

Is utilization of non-dental personnel (clinical officers and assistant clinical officers) justifiable in the 21st century in Tanzania?

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One of long term priorities of the 1st National Plan for Oral Health (1) was to provide treatment activities to pre-school and school children, expectant mothers and general public in urban and rural areas and training of some of the other health personnel in oral health care. In the 2nd National Plan for Oral Health, one of the areas identified to be strengthened is the coverage of the rural population with emergency oral health care services and an established level of oral health personnel for the different levels of health facility (2). The goal of the policy guidelines for oral health care in Tanzania is to improve oral health care and well being of all Tanzanians. In that respect, one of its strategic objectives is ensuring that emergency oral health services are equitably distributed throughout the country (3).

Ntabaye et al 1993 (4) point out that, the provision of emergency oral health services at the rural health centres and strategically located dispensaries involve utilization of non-dental personnel – the clinical officers, (CO) and assistant clinical officers, (ACO), working at the primary health care facilities. The justification being that, they have a good medical background but what they lack is practical skills in the provision of emergency oral health care. However Ntabaye concludes by indicating that the success in utilizing them depends very much on the support of the prime minister's office, regional and local governments, who are directly responsible for the running of the rural health centres and dispensaries. Ngilisho and Nkwera in the 1980's and 1990's when piloting and establishing programme in Mbeya and Tanga Pilot regions concluded that services provided by the trained COs and ACOs were similar to what was being provided by dental therapist at the urban PHC facilities and acceptable to the communities. However, there were some setbacks in that, this was an added activity of the job tasks of the COs and ACOs, with out motivation and incentives, shortage of supplies such as LA and after DANIDA ended its support; there was no continuity in the provision of services (*ref no 5 Ngilisho et al*).

According to the Health Sector Reforms in Tanzania (4) and the policy guidelines for oral health care in Tanzania (3), dental therapists are trained to work at the health centres and dispensaries and private health facilities, providing comprehensive oral health care, school dental services and refer complicated cases beyond their scope to the immediate higher level. Poulsen et al 1994, states that the training of dental therapist was started in Tanga in 1980 and Mbeya 1992. The number of graduates from these schools by the year 1993 was 168 and 64% were working in government clinics. Poulsen also concludes by indicating that two out of three graduate dental therapist end up working in government dental clinic. As regards to assistant dental officers, the loss of the graduates to government employment is far less (5).

The School of Dentistry at Muhimbili University of Health and Allied Sciences (MUHAS) is only Dental School in Tanzania. The School started 30 years ago in 1979. The first batch of 12 candidates from the School of Dentistry graduated in 1984. To-date a total of 25 batches has been graduated totaling to 283 graduates. The mission of the school is to direct and guide students and the general public in attaining quality of life through quality oral and other related health research, training, education and public service, whereas the vision is to become a centre for revolutionizing oral health in Tanzania and in the African region.

One of the reasons for provision of emergency oral health care by utilizing COs and ACOs (1994) was the fact that the number of oral health personnel available in Tanzania at that time was not enough to cover all health centres and dispensaries. Senkoro and Kikwilu (2009) in their presentation to the Tanzania Annual General Meeting and Scientific Conference proposes to restart the programme by training trainers of trainers (ToT) to revive the programme. Is this justifiable in Tanzania in the 21st Century? To my opinion there is no justification of starting the dead programme in the 21st century because of the following reasons:

1. There is an increase in the number of all types of oral health personnel trained at the four dental schools that could be utilized to provide emergency oral care but are currently under utilized or not even employed.
2. According to Ntabaye the success of this programme depends on support from PORALG and not Central Support (MoH). The achievements in the pilot regions (Tanga and Mbeya) were attained due to financial support from DANIDA. Very few districts if any have trained and deployed COs and ACOs in rural health facilities using council's funds.
3. As indicated by Ngilisho and Nkwera trained and deployed COs and ACOs very quickly loose interest if not properly followed up and monitored. Also they point out that motivation/incentives are a key factor for them to continue providing services.
4. COs and ACOs are currently also involved in the following programmes; PMTCT, CTC, VCT, PITC and HIV/TB. All these programmes provide motivation and incentives to the COs and ACOs. Will they be motivated enough to provide emergency oral health care?
5. Provision of emergency oral health care aim at using an appropriate' locally made wooden dental chair, utilize pressure cookers for sterilization and a basic kit of instruments for the provision of emergency oral health care. All these were provided by the TDDHP in the pilot regions Tanga and Mbeya. Are the other districts in the other regions prepared to support the programme in their respective district councils?
6. The government intends to establish dispensaries in most of the registered villages in the country by utilizing the COs and ADOs currently in service with addition to those graduating from the medical training institutions. Is it realistic to assume that the COs and ACOs will have to time to provide emergency oral health care?

With caution it can be concluded by saying that the idea of utilizing the COs and ACOs in the 1980's and 1990's was realistic and sound due to the fact that the number of oral health personnel in the country was inadequate to provide emergency oral health care at the PHC facilities. However with the establishment and expansion of the training facilities (DTs, ADOs and Dos) the number of trained oral health personnel has increased ten folds. Based on what has been discussed above it is not realistic to continue utilizing non-dental personnel in providing emergency oral health care at the PHC facilities in the 21st Century in

Tanzania. As a way forward the following is recommended:

1. Basic and simple oral treatment should be available near where people live and should be available to all
2. The provision of oral health care services at the PHC facilities should be provided by dental therapist as recommended in the Policy Guidelines for Oral Health care in Tanzania (3).
3. Basic dental instruments, materials and supplies should be available at Medical Stores Department.
4. A reasonable level of quality assurance in oral health care could be attained by establishing, rehabilitation and equipping dental clinics at the PHC facilities as recommended in the plan for rehabilitation and equipping dental clinics at all health facilities (9).
5. Provision of appropriate human resources and improvement of infrastructure and the working environment.
6. It is also important that an appropriate oral health care delivery system is developed.

References

1. Muya RJ, Rambusch E, Ferjesckov O, Hobdell MH, Nørmark S. Changing and developing dental health services in Tanzania 1980-2000. United Republic of Tanzania, Ministry of Health-DANIDA, 1984.
2. COHU. National Plan for Oral Health 1988-2001. Central Oral Health Unit, Ministry of Health, United Republic of Tanzania, 1988.
3. COHU. Policy guidelines for oral health care in Tanzania. Ministry of Health United Republic of Tanzania 2002.
4. Ntabaye MK, Mosha HJ, Ngilisho LAF, Nkwera H and Poulsen S. Provision of emergency oral health care to the rural population by utilizing rural medical aides. Ministry of Health 1993.
5. Ngilisho LAF, Nkwera H. Provision of emergency oral health care. Implementation status Tanga and Mbeya regions, Central Oral health Unit (COHU) 1994
6. Ministry of Health, Health Sector Reform 1994.
7. Poulsen S and Mosha HJ. Distribution of dental personnel trained under the TDDHP 1981-1991. Ministry of Health 1994.
8. MUHAS, Faculty of Dentistry. Curriculum for Doctor of Dental Surgery Programme 2002.
9. COHU. Plan for rehabilitation and equipping dental clinics at all health levels in Tanzania. Central Oral Health Unit, Ministry of Health, United Republic of Tanzania, 20001.