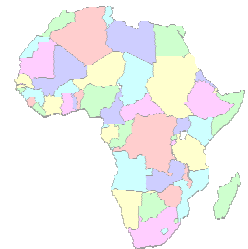


# The Supply Side:

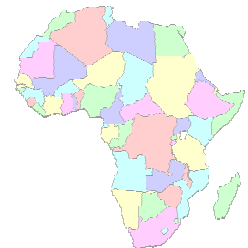
Training to Work at Home

Delanyo Dovlo

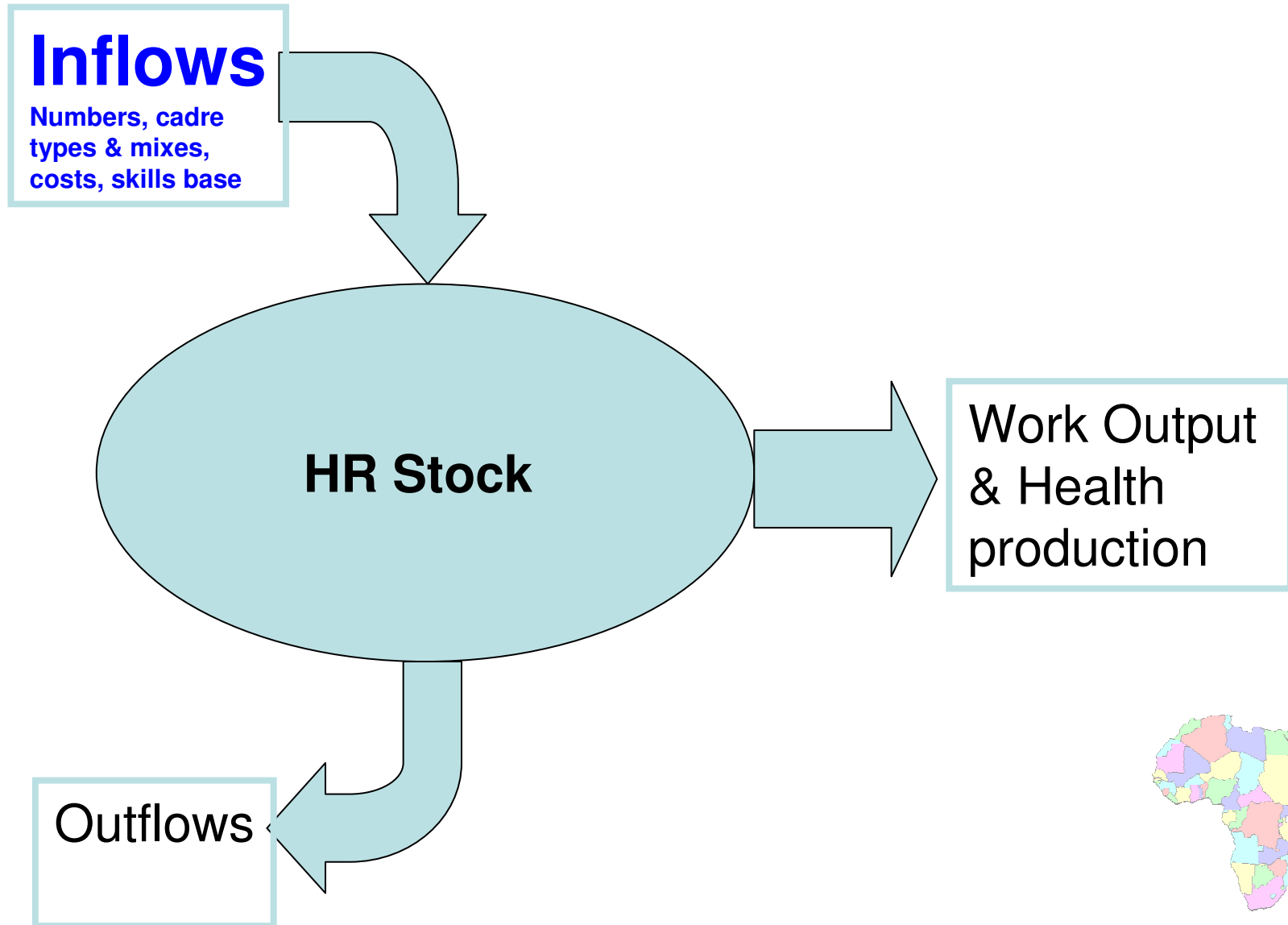


# PARADOXES OF HEALTH IN AFRICA

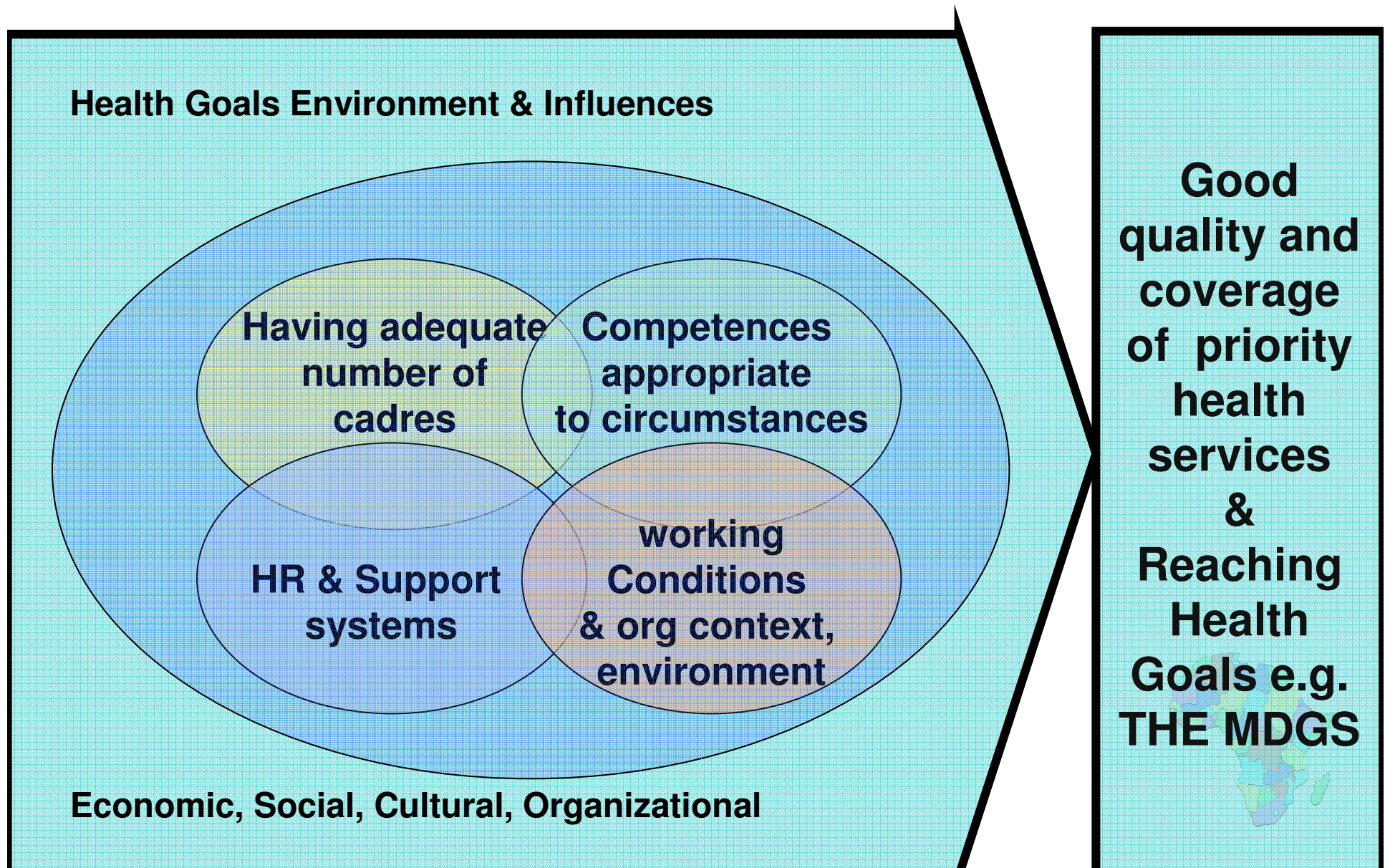
- Highest disease burden/lowest density of HWs/popn.
- Health problems differ but HWs profiled as developed countries.
- Training curricula along lines of industrialized countries?
- Majority of HWs serve a minority of the population in urban areas
- Skill mix/span limited by an "anti-mid-level" HW posture
- Fiscal space restricts taking on more HWs.
- ?70% of popn see untrained Traditional HPs anyway
- Health Professionals lost to countries with much better HW density.
- From JLI Africa working Group report



# Intervention points?

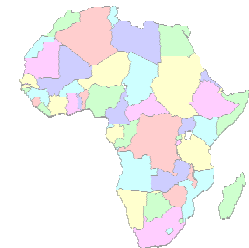


# Strategy Issues: cadres for work at home



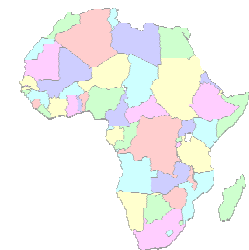
# Supply that Stays

- **Right Numbers**
  - (e.g.: AMOs, COs, MAs) *Substitution* with reduced "international tradability" and limited International reciprocity/professional lobbies
  - Training linked to local needs/demand and to support/oversight.
- **Right Competencies:**
  - Country specificity
  - Motivation and professional horizon
  - Training infrastructure,
- **Working Support Systems:**
  - Supervision support and reinforcement
  - Work tools, skills range commensurate with tasks
  - Job significance & career progression
- **Context & Work Environment influences**
  - Advocacy, national & client acceptability
  - Influence on community services uptake
  - Inter-professions acceptability and coherence.
  - Long term implications –changing context and economics.



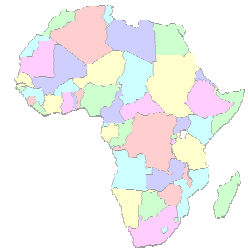
# Critical implementation issues

- Advocacy & building consensus
- (Inter) national configuration & retention
- Regulation & legal frameworks
- Motivation, incentives & career pathways
- Inter-cadre relations (substitutes & substituted)
- Comparisons of quality of care

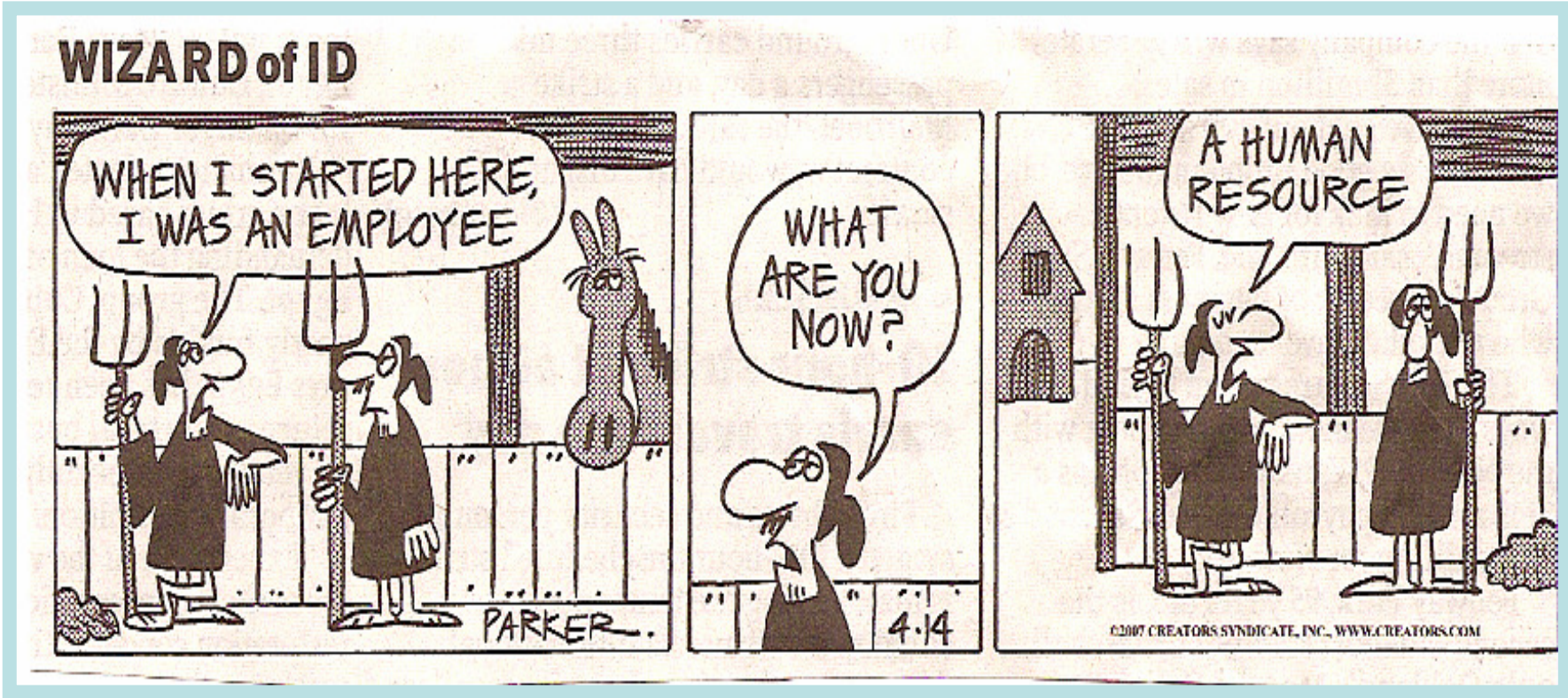


# Implementation Issues cont.

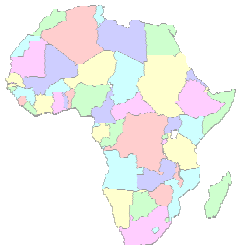
- Comparisons of costs, cost-effectiveness, financing – training, salary, equipping
- Avoiding "Cadre proliferation"
- Avoiding "Wastage" from limited skill span, QoC issues
- Study and understand what works & why



# END



Motivation matters for all cadres

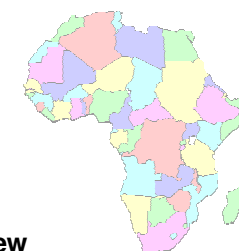




# "substitution"

**Table 1: Summary: types of substitution**

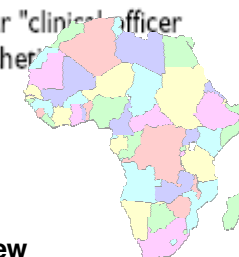
Substitution type	Brief description	Examples
1. <b>Indirect substitution:</b> Delegation of some Professional Tasks	Substituting a professional with an existing but different professional (changes scope of practice of another cadre to cope with delegated tasks)	1. Enhanced midwives' roles in Ghana 2. Nurse anesthetists 3. Enhanced abortion management roles for nurses in Zambia and South Africa
2. <b>Direct substitution:</b> Delegation of most professional skills	Substituting an existing profession with a newly created cadre (both cadres may coexist, with overlapping professional functions)	1. Clinical officers/ medical assistants in Malawi and Ghana 2. Assistant medical officers and surgical technicians in Tanzania and Mozambique
3. <b>Intra-cadre skills assignment</b> or delegation	Delegating some specific "specialist" tasks to professionals with less training, in the same profession	1. Diploma ophthalmologists, psychiatrists, ENT specialists, WAHC 2. Theatre and intensive care nurses without formal training, in Ghana
4. <b>Delegation of non-professional tasks</b>	Delegating certain aspects of tasks in order to relieve professionals of unwarranted workload	1. Health aides in Ghana. 2. Pharmacy assistants in Ghana
5. <b>Informal substitution.</b>	Existing "lower-trained" cadres, especially in remote and rural areas, will carry out tasks in the absence of the appropriately recognized professional	Happens in many rural areas in Africa



# "substitution"

Table 3: Educational structure for "doctor substitutes"

Country	Cadre name	Basic schooling	Basic pre-service education	Postbasic education	Specialized education
<b>Ghana</b>	Medical assistant	12 years	3 years (nursing)	1 year	none
	Nurse anesthetist	12 years	3 years nursing	18 months	none
	<i>Doctor</i>	12 years	6 years		2–5 years
<b>Kenya</b>	Clinical officer	12 years	3 years (clinical officer)	1 – 1.5 yrs	
	<i>Doctor</i>	12 years	6 years (medical school)		3–4 years
<b>Tanzania</b>	Clinical officer	12 years	2 years	3 years (AMO) (+ 5 years' practice)	2 yr (AMOs)
	<i>Doctor</i>	12 years	6 years (medical school)		3–4 years
<b>Mozambique</b> basic, medium & specialist	Medical assistant; surgical/obstetrical technician	10 years	2.5 years medical assistant	1.5 years – surgical/obstetrical technician	
	<i>Doctor</i>	12 years	6 years (medical school)		
<b>Malawi</b>	Medical assistant/clinical officer	12 years	3 years (medical assistant)	1.5 years? (surgery) clinical officer	
	Pharmacy technologist	12	3 years	1 year	
	<i>Doctor</i>	12 years	6 years (medical school)		
<b>Zambia</b>	<i>Clinical officer</i>	12 yrs (O level)	3 years	licentiates 18 months	2 year "clinical officer anesthetist"
	<i>Doctor</i>	12 years	6 years (medical school)		



# "substitution"

Table 4: Estimated production: physicians and substitutes in selected countries

Country	Average annual output		
	Clinical officer/Medical assistants	Assistant medical officer (Postbasic)	Doctors
Ghana	30	0	200
Tanzania	300	40	50
Kenya	300	30	200
Malawi	100	N/A	20
Mozambique	300	N/A	20–25
Zambia		20 (CO Anesthetist)	

