



January - March 2008

Volume 35 Number 1

ISSN 0047-651X

Medical Journal of Zambia



Published by the Zambia Medical Association

Medical Journal of Zambia

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Editorial office:

Dept of Medicine

Room 39

University Teaching Hospital

Lusaka

Postal Address:

P/Bag RW 1X

Lusaka,

Zambia

ISSN: 0047 - 651X

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EDITORIAL

The Healthcare Worker: Rural Retention, Retraining and Professional Development

JS Kachimba¹ and JINM Yikona²

Zambia, like many sub-Saharan countries, has gross disparities between levels of care between urban and rural areas. The noticeable effect of this scenario on health care delivery in our rural areas is profoundly negative. A situation now prevails where about a third of our rural health centres are manned by unqualified health workers.¹ In this issue of the Journal, two feature articles address issues of great importance that play a pivotal role in our goal to provide quality health care.

Munachonga and Siziya present a study that looks at factors associated with staffing of medical doctors and nurses in rural areas.² The study reveals that marital status and a curriculum that prepares one for the rural setting are the predominant determinants. Single qualified staffs were 55% less likely to accept working in a rural area. This has greatly compromised the quality of health services delivered. The authors' objectives were limited to what they called factors that may have not been considered before. These factors are in effect individual factors that depend on personal characteristics, such as age, gender, or marital status.³ They are quite distinct but interrelated with international, national, local and work-related factors that have been addressed to some degree by Government.

In a detailed research article on staffing in rural areas, Lehmann *et al* addressed numerous issues at play in this complex problem.³ Some solutions they put forward to address these individual factors included;

(a) Recruitment and training for rural areas: Targeting locals to train within their home areas would increase the likelihood of them staying in these rural areas after graduation. The introduction of a community-based curricula in medical and nursing schools would improve student perceptions about working in remote areas. The University of Zambia

School of Medicine introduced a community-based education (CBE) component that has expanded to include every year of medical education.⁴ For two weeks every semester the students travel to a remote part of the country and get a feel and appreciation for rural life, people and medical practice.

(b) The use of incentives and compulsory services: The Zambia Health Workers Scheme, initially for medical doctors in rural areas and now encompassing clinical officers and nurses, has been Government's attempt to provide incentives for staff working in rural areas.^{1,3} This scheme has included financial and material incentives such as cars, houses and farm land offered to staff to encourage rural service. Post-registration doctors, nurses and clinical officers are still required to serve a compulsory period of rural service.

c) Improving living and working conditions: Other than the nationwide refurbishment of provincial and district hospitals currently in progress, increasing the number of specialist staff in these hospitals is needed. The rural institution is unquestionably more attractive if it has adequate supervisors for the newly qualified doctors and nurses.

Health planners need to read this paper carefully because it's more interesting to find out about the willingness in those who were 45% more likely to work in the rural area. Munachonga and Siziya should be invited by planners to elucidate the study, answer their queries, expand the study to other hospitals and hence inform policy. Extending this study to the allied paramedic professionals would help determine factors affecting their choice of whether or not to serve in rural areas. It's been observed in other parts of the world where staff shortages pervade the health system, that there is no simple solution to the problem of health worker shortages in rural areas.³ Our healthcare workers and the nation at large will have to cultivate a passion for service to both our rural

¹ Editor, *Medical Journal of Zambia*

² Specialist Registrar, Geriatrics and General Medicine, Cambridge, UK

and vulnerable populations. This is something a Government can not legislate.

The diagnosis and management of clinical diseases or syndromes requires a well resourced healthcare system. Availability of the healthcare practitioner is the most obvious. These include doctors, nurses, clinical officers, allied paramedic professionals and administrators. Everyone involved in delivery of patient care must be well trained in their field. All must undergo continuous professional development (CPD). CPD is important because the half-life of unused knowledge is not very long. The whole life span of professional medical practice is the clinical application of basic sciences learnt during training. In Zambia, successful university completion of these basic sciences leads to the award of a Bachelor of Science degree in Human Biology. A doctor's failure to apply this basic knowledge of physiology, biochemistry, anatomy or microbiology for example, is probably unprincipled and could put patients' lives at risk.

In his article, Banda demonstrates the role of anatomy in clinical practice (5). He spent 2216 contact hours observing medical staff in their usual clinical settings. During this contact, he assessed their qualitative knowledge of anatomy. He found a direct relation between presence of knowledge and confidence of healthcare provision and ability to explain patients' clinical state. In most clinical settings, it's immediately apparent at the bedside that a surgically based specialty like surgery and obstetrics and gynaecology, uses anatomy in an openly evident manner. Comparatively, in internal medicine, though equally indispensable, it may not always be apparent. In a resource-poor setting like Zambia, it is worrying that Banda found less than adequate knowledge of anatomy in internal medicine.

As Banda rightly observes, doctors who had a good knowledge of anatomy (and most certainly this applies all the basic sciences) manifested more confidence and were more competent clinical practitioners.

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