSA
- Or need another 1 million to meet MDGs!

Mid-level health workers

- are front-line health workers in the community, who are not doctors, but who have been trained to diagnose and treat common health problems, to manage emergencies, to refer appropriately and to transfer the seriously ill or injured for further care.

- MLWs active in 25 of 47 sub-Saharan African countries [critical shortage countries]
- 18 countries – non-nurse based programmes, training secondary school leavers, which avoided depleting scarce ranks of nurses
- Example: researchers in Southeast Nigeria found that of 252 health workers in 10 primary care clinics, none were doctors, only 8.8% were nurses and the remainder were various cadres of community health workers

	Total MLW	MLW per 100 000	Physician per 100 000
Kenya	4152	11.9	13.2
Malawi	2900	22.2	1.1
Mozambique	981	4.9	2.4
Uganda	6000	21.2	4.7
Zambia	1000	8.6	6.9

Regulation

- The authority to practice usually granted by a national professional body, such as a Health Professions or Medical Council in conjunction with the MOH
- Kenya has a specific professional board for clinical officers, that regulates both training and practice under an act of parliament.
- Tanzania and Zambia have boards that regulate training but do not register or regulate practice

- Significant informal substitution often occurs – nurses and MLWs perform procedures normally disallowed by regulations – breech deliveries, episiotomies etc – due to unavailability of physicians.
- “if clinical officers are unable to provide these services they may simply become a transit referral point, another bottleneck in emergency care” Dovlo 2004

Quality and morale

- Only 20% doctors and 22% MLWs used adequate diagnostic process in examining an under-five child [Malawi audit]
- MLWs treated as second-best, temporary until enough physicians trained, instead of recognition as key front line health workers responsible for care of their communities
- Poor work environment, perceptions of resource inadequacy, staff members indicating that they had neither sufficient staff nor time to do their work
- Inadequate management support and a sense of not being valued by their managers
- Burnout, emotional exhaustion, low personal accomplishment

- lack of a career structure - feelings of being trapped – leads to internal migration especially in younger MLWs
- Bottleneck to specialisation training and posts – but often do not improve promotion prospects or pay even when completed extra qualifications
- MLWs in Tanzania could progress to asst medical officers but did not get same respect or recognition as doctors

Lessons from other areas

Increasing numbers of MLHWs is not a solution on its own –

- needs accompanying investment in supervision, district team strengthening, morale building and training
- recognition, career and skills development are strong motivators
- positive feedback from patients is valued and seen as indicator of professional conduct
- poor pay and status are linked with difficulties in retention

Advantages of MLHWs

- Trained in less time, with less cost
- Less reliant on hospitals and advanced technology
- Provide a wide range of services such as orthopaedics, minor surgery, anaesthesia
- More connected with community workers
- May uncover unmet need that needs further attention [eg in chronic disease management]
- training is more practical and focused on local health need, serving more deprived populations
- MLHWs are more likely to continue working in rural or district health services than medical doctors

To improve quality standards

- Supportive supervision and mentoring
- Curriculum review and problem based methods of training [adult learning]
- Require release of doctors and senior nurses from routine tasks for leadership roles: to review health information, review complex cases, develop protocols, provide feedback

Task shifting

- Requires changes in regulatory framework, certification, licensing registration, training, monitoring
- Task shift appropriate tasks to community workers, who will need supervision
- Will increase burden on nursing staff unless increase in numbers
- Non-nursing MLWs bring new people in to health work who may not have been attracted to nursing
- Role clarification

Task shifting physician to nurse – HIV management

- Mozambique and Rwanda
- Correct eligibility for ARV treatment
- Correct prescription and adequate monitoring lab control [CD4 counts]
- Good adherence to treatment and probability of retention in care

Task shifting

- 942 hours of nurse time freed up 737 hours of physician time, which could then be expended on more complex cases and work in non-HIV areas, providing increased physician capacity for the health system as a whole [Chung 2008]

Comparable health outcomes

- Nurses achieve health outcomes as good as family physicians, with good patient satisfaction, especially in chronic disease care such as diabetes and hypertension, if detailed management protocols are available or if they receive training

- Use of guidelines, training and supervised rational prescribing have led to reductions in inappropriate injection use and drugs prescribed, increased generic prescribing, improved compliance with recommended protocols for malaria and diarrhoea, and better drug labelling
- Development of clinical pathways and protocols for use by team, and enhancement of these through feedback from the team

Malawi

- Clinical officers conducted 93% of major obstetric operations in government hospitals, and no significant differences were found between their post-operative outcomes compared to medical officers in terms of postoperative well-being, stillbirths or neonatal mortality; outcomes improved with training

Supervision

With close supervision, feedback and follow-up nurse practitioners in SA demonstrated improved quality of care:

- Better record keeping
- Adherence to protocols: 85% STIs vs 68% of control diagnosed by syndromic approach; 97% vs 80% treatment in line with guideline
- Improved staff attitudes were a key factor in patient satisfaction

Need for professionalization

- International recognition as a profession
- Creation of association or professional body, with valued identity and social status
- Recognised body of knowledge
- Standard setting and clear role expectations
- Share experiences in meetings and conferences
- Self-regulation

- Endorsement of altruism and vocation
- Public perception of valued professionals
- Improved motivation leads to improved quality of work

Resistance from other health professionals

- Physicians and nurses opposed MHW programmes
- Competition, inadequate supervision and redundancy of care
- Concern that MLHWs could masquerade as physicians and do work for which they are not trained
- Attitude that this results in second class service

Role of professional bodies

- In protecting interests of their members have defended levels of specialisation inappropriate to the health needs of low and middle income countries
- Uganda – nurses organisations tried to block development of comprehensive nurse cadre
- Restrictions in prescribing: often by legislation

can be overcome

- Task shifting is occurring in rich countries also – increased demand for services, more chronic disease etc
- Evidence of equivalent quality of care [need for this from developing country context] – needs more publicity
- Demonstrate improvements in patient safety through better supervision
- Better value for resource inputs – other professionals can focus on what they do better [nurses & doctors]
- Benefits of reduced workloads and increased time for higher professional demands
- Evidence that initial hostility has changed to collaboration in Mozambique and acceptance in Ghana