



The contribution of the polio eradication initiative to narrowing the gaps in the health workforce in the African Region



Jean Kamso^a, Eddy S. Mvika^b, M.O.C. Ota^{c,*}, Joseph Okeibunor^c, Pascal Mkanda^c, Richard Mihigo^c

^a World Health Organization, Country Representative Office, Ndjamen, Chad

^b World Health Organization, Intercountry Support Office, Libreville, Gabon

^c World Health Organization, Regional Office for Africa, Brazzaville, Congo

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ABSTRACT

Introduction: The Global Polio Eradication Initiative (GPEI) massively invested to overcome the crippling disease in countries of the WHO African Region. In the context of economic crisis, almost all countries in the Region lack an adequate health workforce. Large amounts were invested by GPEI in human resources. This paper shows how the human resources funded by polio contributed to narrowing the gaps in health workforce and helped strengthening and supporting other priority health programmes in Angola, Chad, DRC, Nigeria, Tanzania, and Togo.

Methods: The health workforce strengthening methods used in the five different countries included the following: policy development and strategic planning, microplanning, capacity building of public health and community workers, implementation and services, monitoring and evaluation, advocacy and social mobilization, and programme review.

Results: Staff funded by polio helped with achieving good coverage in vitamin A and insecticide-treated mosquito nets (Angola, Chad); improvement of EPI and integrated disease surveillance indicators, improved quality of data (all five countries), administrative support, smooth introduction of new vaccines, increased case detection, and early isolation of patients suffering from the Guinea worm (Chad); reduction of cholera, extension of directly observed TB short course treatment (Democratic Republic of Congo); significant staff performance improvement (Nigeria).

Discussion: GPEI investment achieved far beyond its primary goal, and contributed to narrowing the gaps in the health workforce in countries of the African Region, as demonstrated by the best practice documentation exercise. We recommend that expertise and experience of polio funded staff should be leveraged to strengthen, expand and support other public health programmes.

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1. Introduction

Cost-effective interventions that can prevent the burden of injuries, communicable and non-communicable diseases exist but their coverage is too low due to health system's weaknesses [1]. Challenges related to health workforce (HWF) are a major cause of health system weakness. Serious gaps exist in the HWF in the African Region, for instance the densities of the following are lower in the Region compared to global averages by: sixfold for pharmaceutical and psychiatrist personnel, 5.4-fold for physicians and midwives, 4.8-fold for dentistry, and 2.4-fold for nurses. Furthermore, 36 (63%) of the 57 countries globally identified as having critical shortages of skilled health workers are in the Region

[2–4]. Sub-Saharan Africa is experiencing the greatest difficulties. While it has 11% of the world population and 24% of the global burden of disease, only 3% of the health workers are engaged in the Region [5]. Shortages and inadequate distribution of appropriately trained and motivated health workers, and inefficiencies in the ways in which the health workforce is managed and utilized, remain the major impediments to the effective implementation of primary health care, and expansion of health service coverage [6]. The high turnover of skilled health personnel in the form of migration and brain drain is the order of the day in many African countries [7].

Narrowing these gaps, requires both long term and short term plans. Innovative and pragmatic approaches are required, including task shifting and skill-mix [6]. While achieving progress in polio eradication, several countries have used lessons and best practices of the poliomyelitis eradication initiative (PEI) that

* Corresponding author.

E-mail address: otama@who.int (M.O.C. Ota).

supported and strengthened the HWF of other priority public health programmes including routine immunization, child health, neglected tropical disease, integrated disease surveillance and response, or non-communicable disease. In this way, PEI provided this short term measure.

WHO African Region countries made significant and measurable progress in polio eradication through ensuring very high immunization coverage as well as ensuring sensitive acute flaccid paralysis (AFP) surveillance [8–10]. To achieve this progress in polio eradication, countries had to implement strategies to overcome barriers to high immunization coverage and sensitive AFP surveillance at all levels of the health system i.e., community, health facility, district, region or province, state as well as at national level.

A documentation exercise was conducted in eight countries between 2014 and 2015 in Angola, Chad, Côte d'Ivoire, Democratic Republic of Congo (DRC), Ethiopia, Nigeria, Tanzania, and Togo. This paper focuses on the best practices that helped strengthening, expanding, and supporting the public health workforce at all levels in Angola, Chad, DRC, Nigeria, Tanzania, and Togo.

2. Methods

In Angola, the community public health workforce capacity building system for polio benefited malaria programme and other vaccine preventable diseases (VPDs), namely measles, tuberculosis, diphtheria, meningitis, pneumonia, yellow fever, tetanus, hepatitis B, yellow fever, rotavirus diarrhea, and pertussis. To achieve this, there was an integrated and programmed training approach.

In Chad, the best practices were implemented through the following activities: training of district management teams on reach every district (RED), supervision, training of health centre service providers and members of the health committee on expanded programme of immunization (EPI); monthly supervision of health centres by district management teams, and assessment of the implementation of the five RED approach components. The five RED components are planning, capacity building, supportive supervision, monitoring for action, and link with the community. A system to re-establish contact with people who have dropped out from routine EPI was introduced and a systematic review of coverage data in each district, of the resources consumed and of difficulties encountered during implementation was undertaken. A dashboard was developed to monitor routine immunization strengthening in priority districts, and assessed on a monthly basis. The basic indicator monitored was the proportion of priority districts in which at least 80% of health facilities reached the routine immunization target set for the third dose pentavalent vaccine (Penta3, diphtheria, pertussis, tetanus, hepatitis B, haemophilus influenzae type B vaccine).

Staff paid by polio hold essential positions within the EPI and the administration. Polio funded staff have been and are continuing to be used by other priority health programmes at all levels: distribution of insecticide-treated mosquito nets (ITN), disease surveillance (with a focus on Guinea worm). Since August 2013, staff funded by polio showed great involvement in activities of the Guinea worm Programme.

In DRC, terms of reference (TORs) of polio funded staff were reviewed to include the following: conduct surveillance activities and activities related to the fight against cholera, rabies, meningitis, Ebola, mother to child infections in addition to vaccine-preventable diseases; support the preparation of multi-annual and annual plans for the provinces and health zones, and support supervision, training, monitoring and evaluation activities in the entire health sector.

Nigeria appeared to be the country where most activities were developed. These included: identification and orientation of experienced technical officers from government (from National Primary

Health Care Development Agency [NPHCDA] and Federal Ministry of Health [FMOH]) and partners on supportive supervisory skills by National Emergency Operation Centres (EOC) prior to every round of supplemental immunization activities (SIAs); deployment of the identified officers to selected high risk, vulnerable or poor performing local government areas (LGA) with a specific mandate for an extended period (i.e., at least 2 weeks before commencement of an SIAs round).

The Management Support Teams (MSTs) were given a detailed checklist and report format for daily evening reviews at the LGA or State and final debriefing of the State EPI technical teams. Each MST was expected to submit a concise written report to the State and National EOC with emphasis on “what needs to be done to improve upcoming rounds of SIAs”.

Standard operation procedures (SOPs) were developed for all staffs under WHO. The SOPs helped to have standardization of performance of specific functions within a program. This has provided a clear management guideline and reference document.

Key performance indicators (KPIs) that affect program implementation and monitor these on regular bases were identified. A tool for ongoing monitoring and periodic evaluation of staffs was developed. Based on the achievements of KPIs, all staffs were evaluated quarterly and administrative actions were taken based on performance. Monitoring and evaluation staff were deployed at Zonal and state levels to develop a system for tracking the activities. A regular monthly feedback was provided for program improvement and quarterly administrative actions based on the accountability framework to account individual staffs based on the selected indicator achievements.

Regular quarterly program reviews with all staff were organized to look into the status of monitoring indicators and implementation of work plans.

An innovative approach was utilization of mobile device data collection using MAGPI software, which is a software to capture supervisory data in real time. A real time data collection with the global positioning system (GPS) coordinates was also used during all supervisions. The supervisory checklists were integrated, cutting across surveillance and routine immunization (RI).

Areas that needed locally recruited personnel were identified and local personnel were actually recruited.

A central server was set up in the data unit to collect feedback, perform data quality checks, analyze data and provide feedback. The data were used for corrective actions at various levels: national, state, LGAs and health facility.

Other activities included: training of the personnel (on their TOR), monitoring and supervision of their activities, development of a standardized supportive supervision tool that is simple and easy to administer, involving all the components, providing required information for corrective action, training of all the manpower and officers on the revised checklist, on the method of supervision, and sending of feedback using SMS technology.

In Tanzania, the following activities were implemented: selection of qualified National Stop Polio Transmission (STOP) team members based on their curriculum vitae and work experiences; training the selected STOP team members 1 week in house; final selection of STOP teams for deployment of 2 weeks; critical analysis of regions and councils with National STOP teams, and evaluation including report writing.

In Togo, PEI initiated and continued to support community surveillance of acute flaccid paralysis (AFP) by community health workers (CHW) and traditional healers which now includes other priority diseases. To achieve this, members of the community in charge of AFP surveillance were trained on case definition of priority diseases. Any suspicious case was notified to the reference health institution. If clinically confirmed, the case was reported to the district core team (DCT) which then organized laboratory

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