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Human Resources for Health

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Developing Effective Human Resources for Health (HRH) as part of Health System Strengthening

By: Augustine B. Kiplagat ZHRC, Lake Zone

Human Resource Management (HRM) in the health care system has often been viewed as the responsibility of Human Resource Officers. However, with the modern trend in health care delivery, nearly all health care managers and health care workers in general have to be empowered with this very important element so as to be able to strengthen the entire health care system. The world is currently experiencing a shift in the global health agenda from an emphasis on disease-specific approaches to the focus on health system strengthening.

Human Resource Management is seen as the integrated use of data, policy and practice to plan for necessary staff, recruitment, deployment, development and to support health care workers. All these elements in HRM are important in ensuring Human Resource for Health (HRH) are managed and empowered well enough so that they provide quality health care services.

A study conducted by World Health Organization (WHO) in 2008 on Challenges in the health workforce identified some of the major challenges that go beyond the shortage of health care workers that include: inadequate payment, motivation, training and supervision as well as the poor working environment.

In response towards strengthening the Human Resource Management beyond the Human Resources officers, the

The Zonal Health Resource Center Office-Lake zone

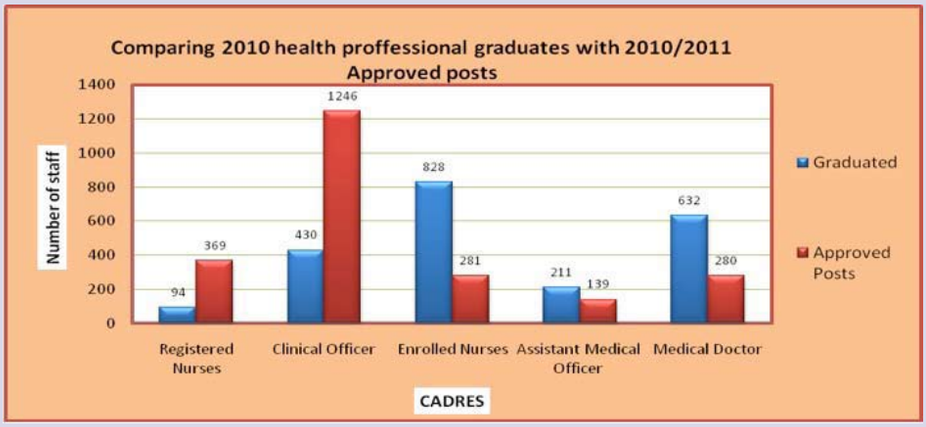
Zonal Health Resource Centre - Lake Zone in collaboration with different development partners like I-TECH, BMAF, JHPIEGO, BAYLOR and Intra Health has been supporting the Districts Health Management Teams (DHMT) in capacity building on the following key issues in effective human resource management such as: Workforce planning, Human Resource Information System (HRIS), Recruitment and deployment, Orientation & Induction of new recruits, Performance Management and the Open Performance Review Appraisal System. Other areas include: professional development, ways of improving the work place environment, Health care workers retention as well as Leadership and Management in the Human Resource context.

The lake zone has realized that all the above mentioned key areas of professional development are very important in strengthening the health care system which is the crucial in the country interventions and Global Health initiative for sustainability of interventions.

Inside this issue:

ABSORPTION OF HEALTH PROFESSIONAL GRADUATES TO THE PUBLIC SECTOR EMPLOYMENT: WHAT IS THE STATUS?

By: Dr. Ellen Senkoro, Benjamin Mkapa Foundation



(Source: Ministry of Health & Social Welfare)

The Analysis shows:

The Government of United Republic of Tanzania for the FY 2010/11 released employment permit of 7,471 approved posts of different health cadres to the public sector. As of March 2011, a total of 6,230 (84.4%) out of the approve posts were posted to respective duty stations.

The Analysis indicates varied levels of absorption of health professionals by cadre into the public service employment system, in relation to the production.

- There were more graduates chasing the few vacancies for enrolled nurses, AMOs and medical doctors. Only 34% of enrolled nurses, 44% of Medical doctors and 66% of Assistant Medical Officers (AMOs) graduates could be recruited to fill the vacancies.
- Some vacancies could not be filled for lack of adequate number of graduates for registered nurses and clinical officers.

Implications and Key message:

- The Local Government Authorities (LGAs)should prioritize cadres that are readily produced in health training institutions in an effort to equitably absorb health professionals that can service HRH needs of both public and faith based health facilities.
- The President's Office Public Service Management should relate the staff establishment with the actual HRH shortage and the comprehensive needs of the LGAs, and other Government Hospitals and Training Institutions.
- The Government and Private sector should adequately plan for producing health workers according to country's need.
- Concerted efforts are required to enhance linkages between the production of health professionals from training institution and the annual employment permit issued for public sector.

WE CALL UPON EACH ONE OF US TO PLAY PART IN IMPROVING THE HUMAN RESOURCE FOR HEALTH SITUATION IN TANZANIA!

Editor's Note

Dear Readers,

Our Dear Readers,

We are happy to welcome you to the 10th edition of the Human Resources for Health (HRH) newsletter.

This edition contains interesting news and research findings on HRH issues Tanzania. You will get to read on HRH development effective in strengthening the health systems and absorption status of health graduates in the Public sector. You will also get to know the new program on "Treat and Train" insisted by Touch Foundation. You will also be able to learn more on how"Task shifting" as a short term solution to the existing HRH crisis in Tanzania. Read on how young children can be saved from febrile illness if only carefully examined.

We hope you enjoy this edition and look forward for your comments.

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The Treat and Train Program - Touch Foundation

By: Tory Ervin, Touch Foundation

Healthcare workers such as doctors, nurses and pharmacists are the lifeblood of the health care systems. Without a strong health care workforce these systems cannot provide basic primary care to tackle HIV/AIDS, Malaria and Maternal mortality, or provide specialist care necessary to manage the rising prevalence of non-communicable diseases e.g. cardiovascular disease, diabetes and cancer. The establishment of a strong health care workforce necessitates expansion of the health care worker training pipeline, as well as effective deployment and retention strategies.

The Touch Foundation's work at Bugando, is supporting the training of 1,100 health care workers across 12 cadres, including 590 physicians. The Touch Foundation's future efforts will continue to focus on training new health care workers, but in addition the Foundation will focus on ensuring their successful deployment and retention to those areas where the greatest need exists.

In the upcoming year the Touch Foundation will be launching a new program, "*Treat and Train",* which will be funded by USAID and other partners and will be centered at Bugando. This program has been created in coordination with the MOHSW.

This innovative program will rotate teams of specialists from Bugando and from two US academic institutions through regional and district hospitals in the Lake Zone, who will treat patients and provide clinical training to students. This will allow for the numbers of health care workers trained at Bugando to continue to increase – or at least maintain currently high levels – while allowing students to gain clinical experience necessary to serve communities effectively post-graduation. Access to highly skilled health care professionals in some of the most under served communities will save and improve the lives of thousands. Clinical education rotations will include an OBS/GYN rotation, ensuring that the MDG 5 is tackled as part of the program.

The launch of "*Treat and Train"* will mark the beginning of an exciting new chapter for the Touch Foundation. We look forward to sharing with you news of our progress in the upcoming months.

For more information please visit *www.touchfoundation.org* or contact Tory Ervin at *Victoria_ervin@mckinsey.com*

Touch Foundation Staff with various health stakeholders

Huge potential for improved health service quality

By: O. Mæstad, S. Lange (CMI) and A. Mwisongo (HSRC)

Health workers' knowledge and skills are much better than their practice suggests. By closing the gap between knowledge and action, the quality of health services will increase substantially. In recent years, much attention has been devoted to the need to increase the number of health workers to strengthen the quality of health services in Africa. A study from rural Tanzania shows that there is also a huge potential for improving service quality with the existing workforce, by reducing the large gap between knowledge and practice. Trained clinicians may be able to provide high quality care without following guidelines 100 per cent. However, with the present level of performance, many cases of serious illness are probably not accurately diagnosed, with the likely consequence that lives are lost and patients are mismanaged.

What are the reasons for the low level of performance? Do health workers lack knowledge? Some do, but their level of knowledge typically exceeds actual performance by far; there is a large gap between knowledge and action. Why then don't the health workers put more of their knowledge into practice? Are they overworked due to a low number of health workers? We find that they are not, and we conclude that health workers are capable of performing at a much higher level than they presently do.

A large know-do gap

We presented health workers with a knowledge test in order to measure whether the level of performance is constrained by lack of knowledge (see Box 1). Health workers perform much better on the test than when they consult real patients. The test result demonstrates that health workers are able to perform almost twice as many diagnostic assessment tasks as they presently do when consulting patients; only 58% of their knowledge is put into practice. In other words, the gap between knowledge and practice (know-do gap) is 42% (Figure 1). Most likely, the know-do gap is even larger, as our measure of knowledge is a very conservative one.

Importantly, some of the procedures that are most important in order to diagnose the severity of illnesses are at the same time the procedures where that gap between knowledge and practice is largest. For example, to auscultate the chest and/or count the respiratory rate are important procedures to detect severe pneumonia. 75 and 56 per cent of the clinical officers mention that they will do these procedures in the knowledge test, but in practice they do it with only around 20 per cent of the children. This suggests that knowledge is presently not the limiting factor for improved performance.

Symptom	Investigation	Performance score (%)	
		In knowledge test	*In practice*
Cough	Auscultate the chest	74.7	21.4
Diarrhea	Pinch abdominal skin	75.8	31.1
Diarrhea	Ask about vomiting	72.4	29.9
Diarrhea	Examine for sunken eyes	70.8	29.2
Diarrhea	Inability to drink or breast feed	71.4	33.2
Cough	Count respiratory rate	56.2	19.5
Fever	Take temperature	80.7	48.0
Fever	Ask about pattern of fever	45.5	14.0
Fever	Ask about cough	69.8	38.3

***Table 1:** The procedures with the largest absolute difference between knowledge test score and practice. Data based on clinical officers' examination of 933 children.*

To say that there is a large gap between knowledge and practice is not to say that more knowledge cannot make a difference. Three in ten patients in our study area were consulted by health workers who are not supposed to prescribe treatments. Although these health workers may have acquired substantial skills through on-the-job training, their performance is not as good as for trained clinicians; a clinical officer performs almost twice as many relevant diagnostic procedures as a medical attendant. To ensure that more health facilities are staffed by trained clinicians should therefore continue to be a high priority. The large gap between knowledge and practice for all groups of health workers shows, however, that training is not enough.

High workload does not explain the large know-do gap

According to the World Health Organization, Tanzania has a critical shortage of health personnel. This might explain the large know-do gap; when the number of patients is too large, there will not be enough time to provide each with proper treatment.

This explanation is not valid in our study area. The number of patients is not as high as one might expect. We found that each clinician had 18 patients per day and that he/she spent 5.7 minutes with each. The average clinician therefore spent less than two full hours a day in patient consultations which is a manageable workload.

There are large differences in workload

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Can Task shifting offer a sustainable solution to the existing HRH crisis in Tanzania?

By: Michael A Munga, National Institute for Medical Research (NIMR)

This article presents preliminary findings of a scoping study done in Kongwa district, Tanzania. The aim of this study was to explore and generate primary evidence to inform the ongoing discussions on whether task shifting practices in the country's health system should be scaled up or not. Specifically, the study sought to explore opportunities and challenges which may potentially be offered/posed by implementing task shifting in the context of limited research evidence and the growing HRH crisis in the country.

The literature review and focused in-depth interviews have revealed a number of interesting findings. Few of these findings are reported in this article. **Firstly**, task shifting has been practiced in the health care delivery system for quite a long time now; and has been accepted as only capable of providing short term solution to the problem of acute shortages of HRH both in terms of numbers and skills. The study has further revealed that both the previous and the current or ongoing implementation of task shifting in Tanzania were/are not evidence based. In this regard, recommendations from the literature and key informants involved in this study emphasized the need to generate and synthesize evidence in order to inform the current practice and policy direction on whether to scale it up or not. The need to think pro-actively and take policy actions for creating long-term and sustainable solution to the problem of shortage of health workers in the country was also emphasized. Such policy actions include increasing the fiscal space of the Ministry of Health and Social Welfare(MoHSW) in order to be able to improve the HRH management systems at all levels (national and district level). In close collaboration with other stakeholders, the MoHSW should strive to increase the training output of the required health workers. Obviously, the training mandate (not just that pertaining to medical professionals) is scattered over many stakeholders of whom the MoHSW has no direct control of. In this case, if the objective is to increase training output, then the MoHSW should take a strong coordinating role of aligning the interests and resources which other stakeholders might potentially bring to bear in all processes leading to increased production of health professionals.

Secondly, it was revealed that implementing task shifting in its current form presents a unique opportunity for increasing coverage and access to health intervention especially in those areas which are critically under served. However, it was cautioned that to delegate tasks of implementing 'complex' interventions to health workers with limited skills might be counterproductive to yet another important goal of health care delivery: that of delivering quality health care services to those in need. Related to this aspect, informants emphasized that for the interest of quality, preference should be more on 'vertical' task-shifting (for example that of shifting tasks of a Medical Officer to Assistant Medical Officer/ Clinical Officer) than 'horizontal' task shifting (for example shifting physician clinician's tasks to non-physician clinician –such as from a Medical doctor to a nursing officer/assistant. It was echoed that the latter form of task shifting is resource intensive as it requires excessive mentoring and supervision-which may in turn compound the thrust of the shortage of qualified.

Thirdly and perhaps more importantly is the finding that in the context of adequate and positive incentives with institutionalized supportive supervision, task shifting might be a motivating factor to those for whom tasks have been delegated. Under supportive supervision and effective mentoring, task shifting can be a motivational factor especially when lower cadre personnel is trusted and assigned responsibilities which would otherwise be performed by a higher cadre. For this to happen, it was emphasised that financial and non financial incentives be provided in tandem with the existence of supportive supervision and effective mentoring. Task shifting was similarly perceived to contribute to increased rural retention of health workers. In both scenarios, informants insisted that in order to substantiate this finding, there is a need for future researches to employ bigger sample sizes than the one used in this study and employ mixed methods for the interest of rigour and better evidence needed to inform both policy and practice.

Fourthly, are the challenges that were perceived to potentially come out due to the implementation of task shifting practices. These challenges are related to the need for more resources for training, mentoring and supervising those health workers to whom tasks might be delegated to. In case of absence or insufficiency of resources, a rush to scaling and formalising implementation of task shifting in health care delivery may very likely compromise the quality of health care services both as perceived by clients and as prescribed in the country national health policy and its corresponding guidelines. **In conclusion, t**he preliminary findings presented in this article provide a context, albeit narrow, for which policy and future research discussions can be premised. In the context where many remote districts in Tanzania have huge shortage of

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across health facilities. Some places are crowded with patients; some of the facilities had between 40 and 50 patients per clinician per day. However, the surprising fact is that the thoroughness of the diagnostic process was not any lower at these health facilities than in places with less than ten patients. This is yet another indication that workload presently is no major reason for low quality health care in these rural areas; even the most crowded facilities were able to maintain the same quality level as other facilities.

Huge potential for improved performance

In sum, our findings suggest that there is a huge potential for improved quality of health services with the existing workforce. Health workers possess more knowledge than they use in practice, and their workload is not so overwhelming that it prevents the provision of quality care. Lack of equipment is not a likely explanation of low performance either, as almost every procedure we have studied can be performed without equipment (only a thermometer and a stethoscope would be required, but these were available, or could be obtained, at most facilities).

Health workers willingness to serve their patients needs to be strengthened

The survey data suggests that health workers lack sufficient motivation to perform up to their potential. This finding is largely confirmed by the qualitative data. Although most clinical officers interviewed said they have a "calling" for their work, many added that their motivation, or 'heart', for doing a good job had gradually been eroded. One third of the informants admitted that their own work ethic is low, and the great majority said that *others* are negligent when consulting patients. One said:

"Salaries are so low, and so is the work morale. You work, but the willingness to give that extra is castrated. Instead of thinking of examining the patient in front of you, however I don't know where I will get school fees for my child. You might find that people look for bribes, but it is not that they like doing it, but because of the hardness of life."

The "knowledge test"

Each clinician (or non-clinician when they do prescribe) is presented with three hypothetical patient cases. One surveyor acts as a patient with a specific illness. He tells the health worker his main symptom(s) in response to questions asked by the clinician. If the clinician wants to make an examination, he will tell the patient which examination, and the patient will tell him what he would find. The clinician then makes a diagnosis. A second surveyor observes and records what the clinician does during the "consultation". The clinician is encouraged to perform up to the best of his knowledge, but the test results are probably still heavily influenced by normal practice. A more theoretical test would probably result in an even higher knowledge score.

This clinician implies that low salaries are the reason for low motivation. However, it would be too hasty to conclude that higher payments would solve the problem. The objective is that health workers should be willing to put in enough effort with each of their patients. This willingness can be installed in various ways, not only through money. In the health sector, a strong professional ethic and emphasis on caring attitudes have been important mechanisms to promote patient-centered services. These values do not presently seem have sufficient foothold among Tanzanian health workers.

One possible way forward is to build a stronger professional ethic amongst health workers. This may be a slow and cumbersome route, but may yield large long-terms gains. Alternatively, or in addition, other sources of motivation have to be activated. It is beyond the scope of this article to discuss the alternatives in detail. We confine ourselves to pointing at two possible avenues, which may be mutually reinforcing. One is to strengthen human resource management within the health sector (this may include a range of measures, from the "soft" ones, such as increased recognition and appreciation of the work that is being done, to the "harder" ones, such as monetary incentives and sanctions). The other avenue is to empower local communities to engage in closer monitoring of their service providers. Both avenues have demonstrated promising impacts in neighboring countries Rwanda and Uganda.

Can Task shifting offer a sustainable solution?

Continued from pg.5

health personnel, it is almost inevitable for task shifting to be considered as one of the quick fixes. However, increasing the capacity of training institutions to produce more professionals as they are needed and empowering employers to be able to recruit and retain health workers, stand to be one of the potential effective and sustainable strategies for dealing with the crisis of HRH which continue to eat the essential vitals of the country's health care system. This can be achieved by involving all important stakeholders in all HRH management functions and ensure that the MoHSW is given the capacity to assume a coordinator and facilitator roles of all the processes related to production, recruitment/ deployment and retention of workers. For whatever policy action taken now or in the future and in the current times of growing body of evidence, task shifting can only serve as a short term solution to the HRH crisis in Tanzania as it will for many health systems face similar challenges.