



## EDITORIAL

# Task-shifting: exposing the cracks in public health systems

Marge Berer

Editor, Reproductive Health Matters, London, UK. E-mail: [mberer@rhmjournal.org.uk](mailto:mberer@rhmjournal.org.uk)

THE papers in this journal issue are about innovative efforts to increase access to skilled reproductive health care, particularly in resource-poor settings, either 1) where physicians are in short supply, or 2) when physicians are not needed because the skills involved in a procedure have been simplified to the point where trained mid-level providers can carry them out instead. Mid-level providers (or non-physician clinicians) in the programmes described in these papers, are most often nurses, nurse-midwives, nurse auxiliaries, general practitioners, medical or clinical officers, medical or health assistants, or community-based health workers. The health care services they were trained to provide included IUD provision, taking Pap smears, doing caesarean sections and providing anaesthesia for emergency obstetric care, providing early medical abortion, and skilled birth attendance in women's homes in one case and in primary care clinics in another with referral for treatment of obstetric complications.

There is a sub-text with these papers, however, which is to do with the lack of capacity or failure of countries in the developing world to build and strengthen their health systems and develop a strong, well-trained public health workforce. This is the elephant in the room in every one of these papers. Many people working in the health field are aware that this elephant is in the room, but there are still few comprehensive efforts being made to do something about it. If that doesn't happen, however, as the published literature on task shifting to date shows, and as the papers in this journal issue strongly indicate too, task shifting itself may not succeed. Why? Because the shifting of tasks from

physicians to mid-level providers, in the absence of sufficient numbers of either, is no more likely to be successful than giving traditional birth attendants minimal training and no resources to deal with obstetric emergencies.

Hence, these papers cannot and do not merely sing the praises of mid-level providers or of task shifting. Nurses and other primary level and community health workers in all the countries covered in this journal have shown an incredible willingness to take on increased workloads, with or without sufficient training, decent salaries and conditions, access to the equipment, resources and drugs they need, or physician back-up, decent career structures, supportive management, or housing and schools for their children. However, they cannot be expected to make up for all the systemic shortcomings around them.

*"The rapid expansion of... [people with] HIV/AIDS and tuberculosis has resulted in a major increase in nurses' workloads: in some parts of Africa, HIV/AIDS has doubled the patient load for nurses, with no commensurate improvement in salary or working conditions. The demands placed on nurses will likely increase with the current drive toward task shifting..."<sup>1</sup>*

This journal issue includes a paper by Unger et al, which analyses the global context in which the human resources crisis in health care, crumbling health systems and task shifting are co-existing. Several decades ago now, a power shift took place at international level in relation to health care, which moved hegemonic control of health care policy from the World Health Organization, which is an inter-governmental public health agency, to the World Bank and

into the hands of neoliberal health economists and private health corporations. People who, it turns out, did not even know how to manage the world's finances safely.

The multiple parameters of the crisis in human resources for health have been widely acknowledged. The fact that many health systems are crumbling has also been acknowledged; indeed, it has become a truism. It's not just physicians who are migrating to private medicine and richer countries, it's mid-level providers too. What is not so often acknowledged is that specific national and international policies have caused health systems to crumble, or fail to develop, policies that are not immutable or inevitable, but changeable.

There is growing recognition that the renewal of a public health approach is needed, with primary care as its backbone (see the 2008 *World Health Report*). The commercialisation, privatisation and verticalisation of health care services, and the undermining of national governmental responsibility for health care are what is making health systems crumble. Britain got this one right at the end of World War II. Comprehensive health care should be delivered through universal, tax-based, government-regulated public health systems, with university-based public health education and comprehensive medical education and training for health professionals. Any externally-controlled funding and non-public delivery of health services should be integrated into and controlled by the public health system. The social determinants of health must also be addressed. Without these, we will continue to witness the failure of governments and health systems globally to promote and protect the public health. In the context of development policies that have made debt-ridden dependents of so many countries in the global south, the prospects are not optimistic, at least in the short term.

### **Task shifting: not a panacea**

The World Health Organization currently has a whole department devoted to task shifting, primarily in relation to the delivery of antiretroviral treatment for people with AIDS, and in 2008 issued guidelines on task shifting. Since then, more and more "global bodies", UN, academic and NGO-led, have set up high-level

international task forces, held conferences, set up programmes of education and training for health workers,<sup>2</sup> issued statements, and called on governments to create ten-year plans to increase their health workforces. The heads of UNICEF, WHO, UNFPA and a senior staff person at the World Bank issued a joint statement in September 2008, for example, on "Accelerating efforts to save the lives of women and newborns", which says – as all such statements have been saying since at least 1987 – that maternal and newborn deaths can be prevented with proven interventions. And the reply always comes back: if only there were health systems and health workers who had the skills and resources to do so. Yet health systems experts and maternal and child health people are apparently not communicating with each other.

Many people with commitment and goodwill are involved in these initiatives, but the initiatives themselves are top-heavy, often elite affairs, and run by people in and from the global north. When will it dawn that this work needs to be done on the ground, in countries and by countries themselves?

As Philips et al in a 2008 *Lancet* article argue,<sup>3</sup> task shifting should not be viewed as a panacea for the human resources problems facing sub-Saharan Africa (or indeed anywhere) but must be part of an overall strategy to remedy public health services. While it is true that with task shifting, many more people with AIDS are on antiretroviral treatment in many developing countries, at what expense has this come for the rest of health care? It was intended that HIV treatment programmes would strengthen health systems. Have they? For example, have they strengthened maternal health care, let alone sexual and reproductive health care more broadly, from a patient-centred perspective?

In all the various forms of task shifting being attempted, what has happened to quality of care and financial remuneration that will sustain health worker outputs? Are there clearly defined tasks for mid-level providers and avoidance of excessive and complex workloads? Has there been adequate training, supervision and support, which are essential to avoid stress and burn-out from new responsibilities? Has there been increased awareness and acceptance in communities of mid-level staff doing the work of physicians?

The papers in this journal issue seek to answer these questions from the perspective of patients and mid-level providers at the grassroots level, and the answers they offer are far from an unequivocal yes.

Mavalankar & Sriram found that task shifting of anaesthesia services has been effective in expanding coverage and access to emergency obstetric surgery in parts of South Asia, but most programmes have not been implemented systematically or as part of an overall human resources strategy, and in no country have they been scaled up. De Brouwere et al found in Senegal that although 11 district teams consisting of an anaesthetist, general practitioner and surgical assistant were trained in emergency obstetric surgery from 2001 to 2006, only six of the teams were functioning by 2006, training was not happening rapidly enough to cover all districts, even by 2015, and unmet need persisted even in districts with teams in place.

In Guatemala, the government has never been sure whether it supports family planning, so its support for the provision of IUDs as long-term

reversible contraception, provided by community nurses, has also been equivocal (see Vernon). Levin et al show that dealing with the consequences of unsafe abortion (primarily treatment of incomplete abortion) costs the Mexican health system far more than providing safe abortions in the first place, and Yarnall et al show that early medical abortions can safely be provided by mid-level providers. But will this incontrovertible evidence mean that countries in Latin American, Africa and Asia will rush to make abortions safe and legal or shift provision of most abortions to nurses or midwives at primary care level? Hardly.

Chinkonde et al and Levy, in research on the programme for prevention of mother-to-child transmission of HIV (PMTCT) in Lilongwe, Malawi, show that women's needs and expectations are often not being met, not only because they are seen as still healthy even when they need anti-retroviral treatment, or because the focus is still on infant health. Even more problematic are the structural weaknesses in the PMTCT programme and in the health system itself, which have led to involuntary disclosure of women's HIV status,



STUART FRANKLIN / MAGNUM PHOTOS

Nurse assists in home-based post-natal care, Lad Prau community, Bangkok, Thailand, 2002

lack of integrated care and timely referral, and HIV being defined exclusively as a medical issue, while the social determinants of health are ignored. Hence, the drop-out rate of women from the programme within six months of delivering their babies has remained high. Neither of these papers is about tasking shifting *per se*, but they are relevant to why task shifting on its own is not enough.

Good intentions with task shifting, then, because they depend on so much more, are bearing only limited fruit and are not capable of making up for more or less dysfunctional health systems overall. Yet, non-physician clinicians, as McAuliffe et al show in Malawi, are keen to take on new skills and responsibilities. Similarly, Patel et al show that in the states of Bihar and Jharkhand in India, mid-level family planning providers are keen to be trained to provide early medical abortion, and at least some family planning physicians are supportive of their doing so.

Mohammad-Alizadeh et al, whose paper is about women's perspectives on improving primary level family planning services, state that Iran ensures provision of basic primary health care to 95% of the rural and 100% of the urban population of the country free of charge, almost exclusively through mid-level providers. Few other developing countries can make a similar claim, particularly as regards services for their rural populations. So it is possible for a universal, accessible primary health care service to be run by mid-level providers in the context of a well-functioning health system. Quality of care issues and valid complaints notwithstanding, the women interviewed for this paper mostly felt they could depend on this system, at least for their family planning needs.

The most successful mid-level provider programme that this journal issue spotlights, in terms of its success in preventing maternal deaths and complications, is that of two health centres located in an interior rural area of Rajasthan, India (Iyengar & Iyengar). These centres have successfully been providing skilled maternal and newborn care for nine years through trained nurse-midwives and active, accompanied referral for obstetric and neonatal complications. The dedication and leadership involved in this programme is as impressive as it is rare. The scaling up of such a high level of care across

India would involve a gargantuan amount of work. Nonetheless, that is the task ahead. What is needed is experience in how to scale up such a programme and achieve population-wide coverage.

### **Other features on sexuality and HIV-related issues**

A second theme for this journal issue was to be on "Reproductive rights across diverse sexual orientations and gender expressions". Unfortunately, it yielded no papers at all, in spite of efforts by a number of RHM editorial advisory board members to encourage contributions. However, it did yield two papers on sexuality-related issues: one seeking to develop a sexual ethics of rights and responsibilities by Dixon-Mueller et al; one on the language of "sexual minorities" and the politics of identity by Rosalind Petchesky on behalf of Sexuality Policy Watch. And there is a brief Round Up section on this theme too. There is also a paper by Rispel & Metcalf on making HIV policies in South Africa meet the needs of men who have sex with men. Lastly, there is a paper by Hillis et al which explores why some 20% of infants born to HIV-positive mothers in Russia are currently being abandoned.

### **Future RHM themes**

"Criminalisation of HIV, sexuality and reproduction" is the journal theme coming up for November 2009, with many submissions. I am hoping to see a similar high level of interest in submitting papers on the theme for May 2010: "Cosmetic surgery, or self-harm?" This is a topic that, if you know nothing about it, you should consider yourself out of touch with today's youth – not just in the developed world but around the globe. We also hope to look at reconstructive surgery, such as breast reconstruction, sex changes, enlarging penises, uncircumcising men, tightening vaginas for sex and virginity tests, and insurance policies to have cosmetic surgery. See the call for papers in June 2009 under Current and future themes and follow RHM's author and submission guidelines on the RHM website at <[www.rhmjournal.org.uk](http://www.rhmjournal.org.uk)>.

### **Important issues in the Round Ups**

The Round Ups in this issue carry some very important news. For example, a study in Brazil

found that heterosexual transmission of HIV is more a function of viral load than the sex of the “index case”, which challenges the belief that heterosexual women are more at risk of transmission than heterosexual men (HIV/AIDS Round Up). Another study has found that a consistently low six-year cumulative incidence rate of CIN3+ among women negative for human papillomavirus (HPV) suggests that cervical screening strategies in which women are screened for HPV every six years are safe and effective (Research Round Up). The Law and Policy Round Up is full of news on abortion, and today’s breaking news (8 May), from Advocates for Youth in the USA, is that President Obama’s first proposed federal budget would eliminate abstinence-only funding programmes for the simple reason that they are ineffective. The Service Delivery Round Up provides the evidence. There is loads of information about medical abortion, maternal health and emergency obstetric care in several Round Ups. Violence against women features too, and the undeclared war on women’s rights in many places, including for women in Afghanistan. And don’t forget those condoms.

### **This Pope and condoms**

What a wonderful furore there was when the Pope made his latest statement against condoms. It was as if no one had previously been listening to this man since he and Bush joined together to make condoms even more scarce in Africa than they had been before. In any case, what do people expect from a person for whom a large proportion of sexual relations are a sin? How-

ever, it was immensely gratifying that so many prominent people reacted to his pronouncements with outrage. Then there was the Roman Catholic bishop who excommunicated not only a sexually abused nine-year-old Brazilian girl, but also her mother and the doctors who arranged for her to have an abortion – but not the man who abused her. This too was roundly condemned; hopefully, it will help to transform the public discussion of abortion in Latin America, which has been so heavily dominated by the Vatican as well.

### **Thought for the day: 32 million extra men in mainland China**

On 11 April 2009, the *South China Morning Post* carried a report from Agence France-Presse on an article in the *BMJ Online* under the headline: “32 million extra men the price of selective abortion”. Looking through a different gender lens at the subject of preference for boys and the use of ultrasound and abortion on grounds of fetal sex, the article describes how second births in a country still pushing a one-child policy are responsible for most of the excess males. However, the good news is that a preference for sons is starting to erode with urbanisation and industrialisation. The article talks about the lead taken by South Korea, which launched a public awareness campaign about the problems excess boys will face as they grow up, combined with strictly enforced laws on sex selection, that have led towards a more balanced sex ratio. Meanwhile, though, what will all the extra heterosexual men do for partners?

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