ASSOCIATION OF MEDICAL COUNCILS OF AFRICA

AMCOA PROTOCOL

ON

TASK SHIFTING IN MEDICAL PRACTICE

01ST AUGUST 2014

AMCOA PROTOCOL ON TASK SHIFTING IN MEDICAL PRACTICE

WHEREAS dealing with **"TASK SHIFTING IN MEDICAL PRACTICE"** in the member councils/boards of AMCOA take various forms both in structure and content; and

RECOGNISING the need to advance the objectives for enhancing and ensuring improved quality of care in relation to task shifting; and

FURTHER RECOGNISING the need to harmonize the procedures in the AMCOA region for the enhancement of Task Shifting in Medical Practice

NOW THEREFORE THE PARTIES TO THIS PROTOCOL DO HEREBY ADOPT THE PRINCIPLES ENSHRINED HEREIN AS A FRAMEWORK FOR DEALING WITH TASK SHIFTING IN MEDICAL PRACTICE IN THE REGION:-

1. DEFINITIONS

In this Protocol, unless the context otherwise indicates:-

"Task Shifting" means *a process whereby specific tasks are moved from a category of health workers when appropriate to a category less trained to maximize the efficient use of health workforce resources.*

"Health Worker" means a (check who)

"Scope of practise" means *the extent to which providers may render healthcare services under supervision or independently.*

2. PROCESS OF IMPLEMENTING TASK SHIFTING

It is agreed that Councils/Boards should ensure that–

1. Specific tasks are moved from a category of health workers when appropriate to a category less trained to maximize the efficient use of health workforce resources.

2. The rationale/challenges to be addressed among others include:-
   a. Shortage of trained health personnel
      i. The rate of manpower production does not support countries' need
      ii. High emigration rate
      iii. Distribution of manpower as demanded by geographic/ demographic needs and affordability
   b. Increased burden of diseases
   c. Pressure to render basic health services

3. Tasks that need to be shifted are identified.

4. The cadres to whom the tasks will be shifted are defined.

5. The stakeholders are identified, adequately consulted and roles defined.

6. Training needs are defined and set documented.
   a. Identify trainees
   b. Identify Trainers
   c. Set Curriculum
   d. Identify Training Platform
   e. Financial Resources
   f. Accredit Training Programmes
7. Training is monitored and evaluated.

3. SCOPE OF PRACTICE & REGULATORY IMPLICATIONS

It is agreed that Councils/Boards should ensure that–

1. The scope of practice is crafted and exercised in relation to clearly defined health care delivery systems.

2. The scope of practice should be finalised prior to the training of the health provider.

3. An enabling legal instrument is developed to govern the organisation and functioning of the task shifting process.

4. A decision is made as to who should regulate the health provider to whom the task has been shifted.

5. Liabilities and accountabilities for the shifted tasks are clearly defined.

6. The registration, licensing and continuing professional development requirements are reviewed.

7. Mechanisms are in place for the monitoring and evaluation of the practice.

4. LEGAL & ETHICAL ISSUES

It is agreed that Councils/Boards should ensure that–

a. The safety of patients is guaranteed by providing guidelines on standard on competences, Scope of Practice and the availability of referral systems.
b. There is acceptance of the process by all stakeholders.
c. The reward system is reviewed to take into consideration the task shifting

Statutes exist to regulate task shifting in the following areas:

i) Definition of competencies
ii) Definition of cadres to whom tasks are being shifted
iii) Definition of scope of practice and legal implications
iv) Supervision to ensure quality service delivery

5. LICENSING IN TASK SHIFTING

It is agreed that Councils/Boards should ensure that the cadres to which the tasks are shifted are appropriately licensed by ensuring the following–

i. Tasks identification
ii. Appropriate training
iii. Clear definition of Scope of Practice
iv. Mechanism for support supervision
v. Relevant CPD programs
vi. Proper mechanism of collaboration among regulatory authorities

6. QUALITY ASSURANCE

It is agreed that Councils/Boards should ensure that –

a. Task shifting does not compromise quality of service delivery
b. Task shifting is not a substitute for recruitment of qualified personnel
c. There is no task shifting to Interns who are trainees under supervision
d. There should be clearly defined timelines for the implementation of task shifting
e. Appropriate human resources policies are implemented to address the following areas for the cadres to whom tasks are shifted:
    i) Roles and competencies
    ii) Training
    iii) Assessment
    iv) certification
    v) Support supervision
    vi) Referral guidelines

7. STANDARDIZATION IN TASK SHIFTING

It is agreed that Councils/Boards should ensure that the following are observed in order to have standardized task shifting processes at national, regional and continental levels in the following areas;

i) Roles and competencies
ii) Training
iii) Assessment
iv) Certification
v) Support supervision
vi) Referral guidelines

ENABLING FRAMEWORK

All member countries that are signatories to this protocol agree to pursue processes of aligning or developing legislative and other policy frameworks to facilitate the implementation of the principles enshrined in this protocol.

THUS DONE AND SIGNED AT SOFITEL, L' IMPERIAL RESORT & SPA, WOLMAR, FLIC EN FLAC, MAURITIUS, ON THIS DAY, FRIDAY, 1ST AUGUST, 2014.

Country	Name & Designation	Signature
1. Botswana	Dr Goabamang Isie	
2. Ghana	Dr CLI ATIKPUI	
3. Kenya	Dr G MAGOA	
4. Lesotho		
5. Malawi	AHC K KAWONGA	
6. Mauritius	DR BOT SERVANSINGH	
7. Namibia	AR KAURA	
8. Rwanda	E. Rwamasirabo	
9. Sierra Leone	Dr A C Williams (President MDCSL)	
10. South Africa	M.S.MOKGOKONG (PRESIDENT: HPCSA)	

11. Swaziland	Dr Samuel Vusi Magagula	
12. Tanzania		
13. Uganda	OKULLO GOZA	
14. Zambia	Dr. Davy M. CHIKAMATA	
15. Zimbabwe	DR. A. MACHEKA	