UNRISD

UNITED NATIONS RESEARCH INSTITUTE FOR SOCIAL DEVELOPMENT

RESEARCH REPORT 4

Paid Care Workers in Tanzania:

A general description of nurses and home base care givers

Ruth Meena

May 2009

The **United Nations Research Institute for Social Development** (**UNRISD**) is an autonomous agency engaging in multidisciplinary research on the social dimensions of contemporary problems affecting development. Its work is guided by the conviction that, for effective development policies to be formulated, an understanding of the social and political context is crucial. The Institute attempts to provide governments, development agencies, grassroots organizations and scholars with a better understanding of how development policies and processes of economic, social and environmental change affect different social groups. Working through an extensive network of national research centres, UNRISD aims to promote original research and strengthen research capacity in developing countries.

Research programmes include: Civil Society and Social Movements; Democracy, Governance and Well-Being; Gender and Development; Identities, Conflict and Cohesion; Markets, Business and Regulation; and Social Policy and Development.

A list of the Institute's free and priced publications can be obtained by contacting the Reference Centre.

UNRISD, Palais des Nations
1211 Geneva 10, Switzerland

Tel: (41 22) 9173020
Fax: (41 22) 9170650
E-mail: info@unrisd.org
Web: http://www.unrisd.org

Copyright © United Nations Research Institute for Social Development (UNRISD).

This is not a formal UNRISD publication. The responsibility for opinions expressed in signed studies rests solely with their author(s), and availability on the UNRISD Web site (http://www.unrisd.org) does not constitute an endorsement by UNRISD of the opinions expressed in them. No publication or distribution of these papers is permitted without the prior authorization of the author(s), except for personal use.

Introduction

Home Based Care services in Tanzania were officially initiated by the Ministry of Health (MoH) in 1996 as a pilot study in 8 districts in two regions that is Rukwa and Coast regions. The essence of the pilot was to train home based care providers who were to support HBC program. During this pilot period which lasted for two years, the MoH trained 51 HBC providers. After this initial period, the ministry instructed districts to 'mainstream' HBC services in their plans and programs (URT/MoH: 1999). Additionally, the MoH in collaboration with TACAIDS developed Home Based Care Guidelines which became operational in 1999 and further revised in 2005. These guidelines spelt out the rights of people living with the HI virus and described the responsibilities of various actors in the continuum of care. According to the HBC guidelines, PLWHA are entitled to: (i) referral facilities, care facilities services and provision of drugs and equipment, (ii) care by community health workers and (iii) support for primary care givers within the family.

In the continuum of care, the family is identified in the guidelines as the primary care giver. While each adult family member is expected to provide some kind of support to the PLWHA, the family is also expected to choose one primary health care giver, who will provide nursing care, emotional support and other services needed by the person suffering from HIV&AIDS-related illness. The centrality of the family in caring for the PLWHA, particularly those who are in their terminal stages, assumes that the family is best suited for emotional support, that public resources will trickle down to this level, and that there will be family members able and willing to support the person with PLWHA.

After the family the PLWHA is expected to be supported by care services which are to be provided through the existing hierarchical structures of the health services. In this hierarchy, the village health services are the lowest level of health care delivery in the country. Ideally, this level is supposed to offer preventive services which can be offered in homes. Each village is expected to have a health post managed by two health workers chosen by the village government among the villagers and be given training before providing services. There is no data to inform how many villages have village health posts in Tanzania. Each village government determines remuneration for the village health workers. The Home Base Community Care givers referred to in this paper are mainly recruited from the villages. In the Tanzanian context, the village is the lowest administrative structure composed of a Village Assembly, Village government, and various development/social committees. Actors in various structures of the village are not formally paid, but a village government has powers to remunerate some of the volunteers depending on the resource base of a village.

The second tier is the Dispensary Services. A dispensary cater for between 6000 to 10,000 people and supervise all the village posts in its ward. The rural dispensaries are staffed by a rural medical aid (RMA) with one or two assistants; in some cases a nurse/midwife is provided. The RMA receives a three year training course in anatomy, physiology and hygiene and is expected to have knowledge in diagnostic methods and treatment of common diseases. A nurse (grade A) receives three year training in a more broad range of knowledge/skills related to care, but not provided with competencies in diagnostic methods. A nurse is supposed to 'aid' the RMA and the RMA is considered to be superior to a nurse/midwife. This superiority is socially constructed and not related to the number of years one has been trained. Within the continuum of care, a nurse from a rural dispensary would supervise the Community care giver, through providing them with rudimentary knowledge on the 'ABCs' of the HIV&AIDS, how to care for PLWHA, as well as provide them with HBC kits when they are available. They also train them on how to keep progress record for the PLWHA.

Supporting the dispensaries are health centres. These are supposed to give priority to preventive measures and hygiene education but in reality they are extensively used for treatment of common diseases. Most of the health centres have room for minor surgery and provide 20-30 beds for in patients including maternity cases. A health centre is run by a Medical Assistance (M.A) with secondary education with more elaborate education in diagnosis and treatment as well as training in minor surgery. This is of higher grade then the rural medical aid. The medical assistant is normally assisted by one or two rural medical aids, a nurse/midwife with one or two maternal and child health aids and health assistant. In the continuum of care the Medical Assistant would provide treatment to the PLWHA who has been referred to by the RMA. The PLWHA might be admitted for treatment or for further diagnoses.

Above the health centre there is a district hospital. This is the base for staffing and supplying all rural units with equipment, and medicine. Generally, there is one district hospital per administrative unit and it is the district hospital that any difficult or serious case is referred to from the lower levels. The district hospitals are provided with medical doctors one or more depending on the size, stores for drugs and equipment, and a diagnostic laboratory, ex ray, operation facilities and beds for referred patients. Each district has a Health Management Team (DHMT). The DHMT is expected to mainstream HBC services in the health services.

Above the district is a regional hospital. Strictly the regional and district hospitals are similar except that the regional hospital has more facilities and more highly skilled health personal that is 5-10 doctors including one specialist. The highest level is the national referral hospitals, endowed with more sophisticated equipment, more specialists, and more staffing across all cadres.

The HBC program is premised on the assumption that a functional referral system is in place, and that resources for HIV&AIDS will trickle down to the households with PLWHAs particularly the poorest households. Additionally, it is further assumed that there will be individuals within and outside the households who will be willing to volunteer to provide needed care for the bedridden patients in their households. Although the HIV&AIDS is supposed to be multi sectoral, the care services highly depend upon the health care facilities. This seems to have overstretched the human resource capacities of the health facilities which were already experiencing a human resource crisis.

One of the major challenges limiting the implementation of health policies and particularly the HIV&AIDS programmes including care and treatment is lack of qualified human resources in the health sector. While data on the size of health workers by category is not easily available in Tanzania, all existing literature and political pronouncements indicate a human resource crisis in the health sector. The CMI report (2006) asserts that Tanzania has the word's lowest coverage of physicians, with only 0.02 medical officers or specialist per 1,000 persons (CMI: 2006: 4). Additionally, at a Joint Health Sector Review in 2004, the Permanent Secretary of Ministry of Health declared that in …. "the area of human resources, I believe we have now reached a crisis point". At the Annual Review of 2005, Minister of Health asserted that the crisis now has reached emergency proportions. In his address to the Regional Medical Officers in 2005, the then President of the United Republic of Tanzania His Excellency Benjamin Mkapa is quoted to have said" the shortage of health personnel … "is a serious problem, which requires urgent steps." (CMI report: 2006: 9).

According to the Human Resource Health (HRH) census in 2001/02, the size of active supply of health workers was 49,900 (MoH: 2004), which translates into staff per population ratio of 148 per 100,000. In 1994/95, active supply was approximately 67,600 health workers (census

1994/95). Hence active supply decreased by 19,300 health workers over the period between 1994/95 and 2001/02 (Dommick and Karowski: 2005). The authors further claim that given the conservative assumption about increments and attrition, the size of the total workforce will continue to decline to approximately 37,900 by 2015 (ibid)
.
The human resource crisis notwithstanding, the HIV&AIDS pandemic and particularly the implementation of the Care and Treatment programmes has increased the demand for human resources for health sector across all categories of health workers. McKinsey study (2004) estimated that the Tanzanian HIV&AIDS care and treatment plan will require almost 10,000 full time health workers. Dominick A and Kurowski C (2004) study further claim that more than 25% of all the health services are provided to patients infected with the virus. These authors further asserted that further increase of this share was expected with the implementation of the NCTP for PLWHA. The Plan had set a target of treating 65,000 PLWHA with antiretroviral drugs (ARVs) by the end of 2005, and at least 400,000 by the year 2008. The WHO suggests an even more ambitious scaling up of care and treatment, aiming to treat 220,000 PLWHA with ARVs by the end of 2005 (MoH, 2003). If the NCTP was to be implemented fully, it was expected that the demand for health workers would have significantly grown. The provision of antiretroviral treatment to approximately 500,000 PLWHA in 2008 would require approximately 9,300 FTEs (URT 2003).

In disaggregating the shortage of health cadre by skill, the CMI report (2006) compares the actual staffing levels to the staffing norms, in which the greatest shortage was found among Assistant Medical Officers/clinical officers and lab technicians (60%) followed by nursing cadre (50% and doctors (40%) (CMI report: 2006: 23).

To make matters worse, the distribution of the health workers is skewed in favour of the higher levels of health services which are not easily available to the majority of people in the rural communities. This is demonstrated in the following table.

Health Facility FTEs Proportion of the total

Health Facility	No of Staff	% of total
Hospitals	24554	55%
Health Centres	5917	13%
Dispensary	14284	32%
Total	**44755**	**100**

Source Census data 2001/02

In a nutshell, there is a serious shortage of human resource in health sector which has impacted all health workers generally. When there is a shortage of skilled human resource, the nursing cadre seem to shoulder a disproportionate burden of care This is the context within which health workers supporting the HIV&AIDS pandemic in treatment and care are expected to deliver quality services including the HBC which heavily rely on the health sector workers.. In the following section we discuss briefly the nursing cadre as it relates to the HBC programme.

Nursing Cadre and HBC Services

Data on the actual size of the nursing cadre is not systematically compiled and hence it is difficult to determine the actual gap in this category. But data compiled by the Tanzania Nurses and Midwives Council (TNMC) suggests that as of July 2007, the country had a total of 20,115 nurses out of whom 7,254 had diploma and higher levels and 12,861 were certificate holders (TNMC: 2008). These data contradict data provided by the shadow Minister of Health from the opposition camp during the 2007/08 budget. He claimed that

Tanzania had only 9,093 nurses out of the needed 14,743 hence generating a gap of 38.3% making Tanzania the 165th country in the world in terms of the ratio of nurses per population. (www.parliment.go.tz/bung/doc/afya. The WHO Country Health System Fact Sheet 2006 for Tanzania records that the nursing density per 1000 population was 0.37 (World health Statistics 2006 www.who.int/whosis/en/). All in all, there is clearly a shortage of the nursing cadre.

There is also geographical variation in terms of nurse: population ratio. The 2005 report from one district council (Morogoro) revealed that the ratio of nurses to population was 1: 888, while for general physicians it was 1:290,316 and for Assistant Medical Officers (AMOs) it was 1:6,598. (URT: 2006: pg.5). In an interview with a retired nurse, we were informed that a maternity wing in the Kilimanjaro Christian Medical Centre (KCMC), a faith-based hospital which acts as a referral hospital, has not been opened for one year now since completion because of shortages of nursing staff (interview in 2008).

Despite the shortage of nursing cadre, the training of nurses for all levels lags behind the needs for this cadre. From 2002 to 2007 for instance, the number of nurses graduating annually from training institutions increased from 910 to 4,000 for diploma holders and from 469 to 13,791 for certificate holders. This increase has not bridged the resource gaps within the nursing cadre.

Services rendered by the health sector are hierarchically provided. In the health pyramid, a nurse is considered as a skilled worker occupying the lowest position in the skill hierarchy of the health workers. While the training of a nurse focuses more on patient care, due to human resource crisis in the health sector, nurses find themselves doing multiple tasks including those which they were not trained for. In an interview, a programme officer of the Reproductive Health Programme with UNFPA, who had previously worked as a nurse for nine years, said that "nurses are multi tasked, at one time they take the role of doctors, as they diagnose and prescribe medicine, they also act as cleaners as they are expected to join the semi-skilled staff in general cleanliness of the facility, while at other times, they act as messengers as they have to deliver health equipment and materials including HIV &AIDS kits, drugs, and other equipment to the lower level health facilities. Those who have not trained as midwives find themselves doing midwife tasks if posted in areas where there is no midwife or when faced with a neighbour who is delivering at home".

In the continuum of care, the nurses offer skilled support to the community-based health workers who in turn support the primary care givers. Some of the nurses attend to the needs of HIV&AIDS patients in a health facility, others supervise the programne from a health facility, some of them are based in a primary health facility in which case they are expected to supervise the non-health staffs who are volunteers, and others are volunteers who have retired from their nursing career. As supervisors they also provide counseling, prescribe ARVs, follow up patients at home to ensure adherence to requirements, as well as compile reports for the program. The nursing cadre is hence critical in the continuum of care. They perform these tasks under very tough working conditions which are further elaborated in the following section of this paper.

The patient care tasks which include bathing a sick person, including cleaning of those who vomit or have diarrhea, caring for TB patients, as well as cleaning and dressing wounds subject nurses to the danger of infections. . The Service Provision Assessment (ORC Macro/NBS/TACAID: 2007) revealed that health workers in both government, private, faith based institutions were subjected to "***hospital acquired infection***" due to lack of infection control facilities. The Tanzania Service Provision Survey (2006) revealed that out of the

hospitals which were included in the survey, only 5% had all items for infection control, which included running water, soap, latex gloves, boxes for disposing sharp items as well as chlorine-related disinfectants. Of the hospitals covered, only 54 % had running water, 74% had soap, 20% had latex gloves, 23% had boxes for disposing sharp items, and 80% had chlorine related disinfectants. Similarly, of the health centres included in the survey, only 11% had all the mentioned infection control facilities, 45% had running water, 56% had soap, 51% had latex gloves, 32% had boxes for disposing sharp items, while 71% had chlorine related disinfectants. Of the dispensaries covered, only 12% had all items for disposal of waste, while 36% had running water, 59% had soap, 51% had latex gloves, 48% had boxes for disposing sharp wastes, and 84% had chlorine related disinfectants. All in all, less than one third of the sample covered had all the needed facilities for waste disposal. This means, most of the health workers are vulnerable to hospital-related infection, but nurses are even more vulnerable than some other cadres due to the nature of the work of patient care. Vulnerability increases with the care of PLWHAs (TSPAS : 2006).

During the celebrations of 'Nurses' Day' in 2008 the chairperson of the Nurses Association called upon the government to support the nurses whom she claimed were working under very stressful conditions, with low salaries, without adequate working tools, and without any incentives (www.habarileo.co.tz/biasharafedha)

Like other professionals in the health sector, the nurses receive very low salaries given the level of their qualifications and the responsibilities they carry. A diploma holder in nursing take home salary that is after all taxes deductions is US$230 per month. This nurse will use roughly $ 80 per month for fair, another $80 for a room; she will need a house keeper if she has a baby or children. At the end of the day, she hardly has a balance worth a decent meal (Interview: 2009) Nurses as other health workers in the public sector are civil servants who receive benefits in the form of salaries, and pension contributions. Only a few additional benefits exist such as the travel allowances. Salaries of public sector health workers are set according to the Tanzanian Government Scale with few executive scales for senior/political positions and a different arrangement for government agencies/departments whose salaries are influenced by the market. An analysis of the wage scales for health workers revealed a highly compressed wage scale for health professionals. For instance, the basic salary of a trained nurse or clinical officer exceeds the salary of an unskilled worker who was trained on the job by TTS. 10,000 ($7) per month (ibid).

According to information from the MoH, the compensation framework in the public sector lacks monetary incentives that are explicitly linked to performance attributes. For example, health workers do not receive any reward for serving in hardship areas, such as remote rural areas, like other professionals. In Tanzania, there are only two separate tools to enhance performance of health workers, one implemented at Muhimbili College of Health Science (MUCHS) in respect of teaching and administrative staff, and the other in the form of Selective Accelerated Salary Enhancement (SASE) The latter mainly applies to staff in various ministries. The nursing staff at the 'coalface' is not eligible for either of these.

Implementation of the SASE began in 2001. The scheme provides stop-gap enhancements of pay for those with critical skills and high performance in the public service. SASE targets senior administrative staff and a few non-senior staff who perform special tasks. Nurses are not considered for inclusion in this category. The McKinsey (2004) report claims that the impact of SASE has been far less than desired and potentially counter-productive. The program appears to have demoralized many front-line workers (which includes the nursing cadre), as the benefits were limited to higher-ranking officials.

Unclear terms of service further erode the morale and discourage trained nurses from continuing to render their services in public health facilities. In an interview with one of the daily papers, a graduate in BSc nursing expressed her frustrations which forced her to resign from her MoHSW post this year. She claimed that she graduated in BSc, nursing in 2005 and applied for a job in the ministry as a Nursing Officer Grade 3, carrying a salary of 260,000 Tshs a month (US$230) per month. The MoHSW offered her a job but refused to offer her this scale on the grounds that those who had been offered this scale in the previous years had been treated as special cases filling in emergency gaps. After lengthy communications with high authorities of this ministry in vain, the nurse decided to resign from the job (www.jambonetwork.com/blo.sept. 1st 2008).

Workload is another challenge which nursing cadre faces in Tanzania. In his alternate budget speech for 2007/08, the Shadow Minister of the MoHSW questioned government commitment in addressing the human resource crisis of the ministry. Making reference to the maternity ward of the Mhimbili hospital, the minister claimed that one nurse is serving 50 babies in the maternity ward, while one nurse in a general ward is serving up to 60 patients per day. (It should be noted here that reports from various sources claim that at least 50% of hospital beds are occupied by patients suffering from HIV&AIDS-related illness (NMSF: 2008). Thus a large proportion of this large number of patients would be HIV-positive or have AIDS.) This is an unbearable workload according to the minister. He also questioned the rationale of paying an incredibly low 'call allowance' for nurses of Tshs 150, ($ 15 cents). He further wondered as to why nurses were not paid a risk allowance considering the difficult conditions to which they are exposed during working hours (www.parliament/go.tz/bunge/docs/afya).

In an interview with the head of a government-owned voluntary counseling and testing facility in Rangi Tatu dispensary in Ilala District in Dar es Salaam, we were informed that the workload for the nurses working in this centre was high, as the physical facility was too small to accommodate additional staff. Additionally, it has not been possible to conduct follow-up visits for patients under ART because of the workload. And yet there is a good number of patients who attend the clinic once, and after the prescription of ARVs, they do not turn up on prescribed dates. Under ideal circumstance, the nurses are expected to do follow up visit in their homes to check on progress. This is not happening due to shortage of staff.

The Baseline Study Report from Muhimbili National Hospital (Mwahonda 2004) indicated that the overall motivation level among staff is low. Roughly 50% of doctors and nurses were not satisfied with the working conditions. Dissatisfaction was attributed to a lack of clear job descriptions, lack of performance management, limited opportunities to participate in decision making, poor information flows between management and staff, poor supervision, low

预览已结束，完整报告链接和二维码如下：
https://www.yunbaogao.cn/report/index/report?reportId=5_21106