The South African Academy of Family Practice's Rural Health Initiative (RHI) is proud to be able to bring you the following section of the journal, that will concentrate on issues pertaining to rural health in South Africa. We hope to provoke discussion on these issues and would encourage anyone interested in rural health to offer contributions to future issues.

Midlevel workers in other countries

As part of the discussion around the proposed midlevel medical worker for South Africa, the RHI column will focus on midlevel workers in other countries. In most cases, these midlevel workers function primarily in rural areas. This month we look at Malawi and Nepal; future editions are planned to focus on Iran and Zimbabwe. Rural doctors with experience of midlevel workers in other countries are welcome to contribute to the discussion.

The articles that follow are written by doctors with experience of rural health in South Africa, who are now working with midlevel workers in other countries. Dr Rudi Thetard, together with his colleague Mr Alan Macheso, describes the functions and training of clinical officers in Malawi. Dr Colin Pfaff gives an overview of the range of midlevel workers in the primary health care system in Nepal.

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Clinical Officers in Malawi

Malawi had 123 doctors serving a population in excess of 10 million in 2002-2003 (doctor: population ratio of 1: 89,962)[1]. Four out of 26 health districts had no doctors whilst a further 6 had only one doctor. Malawi has responded to this problem by training and relying on the clinical officer cadre since 1980, when the first group of clinical officers commenced service delivery.

Clinical officers are largely responsible for the provision of clinical care at district hospital level and play a very important role in the larger central hospitals. Often clinical officers will be supported by doctors but they have shown themselves able to function well without medical officer support. Their duties include OPD care, emergency care, ward management of hospitalized patients and surgical care. Clinical officers carry out a range of surgical procedures including, amongst others, caesarean sections, hernia repairs, management of ectopic pregnancies and fracture management. With the advent of the provision of anti-retroviral agents (ARVs) to public sector patients it is clear that the clinical officers will be leading the teams responsible for delivery of ARVs in many health districts.

Clinical officers undergo a four year training which includes anatomy, physiology, pharmacology, paediatrics, medicine, surgery, obstetrics and gynaecology. A separate cadre, medical assistants (two years of training), are allowed to upgrade to the clinical officer level after some years of practise – they are then trained specifically as anaesthetists and orthopaedic officers.

Many clinical officers have moved beyond the clinical care sector to lead district health management teams (as district health officers) and to support many of the important programmes in Malawi such as TB Control, Malaria Control, IMCI and others. Here they are active as programme managers and as researchers.

It is clear that clinical care at hospital level in Malawi will be severely hampered, if not impossible, without the clinical officer cadre. The lesson for South Africa is that in those areas where doctors are reluctant to go the introduction of a clinical officer cadre can ensure effective service delivery of good quality.

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1. Annual Report July 2002-June 2003. Malawi Health Management Information Bulletin. Health Management Information Unit, Planning Department, Ministry of Health and Population, December 2003.

Midlevel Primary Health Care Workers in Nepal

Nepal is one of the poorest and least developed nations in South Asia. Its dramatic geography, stretching from the highest mountains in the world, to the tropical low lying plains in the south presents a great obstacle to improving the health of its 23,4 million people.

The Nepal Health Care system is based on the district health system. The country is divided into 75 districts, each district being further divided into village development committees (VDC), which in turn comprise of 9 to 11 wards. Most, but not all, districts have a district hospital. The District Public Health Officer is responsible for all primary health care services in the district.

Each district usually has one or two health centres, and several health posts and sub health posts. These are staffed by a variety of different levels of trained health work-

ers that are referred to by a bewildering yet widely used array of acronyms. Health posts are staffed by Health Assistants (HA) who have undergone 3 years clinical training. Sub Health Posts are staffed by Auxiliary Health Workers (AHW), also known as Community Medical Assistants (CMA), who have had 18 months clinical training. These categories of staff are able to diagnose and treat the common illnesses in their area. Many of the more experienced ones have extensive clinical knowledge, sometimes more than the doctors to whom they refer. However, they also have several widely-held poor practices that I have observed across the country. Overprescribing and polypharmacy are very common.

Many CMAs also have their own private medical shops in their homes or the nearby bazaar. I have observed that in some cases this business takes priority over the working hours of the health post, which should be open from 10 am to 2 pm. This co-existing private system, together with the fact that the government only delivers drug supplies twice a year, which are thus often inadequate, gives very little incentive to the midlevel workers to maintain a good supply of medicines in the health post. On more than one occasion I have heard complaints that these supplies make it on to the shelves of the CMAs' private medicine shops before they see the storage cupboard of the health post. The lack of medicines is frequently cited by the community as a reason why they do not attend the health post. However, of the many health posts I have visited across the country, I have yet to find one with so little stock that it was not able to function. There was always one choice of antibiotic available and many other useful medicines. I have also met many skilled and dedicated CMAs, from whom I have also learnt a lot. It is hard to generalise. I have been as disappointed in some places as I have been impressed in others.

There are several other community based workers that are under the authority of each health post or sub health post. Each health post has an auxiliary nurse midwife (ANM). This person is responsible for antenatal care, deliveries in the health posts or at home, and immunisation and growth monitoring of children. She is also responsible for implementing vertical programmes such as polio immunisation days or vitamin A distribution campaigns. These workers have undergone 15 months clinical training, including practical training around conducting deliveries. They are often in short supply at a health post level. Those who work at the district hospital level are usually very well experienced. A study on traditional birth attendants (TBAs) in Nepal found that one third of the sanctioned ANM posts in health posts were not manned[1].

Sub health posts do not employ an ANM and instead make use of the services of a Maternal and Child Health Worker (MCHW). These women have had 3 months of training followed by a 6 week refresher course. They are responsible for immunisation and antenatal care at a sub health post level.

Both health posts and sub health posts also employ a village health worker (VHW). This worker has also had 3 months training, and is responsible for house to house visits, follow up of TB cases, assistance with immunisation programs, treatment of pneumonia, giving worm medicine and contraceptives.

A final category of worker is the female community health volunteer (FCHV). These are women chosen by women's groups in the community. They have 14 days of initial training and then a refresher course of a few days twice a year. For the training days they are paid. Otherwise their work is voluntary and their main task is education about maternal health issues. They also distribute condoms, vitamin A tablets and oral rehydration solution.

Traditional birth attendants (TBA) are also used and found all over the district. Many of these women have been trained either by mission hospitals or by the government. However the training of TBAs has fallen out of favour internationally and this programme no longer receives funding.

Although this system sounds impressive and well organised, in many situations it functions poorly. Staff positions may not be filled, or if filled, staff may not present for duty. The services are open for only a few hours daily. There seems to be more emphasis on collecting statistics for reports than on providing quality care. The system is often corrupt. These issues provide important lessons for South Africa.

In an attempt to try and improve management and service delivery, the government has recently handed over control of the health posts in certain districts to the village development committees. This happened last week in the district in which I am working. The results remain to be seen.

In spite of problems the government of Nepal has managed to distribute health posts and sub health posts through out the country and has done well in making health systems accessible to all its people. While visiting many villages and sometimes walking for several days I have never found myself in a village more than 2 hours walk from the nearest health post. Midlevel workers make this possible. For this Nepal is to be commended. While the system functions poorly at times, it at least provides a structure on which to build.

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1. Department of Health services. The contributions of trained TBAs in Nepal. Family Health Division. Kathmandu: His Majesty's Government of Nepal, 1998