

Commentary

The Challenges in Implementing Task Shifting in Mental Health Service in Zimbabwe

Munyaradzi Madhombiro*, Michelle Dube, Bazondlile Dube-Marimbe and Wilson Mutsvuke

Department of Psychiatry, University of Zimbabwe, Zimbabwe

***Corresponding author**

Munyaradzi Madhombiro, Department of Psychiatry, University of Zimbabwe, College of Health Sciences, Zimbabwe, Email: mmadhombiro@gmail.com

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Abstract

Non-communicable chronic diseases including mental disorders contribute significantly to the world health burden according to World Health Organization (WHO). Common mental disorders, neurological diseases and HIV related mental disorders are under-diagnosed and cause significant morbidity. Mental health has faced the challenge of lack of the necessary cadres such as psychiatrists, primary care physicians that are interested in psychiatry and mental health nurses this has therefore called for a need to develop reintroduce and regularize task shifting especially in mental health spheres. Task shifting has been advocated as the solution to the shortage of manpower. By definition task shifting is the process of sharing tasks from expensive and scarce specialist resources to the available, relatively cheaper staff in order to upscale the programs. Task shifting has been recognized for its ability to access hard to reach communities. The guidelines that include the regulatory framework, ethical processes, training guidelines, prior qualifications of the cadre to be up skilled, issues of fidelity to treatment delivery and remuneration of the cadre need to be developed and implemented.

INTRODUCTION

Non-communicable chronic diseases including mental disorders contribute significantly to the world health burden according to WHO [1]. Common mental disorders, neurological diseases and HIV related mental disorders are under-diagnosed and cause significant morbidity. Mental illness contributes 12% to ill health adjusted life years [2,3].

There are many issues regarding mental health problems, such as lack of personnel, facilities and funding gaps. Because there is a chronic shortage of mental health professionals and there is demand for them worldwide but especially in low and medium income countries [4,5]. Investment in mental health care has been low and individuals with mental disorders face stigma and discrimination [6]. The mental health users and workers regularly complain of discrimination as well [7]. Training in mental health and psychiatry is less preferred in many countries [8]. The number of psychiatrists per population is thus very unfavorable. Equally, there are few nurses willing to train in mental health nursing and psychiatry. This impacts negatively on the service reach to the psychiatric patients.

HIV care has seen the most dramatic growth and population reach, due to the huge investment that was put into identification; prevention and treatment though probably the greatest impact came from task shifting [9]. Many patients with HIV do present often with mental health problems such as depression and psychosis. Due to the use of cadres that are found in the local population, the stigma that was associated with pandemic has been managed in a way that HIV has been integrated in the primary care set-up [10].

Mental health services have faced the challenge of lack of the necessary cadres such as psychiatrists, primary care physicians that are interested in psychiatry and mental health nurses. Task shifting has been advocated as the solution to the shortage of manpower [11]. It has developed from an alternative to the most essential and probably only way to solve the mental health personnel shortage.

Zimbabwe has had task shifting in health from colonial era, which consisted of clinical officers and state registered nurses. The clinical officer was meant to do physician duties where they were not there like rural and district hospital. State registered nurses do registered general nurses duties again in remote areas.

The state registered nurse has been slowly phased out through attrition. However, due to the recognition of the value of this cadre, there has been some attempt to allow these cadres to come back with other titles such as primary care nurses (PCN). Besides the nurses, there has been a cadre called a clinical officer. Clinical officers have in many instances done the job of a physicians. However, due to an increase in training of physicians, there has been an attempt to do away with the cadre through allowing natural attrition.

There is still a glaring shortage of personnel, especially so in mental health. The recommendations by WHO for countries to embrace task shifting will especially apply in Zimbabwe. Apart from a few studies that have majored in addressing mental health concerns, there have not been instances where formalized task shifting is taking place [12]. Where there is acceptance of task shifting, as the solution, the regulatory authorities have not come up with a framework to enable the up skilled cadres to work with protection of the law.

There is therefore need to develop, reintroduce and regularize task shifting especially in mental health services. Task shifting has been recognized for its ability to access hard to reach communities [13]. However it is not clear how much it has not been embraced.

This paper will dwell on the regulatory framework, ethical processes, training guidelines, prior qualifications of the cadre to be up skilled, issues of fidelity to treatment delivery and remuneration of the cadre.

ETHICS CONCERNS

Although task shifting has been used in HIV care, the environment of HIV treatment is faces ethical challenges. Patients with HIV face discrimination and stigmatization. The staff that provides the treatment lack training in ethics resulting in stigma. These cadres thus need to be trained in good clinical practice. Further, there are no formal procedures to censure those who deviate from the expected treatment guidelines and breaches in confidentiality. With the complexity involved and need for greater confidentiality, this poses challenges in the application of task shifting in mental health services. There is need for the country to develop and implement regulations for task shifting as research from elsewhere suggest [14].

TRAINING GUIDELINES

Most of the training of cadres who are up skilled is carried out by the individual organizations that need to offer the services in order to cut costs. It is also convenient and fosters the reliance on local resources. However, the lack of standard training guidelines may lead to compromise in quality. There is therefore need for standardization of training and mental health services need to have these guidelines before the widespread use of task shifting.

PRIOR QUALIFICATIONS OF THE UP SKILLED CADRE

Task shifting allows cost cutting and improvement of the reach of services. It therefore inevitably requires cadres whose qualifications are lower than the routine providers. However, the task that is shifted may still have complexities that require some

minimal level of training. Accordingly, the level of basic education required needs to be specified in order not to compromise the quality of the resulting service [15]. The situation is complex in mental health due to the specialized nature and the constant need for teamwork.

FIDELITY

For the services to be expanded without loss of their important elements, there is need to maintain fidelity. This is usually achieved by manualization of treatment guidelines, supervision, and using tools that assess the patient experience. The WHO has developed the mental health-GAP intervention which is a guide to assist non-specialist workers provide care for mental, neurological and substance use disorders. It is in the form of a manual, nurses are able to keep to a higher level of fidelity in mental health care provision. In Zimbabwe, supervision of staff that offers the treatment is the most common method that used to maintain fidelity. However, this requires funding and the supervisory staff need extra-training. This may end up inflating the budget. In mental health, supervision may require psychiatrists. However with the scarcity of psychiatrists, supervision by may not be feasible. Consequently, supervision may have to be carried out by mental health nurses.

REMUNERATION

Task sharing has been advocated for as an inexpensive way to improve the services. Indeed, this has been realized in the field of HIV care. Whereas in some countries, mechanisms to remunerate the cadres providing these services have been made, in many cases where for example, nurses provide the services, there has not been commensurate improvement in remuneration. This has been a source of dissatisfaction and has impacted negatively on the service. It is against this background that there has been calls to compensate the staff for any extra-training they get.

CONCLUSION

Task shifting is essential given the acute shortage of staff, in order to increase access to mental health services in Zimbabwe. The lack of regulatory framework, remuneration guidelines and training and essential ethics training are the major challenges. The development of ethical, regulatory guides is essential. There is need for the adoption of syllabi for the task shifting training. Consideration needs to be given to the need for adequate remuneration to increase uptake of task-shifted activities. Mental health services can be improved if the barriers to the task shifting are dealt with.

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