The CQUIN Learning Network

The Science & Practice of Scale Up

The Impact of DSD on the Nursing Workforce

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HIV LEARNING NETWORK
The CQUIN Project for Differentiated Service Delivery

The Science & Practice of SCALE-UP

Empowering Health for 15 years ICAP
Columbia University Mailman School of Public Health

Outline

- **Background/Context**
- Lessons from NIMART
- DSD and the Nursing Workforce

Nursing in Sub-Saharan Africa: Overview and Context

Nurses are the core of the health workforce in sub-Saharan Africa

- They comprise the largest proportion of the health workforce
- They deliver up to 90% of health care services
- They work under conditions of scarcity: critical HRH shortages
- They are essential to the HIV response and to achieving epidemic control

Nursing in Sub-Saharan Africa: Overview and Context

- Africa has generally given comparative priority to producing nurses - having nurses form the backbone of core health work
- In terms of professional mix, the nurse:physician ratio in Africa is generally higher than elsewhere in the world
- The nurse:physician cadre mix ranges from a low of 2.5:1 in Central African Republic to a high of 20:1 in Tanzania.
- Both professions (physicians and nurses) have been migrating in increasing numbers, rising nurse mobility may begin to erode this status of higher nurses' concentration and negatively affect the already perilous health status indicators of sub-Saharan Africa

Source: WHO-AFRO Division of Health Systems (2004).

Region	Nurse:physician ratio
Africa	5.5:1
East Asia	4.5:1
Europe	2.4:1
South Asia	2.3:1
Latin America	1.9:1

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Nursing and the HIV Response

Lessons from NIMART:

- Nurses are able to initiate and manage HIV treatment with excellence
- NIMART is critical to the decentralization and scale up of HIV treatment
- Key enablers include adaptations in:
  - ✓ Task sharing and task shifting
  - ✓ Training, management and work culture
  - ✓ Policy, norms and regulations

Lessons from NIMART, continued

Task sharing and task shifting:

- Care is delivered by nurses. If UHC is to be achieved, it will be achieved with nurses
- World Health Organization defined task shifting as "the rational re-distribution of tasks among health workforce teams" in which specific tasks are moved from highly qualified health workers to those who have fewer qualifications in order to make more efficient use of available resources(2008).
- From task shifting to task sharing – need for a team based approach. Care isn't physician – centred anymore
- Kenya has task shifting guidelines – has allowed for an underpinning policy framework to expand nurses scope of practice
- NIMART has provided quality HIV care – reduced waiting time, increased adherence and retention, allowed for management of stable patients and non interruption of care

"1.6 Global Evidence-based Recommendations for Task Sharing

The WHO ART Guidelines support formalization of task sharing in countries with a high burden of HIV.3

Summary recommendations from the WHO ART Guidelines (2013) include:

- ***Trained non-physician clinicians, midwives and nurses can initiate first-line ART.***
- ***Trained non-physician clinicians, midwives and nurses can maintain ART.***
- ***Trained and supervised community health workers can dispense ART between regular visits"***

Excerpt from the 2017 Kenya Task Sharing Guidelines

Lessons from NIMART, continued

Training, management and work culture:

- In-service and pre-service training
- Effective supervision
- Safe workplace and access to post-exposure prophylaxis
- Equitable access to HIV testing and treatment services

Lessons from NIMART, continued

Policy, norms and regulations:

- Changes in professional scopes of practice have significant implications for certification, licensure and legal protection of nurses
- Need to engage nursing councils and regulatory authorities re:
  - Certification and licensing
  - Establishing curricular standards
  - Accreditation of pre-service, in-service and continuing professional development programs
  - Ensuring legal protection

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Nursing and Differentiated Service Delivery

- DSD models for stable patients will accelerate existing trends towards decentralization, task sharing, and task shifting
  - Moving services out of tertiary and secondary health facilities means moving them to nurses → primary, rural and remote areas
  - Moving services into the community means expanding the role of nurses in *overseeing* community-based activities, whether delivered by CHWs or lay staff (peer educators)
- Nurses have played, can play, and should play a critical role in the design and delivery of DSD models

Challenges of Implementing DSD for Nursing

- Severe nursing and midwifery shortage – need to address the challenges of attrition, recruitment, retention, motivation and career progression
- Lack of an enabling regulatory environment for implementation of DSD
- Need to define the role of nurses in this new DSD dispensation
- Is DSD task sharing? Often seen as such and thus confusion and sometimes conflict
- Specialised training for nurses and midwives on DSD to include CPD. The curriculum and training for this should be competency based

Recommendations for Nursing to Implement DSD

- Addressing the nursing workforce shortage
  - Achieve a balance between professional and auxiliary nursing cadres
  - Rural recruitment of student nurses
  - Non– financial incentives
  - Transparent and clear career progression system
  - Optimise pay and benefits
- Autonomous and independent Councils to regulate the profession
- Tackle HIV and other welfare issues that affect nurses

Our tasks for the future with regard to DSD and nursing

1. Curriculum relevance
2. Training methodologies
3. Retention
4. Staffing models that take the following into consideration
   i. Nursing categories
   ii. Nursing ratios
   iii. Nursing competencies
   iv. Meaningful curriculum content
5. Changes in regulation
6. Strengthening information systems

Siyabonga….I thank you for listening