

REPORT
HUMAN RESOURCES FOR
HEALTH

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Final Version

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CBO	Community-Based Organization
CHW	Community Health Worker
CSO	Civil Society Organizations
DFID	Department for International Development
EU	European Union
GFATM	Global Fund for AIDS, TB and Malaria
HIV	Human Immuno-Deficiency Virus
HRH	Human Resources for Health
HR	Human Resources
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MMR	Maternal Morality Ratio
MOH	Ministry of Health
NGO	Non-Governmental Organization
PNFP	Private-not-for-profit Providers
PPP	Public-Private Partnership
SWAp	Sector Wide Approach
TA	Technical Assistance
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

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Executive Summary

Human Resources for Health (HRH) relates to the development, management, coordination, financing and remuneration of the human capital in a national health workforce to achieve access, coverage and quality of health services. Human resources for health constitute one of the six main building blocks of the health system, defined by WHO.

Healthcare is a labour intensive industry and there is plenty of evidence to show how health worker numbers and quality are closely linked to infant, child and maternal survival. Sida is currently in the process of preparing the background note to a new policy for health and knowledge in Swedish development cooperation. This desk study on Human Resources for Health is aimed at feeding into this process.

The global HRH Crisis

During the early 2000's it became clear that there was a global human resource crisis in the health sector. The 2006 World Health Report revealed that 57 countries - of which 36 are in Africa - were deemed to have critical workforce shortages which limited their capacity to deliver essential health services and achieve the health related Millennium Development Goals (MDGs).

Initially, the international debate centred on the issue of migration and so called *Brain Drain*. In the last couple of years it has however been recognised that international migration is neither the main cause of healthcare shortages in developing countries.

There is international agreement that there is a general need to drastically increase training capacity (to ensure enough workers both in developing and developed countries), to improve retention and to better monitor workforce flows.

International action has been taken as many OECD countries have increased their training rates significantly and in parallel, WHO has developed an international *Code of Practice* (2010) regarding migration. Despite this, however, improved funding is still needed in many developing countries; for increasing training, for staff retention and for ensuring that staff is provided with good working conditions.

Working lifespan strategies

But training is not only about numbers. It is important to look at categories of staff needed, and in many countries there are also severe shortages of *public health specialists* and of *health care managers* in addition to the clinical staff. Gender imbalances need also to be addressed as well as rural/urban imbalances and ensuring staff is available to cater for different language and ethnic needs.

In order to assist countries, WHO has developed the working lifespan strategies concept as a guide which includes support and best practices within a conceptual framework that has three phases; 1) Entry into workforce, 2) Workforce which includes how to enhance worker performance and management, and 3) Exit which gives countries guidance on managing migration and attrition.

It is important to recognize that human resources are closely linked to the wider health system agenda in many different ways. It must further be noted how the principles of respecting human rights and taking a gender perspective should guide the human resource decisions in the health sector at the country level as well as internationally.

Fragile states

Providing health services in fragile situations is a highly complex task. Populations in fragile states suffer a significantly higher burden of disease and mortality which adds to the already significant challenges in over-stretched and weak structures, with staff sometimes operating in dangerous conditions.

There are several problems in fragile settings. The first relate to the fact that relief agencies and NGOs have a tendency to recruit the already scarce local personnel for services to refugees by providing significantly better conditions in terms of salary etc. Another problem is that emergency situations seem to encourage improvised training and abbreviated courses for staff. While some of this training may be necessary, it risks undermining staff developing proper skills in the longer term and it takes key staff out of service during times when their presence is most needed.

There are several options for solving some of the HRH needs in fragile states, through for example using task-shifting and expanding the use of community health workers (please see chapter on Country Examples).

This report also recommends that a longer term perspective (a development- rather than an emergency-) perspective is taken by all partners, under the leadership of the country if at all possible, already from the beginning. It is important that in particular the civil society organisations and non-governmental organisations that provide initial relief come to the table as well.

Donor perspectives

Although all development partners who are concerned with health are more or less involved in working with human resources, only a handful have explicit HRH strategies. Within the multilateral organisations, the World Health Organization (WHO) has a lead role. Between the bilateral organisations, DFID and USAID seem to be the organisations (in addition to Sweden) that have explicit support to human resources for health.

Recommendations for Sweden/Sida

International experience shows that each country has to develop HRH policies and strategies that are suited to its specific context as part of the human rights core obligations. While there are international recommendations, standards and frameworks that can be used, there is no blue print and no one-size-fits-all solution.

This report recommends that Sweden should continue to work towards the implementation of the Paris Declaration and the Accra Agenda. There is a need for increased harmonisation and alignment– even in fragile states – with a longer term development perspective. Country ownership is key and should be supported in all settings where possible. Sweden can – in addition to providing financial support for HRH and support government leadership - take a role in a) lobbying for increased harmonisation of per diems and allowances, b) promoting on the job training instead of workshops/short courses, c) assisting ministries of health to advocate for

sufficient resources for HRH in national budgets, d) continuing to strengthen the role of the midwife, as well as e) promoting more research into gender aspects of HRH.

1. Introduction

Healthcare is a labour intensive industry. At the heart of each health system, the workforce is central to advancing health. There is ample evidence to show that health worker numbers and quality are associated with for example infant, child and maternal survival. Human Resources make up one of the six interdependent health system building blocks – finance, workforce, services, technologies, information, and governance – all that are key to a well-functioning health system¹, according to WHO.

Sida is currently in the process of preparing the background note to a new policy for health and knowledge in Swedish development cooperation. This desk study on Human Resources for Health is aimed to feed into this process.

2. Methodology

This is a desk study that includes a literature review of human resources for health documents primarily from several international organisations but with input from documents from research organisations, local organisations and specifically selected development partners that have a high profile and/or have shown a prioritisation on human resources. The examples are mainly from Africa (where the problems have been identified as the biggest) but also from other parts of the world, and include countries in a relatively stable development phase as well as countries in conflict situations and so called fragile states, like from the earlier post-conflict situation in Mozambique as well as examples from Afghanistan and Sudan.

3. Sweden's guiding principles in Development Cooperation and their effects on Human Resources for Health (HRH)

Sweden's guiding principles on health systems, including human resources are embodied in various policy documents². These principles and guiding documents lay the foundation for the Swedish investments into Human Resources for Health.

In addition, Sweden's guiding principles of human rights and gender with a focus on the poor and vulnerable populations require these aspects to be taken into account when supporting country strategies for human resources in health. This translates into ensuring that when countries are supported to meet the Millennium Development Goals for example, it is not only about meeting the goals but also about who the services are targeted to and how and where the services are provided.

¹ WHO website on health systems

² *Policy for Health and Development: Health is Wealth (2002), Good Humanitarian Principles, The Government's Humanitarian Aid Policy (2004/05:52), Humanitarian Strategy (2008-2010), Sweden's Policy for global development 2007/08:89, The Right to Future- Policy for Sweden's International HIV and AIDS Efforts, Sveriges internationella politik för sexuell och reproduktiv hälsa och rättigheter, Policy för jämställdhet och kvinnors rättigheter 2010-2015, Policy för Sveriges stöd till det civila samhället i utvecklingsländer inom svenskt utvecklingsarbete, Forskning för utveckling, Policy för forskning inom det svenska utvecklingsarbetet 2010-2014, Policy för frihet – Policy för demokratisk utveckling och mänskliga rättigheter inom svenskt utvecklingsarbete 2010-2014, Policy för Sveriges humanitära bistånd 2010-2016 and International guiding principles and Declarations, such as the 2005 Paris Declaration, Accra Agenda for Action, Fragile States Principles, Good Humanitarian Donor ship, DAC Principles of Good International Engagement in Fragile States and situations.*

The Paris and Accra Declarations further emphasise that Sweden has committed to work in a harmonised way with other development partners and align its support to partner systems. This is particularly important in the area of human resources as there are still large variations between donors as to if and how human resources recurrent costs can be met and how to support training and development programmes for human resources. Critical to success is country ownership and the need for development partners - both bi-lateral and multi-lateral – as well as civil society organisations active in the country to fit into and respect national health plans and strategies.

In the specific area of human resources, the existing guidelines lift the role of skilled attendance at birth through focusing on the role of the midwife. This has important implications for the Swedish support in human resources for health and Sweden can promote – and export - the good national experiences with the system emphasis on the role of midwives.

4. Global situation analysis and global trends

4.1 Definition of Human Resources for Health (HRH)

Human Resources for Health (HRH) relates to the development, management, coordination, financing and remuneration of the human capital in a national health workforce to achieve access, coverage and quality of health services. It primarily involves the *health workforce* or *health workers* who are 'All individuals engaged in the promotion, protection, or improvement of population health, from both the formal and informal sector'.³ Human Resource Management (HRM) is the discipline that seeks to coordinate the efficiency and effectiveness of the health workforce to deliver services aligned to national health priorities and plans.

4.2 The global Human Resources for Health Crisis

During the early 2000s it became clear that there was a human resource crisis globally in the health sector. Several reports and initiatives were taken to look deeper into this problem⁴. The 2006 World Health Report focussed on the crisis of human resources for health in many of the poorest countries in the world. 57 countries - of which 36 are in Africa - were deemed to have critical workforce shortages⁵ which limit the capacity of these countries to deliver an essential package of services and achieve the health related Millennium Development Goals (MDGs). The other countries with critical shortages are mainly found in Asia with a few in Latin America (like Honduras, Nicaragua and Peru) as well as in the Middle East (like Yemen and Iraq).

WHO estimated that the critical shortage was equal to a deficit globally of 2.4 million doctors, nurses and midwives. The shortages were particularly bad in the Africa region which was estimated to have 24% of the global disease burden but only 3% of the health workers and less than 1% of the world health expenditure. The exodus of skilled staff to greener pastures - the so called *Brain Drain* – has in addition hit Africa particularly hard. Although no exact figures seem to exist on health worker migrants by gender, the ILO estimates that in general, 48% of the international migrant workers are women⁶.

³ World Health Organization (WHO), World Health Report 2006

⁴ Joint Learning Initiative 2004, Human Resources for Health, Overcoming the Crisis

⁵ defined as less than 2.3 doctors, nurses and midwives per 1000 population

⁶ ILO, SECTORAL ACTIVITIES PROGRAMME, Working Paper International migration of health workers: Labour and social issues
Dr. Stephen Bach, International Labour Office Geneva July 2003. Page 14

Over the last decade, the global HRH debate has centred on the issue of skilled staff leaving their countries of origin to work elsewhere. In the last couple of years it has however been recognised that this crisis goes far beyond the migration problem. OECD and WHO have shown that *...“international migration is neither the main cause of healthcare shortages in developing countries, nor would its reduction be enough to address the worldwide health human resource crisis”⁷*.

The conclusion is that globally, there are not enough trained health workers and there are serious challenges with regards to training new staff as well as retaining and distributing the existing workforce. To tackle the global crisis, there is a need to drastically increase capacity to conduct high-quality training, improve retention and to better monitor workforce flows. Many OECD countries have made significant efforts to increase training rates in the recent years, which will reduce to some extent the so-called pull factors (see below) on scarce staff in developing countries. There is also an international *Code of Practice developed by WHO in 2010* on principles for setting voluntary standards to promote an equitable balance of interest among health personnel and source and destination countries. (See also chapter 5.3.1)

Increasing the national capacity to train workers will require significant investments. Assessments have been made about the cost of the additional training needs and the average estimated cost per country is 136 million US\$. Financing such investments will require an increase of health expenditures with on average 2.8 US\$ per person and year in the average country, and the annual cost for employing the new staff is estimated to 311 million US\$ per country (2004 prices). By 2015 the salaries of the new work force will cost a minimum of 7.5 US\$ per capita in the average country⁸. Hence investments in the health sector (from national governments and where needed with support from donors) are necessary if the human resources gaps are to be addressed and quality services delivered along with continued measures in developed countries (like Sweden) to train sufficient staff for the national needs and sign up for the voluntary international agreements that have been developed to manage migration.

However, an adequate workforce is not only about numbers but also about composition. Health workers are both individuals and form part of a team in which every member contributes with different skills and perform different functions. From a global perspective, many imbalances exist; for example countries have an enormous diversity in the skill mix of health teams; the ratio of nurses to doctors ranges from 8:1 in Africa to 1.5:1 in the Western Pacific region.⁹ In many countries, there are also severe shortages of *public health specialists* and of *health care managers*, in addition to the deficits of medical staff of different specialization (such as psychiatry?mental health).

Gender imbalances are also obvious in the health workforce at large. Typically 70% of the doctors are male while more than 70% of the nurses are female. There are also frequent imbalances between the private and the public sectors, with about two thirds of the workers being employed by the public sector. In addition, almost all countries suffer from imbalances characterized by urban concentration of staff and rural deficits. It may be interesting to note that little or no information seems to be available on deficits of staff relating to ethnicity.

⁷ OECD/WHO Policy Brief February 2010 International Migration of Health Workers

⁸ WHO World Health Report 2006

⁹ WHO World Health Report 2006, page xvi

New challenges have emerged and are emerging that affects the health work force. For example, the HIV/AIDS pandemic constitutes a huge workload as well as a risk in many of Sweden's partner countries and new infectious diseases such as the outbreak of the H1N1 influenza constituted an additional burden which showed how important it is to have a sufficient health workforce globally. Specific and very difficult challenges face countries in conflict situations (**please see chapter 6**), where the health workforce is particularly affected.

5. Health Workforce at Country Level - Working Lifespan Strategies

WHO has defined the workforce goal as *"to get the right workers with the right skills in the right place doing the right things"*¹⁰. From a global perspective, it is noted that there is no blueprint for effective workforce strategies; each country must match its strategies to its unique needs and characteristics. WHO has developed the working lifespan strategies concept as a guide which can assist from a policy and management perspective at key decision-making times:

1. Entry – preparing the workforce through strategic investments in education and effective and ethical recruitment practices.
2. Workforce - enhancing worker performance through better management of workers in both public and private sectors.
3. Exit – managing migration and attrition to reduce wasteful loss of human resources.

5.1 Entry

The entry phase of the working lifespan strategies revolves around training and recruitment, which the global crisis has showed is more important than perhaps previously thought. This includes the number of people trained, the quality of the training and the diversity in terms of socio-cultural and demographic characteristics and the competencies.

Training institutions are key and they undertake six main functions: stewardship, provision of educational services, selection and employment of staff, financing of training, development and maintenance of infrastructure and technology, and generation of information and knowledge.

A key issue in all countries is to get the right balance of schools and graduates. From a global perspective, training institutions are skewed towards the production of doctors and nurses. In order to be able to respond to shortages or surpluses, it is necessary to evaluate the current capacity to train at country level – keeping in mind that the cost of opening a new training institution may appear high but must be compared with the how much it would cost to attract staff trained abroad or to tempt staff to return to the country. There is also a need to address critical shortages of certain staff groups, such as the public health and health management cadres as well as shortages in cadres of staff with specialist competencies like psychiatry and midwifery (the shortages will be different in each individual country).

Another important aspect to consider in the training is quality control. The government does not have to train itself but as part of the stewardship role it must ensure that training institutions provide quality services, which can be done through accreditation. Accreditation programmes exist in about half of the countries in South-East Asia, but only in one third of the African countries.

In addition to numbers and skills mix, it is important to address the gender, socio-cultural and linguistic needs already at the training stage. *Admission quotas* is one option and *outreach programmes* to reach certain groups to become health professionals is another one, as well as

¹⁰ WHO World Health Report 2006 page xx

specialized programmes for under-represented students in secondary school and expanded selection criteria for admission of students with personal attributes that make them suited to providing health services.

The recruitment phase is the entry into the health workforce. This is a critical function and it has to be managed both at a system level as well as at the individual employer. A balance relating to *numbers, competencies, background/diversity, location and time* needs to be found. The labour market for health workers is to a large degree imperfect which is why interventions may be needed to ensure that all groups of the population can get access to quality health services.

Countries have to assess the skills mix needed for their particular circumstances but as a rule-of-thumb 2.5 workers per 1000 population is considered a threshold of worker density necessary to attain adequate coverage¹¹.

5.2 Workforce

A well-performing workforce is critical and it has an immediate effect on service delivery and population health. In order to make the best use of the existing workforce, some element of performance monitoring is needed. The performance monitoring systems are often weak or non-existent but can be very useful. According to a study¹² in two African countries, the potential gains in productivity of existing staff could be as much as 26-35%. Therefore, an important aspect which needs more work globally and at country level is measuring work performance.

Human Resource indicators used to assess performance are:

Availability	Staff ratio, absence rates, waiting time
Competence	Individual; prescribing practices Institutional; readmission rates, live births, cross-infections
Responsiveness	Patient satisfaction, assessment of responsiveness
Productivity	Bed occupancy, outpatient visits, interventions per worker

5.2.1 Factors that affect health worker's performance

A number of factors can influence the performance of existing health workers:

- *Clear job descriptions*: job description that spells out the objectives, responsibilities, authority and lines of accountability are linked to improved achievements. In many countries, health workers still lack job descriptions and this is a non-costly way of increasing both outputs and job satisfaction.
- *Support norms and codes of conduct*: these set the principles and parameters of the health workers; however they have to be widely publicised and disseminated to have an effect.
- *Match skills to task*: A number of problems are normally found in both resource rich and resource constrained systems such as nurses doing clerical work, management tasks being carried out by medical staff and vice versa when untrained personnel carry out skilled tasks such as birth deliveries. Other problems often encountered are excessive time used on

¹¹Joint Learning Initiative 2004. Human Resources for Health Overcoming the Crisis, p 24

¹²World Health Report 2006 p 69

certain tasks, such as hosting missions, or health workers not being at the health facility when the workload is highest. Some possible ways of tackling these problems can be found in Annex 1.

5.2.2 Linkages to wider health system

The performance of health workers is also closely linked to the wider health system in a number of areas:

- *Good working conditions*: timely payment of salaries, adequate salaries (to prevent staff from having to have other means of income), reasonable conditions in relation to social security and time for rest/vacation (linking to the health systems building blocks of health financing and leadership and governance of the health system).
- *Information and communication*: you manage what you measure. Health workers need a well-functioning health information system in order to provide accurate services. It is also important to ensure that the Health Information System collects data that is disaggregated by sex and age and where possible/applicable by socioeconomic groups as well as geographic location.
- *Infrastructure and supplies*: health workers cannot do their job properly without well-equipped facilities with basic amenities such as clean water, lighting, heating, vehicles and drugs. The work environment is crucial for job satisfaction and performance.
- *Effective team management*: HR in the health sector has been focused on clinical knowledge and skills rather than on system skills like management, accounting, procurement and logistics. This has resulted in many low income countries getting support to scale up services without sufficient capacity to manage the support system. HR must be seen from a holistic system perspective.

5.2.3 Promoting lifelong learning

While perhaps sometimes working as an incentive, conferences, workshops and short courses that do not include any opportunity to practice new skills with no practice have little or no effect on performance change¹³. Evidence shows that in-service training is most likely to change worker behaviour when it is interactive, based on real experiences and coupled with continuing support, such as mentoring and supervision. Experiences also clearly show that disseminating guidelines is ineffective unless they are utilised during a training course.

Workshops and short courses are unfortunately undermining services in many resource-poor settings. Not only do they remove critical staff from their duty stations for extended periods of time, but the per diems have become a supplementary source of income that are never taxed. A study in two districts in Burkina Faso showed that health workers' median annual income from per diems exceeded their salaries. The magnitude of per diems at a country level could be much better utilised for improving worker performance, in Tanzania for example the allowances/per diems for the 2008/09 fiscal year amounted to 390 million US Dollars.¹⁴

5.2.4 Gender issues

Gender greatly influences the roles of women and men in the health work force. As part of a larger gender context in each country and internationally, gender biases influence how work is recognised, valued and supported. The resulting health system outcomes are inequitable and show many biases as women are over-represented in caring, informal, part-time, unskilled and unpaid work. Despite increased attention to HRH there is a lack of research dedicated to gender issues in the health work

¹³ World Health Report 2006 p 82

¹⁴ *Per diems undermine health interventions, systems and research in Africa*, Tropical Medicine (2010), Ridde, Valery

force and for assessing interventions that address gender inequalities¹⁵. Gender bias exists across as well as within health occupations. As a result, measures like substitution and delegation should not only be seen as technical interventions but also from a gender perspective.

A gender lens needs to be applied throughout the HRH process, from the workforce entry (when admitting/encouraging students to the medical profession including to support functions), in the recruitment (also keeping in mind the issue of ensuring services in remote areas and the local gender context), in monitoring and data systems, and at the exit stage. It is worth noting that in the abundant literature on HRH, very few articles and reports bring out the gender balance issue neither within the workforce itself, nor in the context of the populations that are to be served.

5.2.5 Human Rights aspects

The UN Committee on Economic, Cultural and Social Rights has commented on the right to the highest attainable standard of health. Its view is that this means that services, goods and facilities should be Available, Accessible, Acceptable and of good Quality (the so-called AAAQ model).

General Comment 14 sets out four criteria by which to evaluate the right to health¹⁶:

Availability. Functioning public health and health facilities, goods and services, as well as programmes, have to be available in sufficient quantity.

Accessibility. Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions: 1) non-discrimination; 2) physical accessibility; 3) economic accessibility (affordability – including issues such as fee levels); and 4) information accessibility.

Acceptability. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

Quality. Health facilities, goods and services must be scientifically and medically appropriate and of good quality.

This must also be reflected in the human resources for health strategies at country level. For example, regarding acceptability with regard to HRH, women cite bad treatment by health care staff as a reason for not delivering in facilities, which undermines efforts to reduce maternal mortality. Cultural acceptability is also a key issue which relates to the right of having services in a language that the patient can understand and being treated in a culturally sensitive manner, for example being allowed to keep cultural traditions at birth like what to do with the placenta, which position to give birth in etc. Language considerations are also linked to accessibility in the sense that if patients cannot access services in their own language, they are likely to not seek care.

5.2.6 Serving rural populations

Most countries struggle to achieve health equity and to meet the needs of in particular vulnerable and disadvantaged groups. A key challenge is to provide people living in rural and remote locations with access to trained health workers. About half of the global population lives in rural areas but these areas are served by only 38 per cent of the total nursing work force and less than 25 per cent of the total physician work force¹⁷. WHO have, based on evidence collected over a number of years,

¹⁵ *Human Resources for Health: A Gender Analysis*, Asha George, Background paper prepared for the Women and Gender Equity Knowledge Network and the Health Systems Knowledge Network of the WHO Commission on Social Determinants of Health 2007

¹⁶ Human Rights, Health and Poverty Reduction Strategies, WHO Geneva 2008, This document describes how the UN Committee on Economic, Social and Cultural Rights, which monitors compliance with the ICESCR, has clarified the scope and content of the right to health through adopting a General Comment on the Right to Health in 2000. This General Comment is referred to as “General Comment 14”.

¹⁷ *Increasing access to health workers in remote rural areas through improved retention*, Global Policy Recommendations, WHO 2010

put together policy recommendations for countries to address the rural-urban dilemma in the health sector. For a summary of the recommendations please see Annex 2.

5.2.7 *The strategic role of nurses and midwives*

Over the last decade, the critical role of nurses and midwives has been recognised and international efforts made towards improving global nursing and midwifery workforce strategies (WHA resolutions, Chiang Mai declaration 2008, the Kampala Declaration and Agenda for Global Action (2008)). However, systems that monitor progress in these fields suggest that while it may be an important step to develop national human resources policies for nurses and midwives – which many countries have done - policies are not enough to have a positive change in working conditions. It is more important to have a presence of regulatory bodies that monitor the working conditions and set standards. Countries must ensure that there are bodies in place to evaluate workplace initiatives and to provide workplaces with defined goals in this field¹⁸.

5.3 Exit from the health work force

The main reasons why staff leaves the health workforce are migration, risk of violence (from for example working in a violent area, from working in a country that has ended up in conflict as well as from being from a group/ethnic origin that is subjected to violence in the area where the staff is working), change of occupation or work status and retirement. Some leave temporarily (studies, maternity) while others leave partially for part-time employment elsewhere. The opportunities for other family members to find work and schooling in the area are also important, including issues such as employment possibilities for spouses, educational opportunities for children etc. The working lifespan of health workers has changed over the last decades due to factors such as growing morbidity and mortality (in particular in Africa, due mainly to HIV/AIDS and tuberculosis) increasing migration and ageing (mainly in developed countries). A high turnover of the workforce often leads to higher provider costs and threatens the quality of care as it disrupts the system.

5.3.1 *Migration*

Over the last decade, an international debate has developed around the problem of migration of health workers from developing to developed countries. Data to assess the magnitude of the problem is incomplete but as an indication, the World Health Organization estimates that about one quarter (23%) of the current doctor workforce in sub-Saharan Africa now work in the OECD countries. Nurses and midwives trained in sub-Saharan Africa and working in OECD countries constitute about 5% of the current workforce but with a wide range (from as low as 0.1% in Uganda to about 34% in Zimbabwe).¹⁹

The reasons for migration are many and they range from so called *push-factors* such as dissatisfaction with the existing conditions to *pull-factors* such as awareness of better pay and better work/life situation elsewhere. Both push-and-pull factors play a role in migration where better remuneration, safer environment, living conditions, lack of facilities and lack of promotion as the top five causes for migration²⁰.

The accelerated globalization of the service sector as well as the growing demand for health workers in high income countries due to an ageing population have contributed to the migration. A growing body of evidence shows what can be done at several levels to manage migration (see Annex 3). As

¹⁸ A global survey monitoring progress in nursing and midwifery, WHO 2010

¹⁹ World Health Report 2006 p 99

²⁰ Health workers from Cameroon, South Africa, Uganda and Zimbabwe

mentioned above, there is also an international *Code of Practice* developed by WHO in 2010 which helps countries to set voluntary standards for international migration.

5.3.2 HIV/AIDS

HIV/AIDS has had an alarming impact on the health workforce in many of the Swedish partner countries. Estimates show that Botswana lost 17% of its health workforce to AIDS between 1999 and 2005 and in Malawi and Lesotho; death is the main cause of attrition. Absenteeism can reach up to 50% of a health workers' working time in the final year of life. This poses a serious additional burden on many countries. The effects also have a gender dimension. In Botswana, as elsewhere, women have outnumbered male health workers by a ratio of 1.9 to 1. Yet more women than men are infected with HIV and affected by HIV/AIDS and therefore women have more morbidity and mortality, leading to higher attrition rates. Women also have a higher internal and external migration from the national health workforce.²¹

5.3.3 Ghost workers and absenteeism

Absenteeism is a big problem in many countries, in particular in South-East Asia. Studies show rates of medical personnel absenteeism between 23-40%.²² The main reasons were remoteness of facilities but absenteeism was also worse in facilities with poor working conditions. This shows that if conditions improve, so can the presence and productivity of staff.

Ghost workers are workers listed on the pay-roll but who do not exist or are not in service any longer. Many countries with centralised pay-rolls in the public health system are battling with eliminating ghost workers. Although it is a complex task it is worth doing as it does drain already scarce resources. Ghana found that of the 131 000 civil servants on the pay-roll 1500 had already left the service. Decentralised salary systems can be a solution to this problem.

5.4 Human Resource spending, civil service reform and multi-sectorial aspects

In general, countries devote around 42%²³ of the total general government health expenditure to paying the health workforce. This varies between countries and regions and as data is not available for the private sector, this only reflects the public sector.

It must be noted that the spending on human resources for health is closely linked to the overall civil service for the public sector. Historically there have been issues with Ministries of Finance not appreciating the labour intensiveness of the health sector and thus wanting to cap the amount allocated to staff at unrealistically low levels. While there is more understanding in recent years, it remains a debate in the wider civil service reform and undertakings in the health sector need to be linked to the wider system.

It is further important to underline the multi-sectorial aspects of the HRH agenda. Ministries of education are important for the training component, ministries of local government in cases of decentralised recruitment etc.

The linkages between the private and the public sector must also be emphasised. It must be recognised that the private sector (often through faith-based organisation) deliver key services to vulnerable groups. There is a need to ensure that adequate human resources are available for these services and in some countries, the public sector second and/or support staff to these providers.

²¹ The impact of HIV/AIDS on the health workforce in developing countries, Linda Tawfik and Stephen N. Kinoti, March 2006

²² Bangladesh, Ecuador, India, Indonesia, Peru, and Uganda, World Health Report 2006 p 108

²³ World Health Report 2006 p 8

6. Human Resources for Health in Fragile states and States in transition from conflict to development

Providing health services and rebuilding health systems in fragile states is a highly complex task. Added to that, populations in fragile states suffer a significantly higher burden of disease and mortality, which poses additional challenges²⁴.

With regard to human resources, there are some specific issues. During long-standing humanitarian crises, the upper cadre of professionals is often the first to leave the country. This includes skilled health workers. While reconstruction activities come rapidly and in large amounts, building up a cadre of qualified staff does not appear to be the immediate priority for agencies and donors.²⁵

Relief agencies and NGOs have a tendency to recruit personnel for services to refugees in long lasting conflict areas and to provide better conditions in terms of salary etc. This may result in taking the few available health workers away from the local public service as well as it being difficult for staff to reintegrate into a national salary setting having had better conditions while working for an NGO or a development partner/international agency. In areas where local skilled staffs are few, there is a history of sky-rocketing salaries which cause inequalities and which is not sustainable in the long run.

Another problem is the crash-courses for staff intended to prepare for, for example, epidemics and sexual violence during a crisis. The urgency pushes forward improvised training and abbreviated courses where the full complexities of training health personnel are ignored. This hampers the recovery of the health sector after the conflict has ended and takes key staff out of service during times when their presence is most needed (leading to a higher reliance on international experts). Staff is also trained by many different organisations and systems which raise questions about how training can be standardized and accredited so that staff can be easily absorbed back into the system.

There are also the options of using task-shifting and community health workers to fill human resources gaps (see below).

There are two main approaches to health service delivery in fragile states, the humanitarian approach and the development approach (also called the health systems approach). In the humanitarian approach saving lives comes first and there are sometimes conflicts between the humanitarian, impartial and neutral principles and the need support /work with or through a government to build institutions and provide services. Internationally, there are increasing overlaps between these approaches and recognition of the benefits of supporting health systems as a whole in fragile states.

Some recommendations seem to be emerging from the work on fragile states in relation to human resources for health:

- It is important to promote investment in the full range of human resources for health training – avoiding abbreviated courses where possible and thinking of the longer term perspective from start

²⁴ *Health service delivery in fragile states*, Egbert Sondorp

²⁵ *Early Recovery in the Health Sector: Human Resources Needed*, Annemarie ter Veen, LSHTM, power-point presentation

- It is important to promote a longer term vision by humanitarian agencies and donors to look at the reconstruction phase already during the conflict/emergency phase
- In this, it is important for ALL partners to come to the table, with a particular reference to humanitarian actors and NGOs who often do not see themselves as part of the longer-term development agenda (but who may undermine – even unintentionally - the longer term development if not included in the dialogue)
- Partners could explore possibilities of public-private partnerships that can result in capacity building and retention of key staff(possible: international universities offering courses locally) but keeping in mind that even in a fragile situation some institution (can be international) has to have the oversight role to ensure quality
- As part of the longer term vision, it is important to discuss joint agreements between government, private sector and donor agencies on using national salary scales and the issue of how integrate NGO/humanitarian staff into the system
- A centralised training plan and database and a functioning human resources department for key professional groups is important

In relation to the MDG debate, it is worth noting that almost 50% of maternal deaths occur in fragile states where the average health spend is around 9 USD per person per year. As the health workforce is the largest recurrent cost in the health budget, fragile states have little funding to train and support sufficient staff. There is on average less than one health worker for every 1000 people in fragile states and one in four women deliver alone or with a family member²⁶. A focus on skilled delivery at birth through midwives, working with traditional birth attendants and incentives to ensure referral are opportunities to save mothers also in fragile states.

7. Key bilateral and multilateral positions , principles and funding

All development partners who are concerned with health are more or less involved in working with human resources for health. Even organisations that do not specifically work with HRH are normally involved in training of staff for different purposes and/or in implementing service delivery programmes through the health workforce. Some of the major partners are:

DFID/UKAID has since long promoted a health systems strengthening approach and works in several ways to promote HRH, both as one of the six building blocks of a health system and as a recognised supply barrier in achieving equitable access and delivering quality health services. DFID works with HRH at global, regional and country levels. DFID funds health care workers (including midwives) through various channels including through bilateral programmes, direct support to national health sector plans of partner countries, and multilateral organisations and global funding instruments. At central level, DFID supports the Royal College of Obstetrics and Gynaecologists to provide training to midwives and doctors in five countries. The Tropical Health and Education Trust (THET) promotes partnerships that strengthen capacity and improve health worker capacity in developing countries through training (£3 million). DFID is currently developing a new Health Partnership Scheme to enable UK based health workers to support human resources training in partner countries. The programme will be funded up to £5 million per year²⁷.

USAID's approach to health systems strengthening combines field-level assistance with technical support and development of innovative solutions to health system problems, including human resources. Most USAID country assistance health programs include health systems strengthening activities. Through the new Global Health Initiative, USAID will work in a more integrated manner in a country-led country-owned process. The exact effects of this new approach on HRH are yet to be

²⁶ Merlin: *All mothers matter, Investing in health workers to save lives in fragile states*, 2009, p 9

²⁷ HSS Thematic Policy Papers, DFID/UKAID, July 2010

determined. In HRH, USAID supports strengthening of leadership, management and communication skills, the promotion of knowledge sharing, and development of workforce hiring, training, and retention plans, practices, and policies. USAID builds tools for evidence-based and strategic HRH decision-making and works to improve the performance and health workforce capacity to respond to changing environments and implements its programmes through several projects. One of these is the Capacity Plus project, which is a global project focussed on the health workforce needed to achieve the MDGs²⁸.

The World Bank in the Health, Population and Nutrition Strategy does not focus specifically on human resources for health but includes it as one of the parts in the overall health systems support. A search among the World Bank supported health projects reveal that few have a specific human resources focus, it is rather an integrated part of the overall support. The World Bank works together with other agencies such as WHO and global initiatives to support the wider health systems agenda (Health Systems Platform together with GAVI and GFATM).

The **World Health Organization (WHO)** is taking a lead role in human resources for health. WHO has a strategy for the Health Workforce (2010 – 2015) and is leading efforts to manage international migration and motivate health workers to remain in their workplaces. Other priorities include support for education and training for health workers, the strengthening of governance capacities, and a special focus on nurses and midwives. The organization is also harnessing experience and expertise around the world through a Health Professions Network.

The **EU** has decided to concentrate its support on strengthening of health systems to ensure that their main components – which include the health workforce – are effective enough to deliver basic equitable and quality health care for all without discrimination. This approach is particularly important for MDG 5. The EU supports the International Health Partnership (IHP) approach in assessing comprehensive national health plans, funding one national health budget and one monitoring process. The communication further states that EU Members should ensure that their migration policies do not undermine the availability of health professionals in third countries whilst respecting the individual freedom of movement. EU should speed up progress towards the commitments of the *European Union Strategy for Action on the Crisis in Human Resources for Health in Developing Countries* and contribute to the *WHO Code of Practice on the International Recruitment of Health Personnel*²⁹.

UNICEF – UNICEF does not have a specific Human Resources for Health policy per se. However, UNICEF can support human resources (staff costs) in emergency situations. UNICEF also works with training and capacity development in core areas of the UNICEF mandate. At the High Level Event on the Millennium Development Goals held in September 2008 at the UN General Assembly, the four major UN health agencies – WHO, UNICEF, UNFPA and the World Bank – made a declaration of their intent to intensify and harmonize efforts towards Millennium Development Goal 5. The main objective of this commitment was to coordinate efforts at the country level and jointly raise required resources³⁰. A division of labour between the organisations were identified, with WHO as the focal agency for Human Resources for Health but with UNICEF as one of the partners. UNICEF supports countries in HRH in several ways with reference to child, maternal and new-born health. For example in Kenya, UNICEF funded nurses in hard-to-reach areas during a critical shortage period,

²⁸ USAID website on health

²⁹ EUs role in global health

³⁰ WHO-UNFPA-UNICEF-World Bank Joint Country Support for Accelerated Implementation of Maternal and Newborn Continuum of Care, 22 July 2008.

until the Government of Kenya took over the contracts. UNICEF is also active in fragile states like Sudan for example³¹ and hence is an important partner to coordinate with in such situations.

UNFPA – like UNICEF, UNFPA is involved in human resource for health from their technical angle of sexual and reproductive health and rights. UNFPA has established a Maternal Health Thematic Fund (supported by Austria, Finland, Ireland, Luxembourg, Spain and Sweden) and has partnered with the International Confederation of Midwives to address the critical gap of midwives in developing countries. The Midwifery Program is operational in 15 Maternal Health Thematic Fund supported countries, with a focus on improving and expanding midwifery training and strengthening national midwifery associations³².

8. Country examples

The human resource crisis in health, in particular in Africa, has led to a number of innovative approaches:

8.1 Substitute health workers

One approach that has been tested by several countries, with varying results, is the substitute health worker (SHW). The SHWs are cadres of health workers who have taken on jobs, functions and roles that are normally the tasks of internationally recognized health professionals such as doctors, nurses and pharmacists. These "substitutes" usually receive shorter pre-service training than the original cadres and perform some or parts of the tasks normally carried out by the higher cadre.

War and conflict situations often result in high demand for surgical, orthopaedic and obstetric skills in the absence of trained doctors. **Eritrea and Mozambique** are examples of this scenario.

Mozambique decided in 1984, after the war of independence, to initiate what is now known as the Surgical Technician program, after the emigration of around 85% of its doctors³³. In **Mozambique** the "*tecnico de cirurgia*" were accepted as a temporary solution to a critical problem but as no clear attention was paid to the institutional and organizational implications of introducing a cadre their career progression was ill-defined.

Primary health care and other basic care concepts have necessitated creation of new cadres to cater for non-traditional services as countries expand rural health centres and try to shift emphasis from hospitals. **Ghana** has established a "Rural Health Service" after independence with training of "health centre superintendents" later known as medical assistants. However, this cadre was not equipped with certain life-saving procedures, such as IV injections, removal of retained placentae, caesarean sections, etc. even for postings in environments where help for a patient in an emergency is several hours or even days away. This means that some of the most urgent needs of communities were often not met by the kinds of staff available³⁴.

Many countries have introduced or re-introduced Community Health Worker (CHW) programmes in situations where staff has been scarce. These are community-based lay persons providing community based health services. Originally, the CHWs were focussing on prevention and health promotion activities but with the HIV/AIDS pandemic, many countries in particular in Africa have shifted the CHW role to increasingly provide care and support to people who are infected and

³¹ See for example Evaluation of UNICEF GoS 2002-2006 Country Health and Nutrition Programme, Unicef, Dr. Hongyi XU Professor Ahmed Bayoumi, 2009

³² UNFPA website on Maternal Health Thematic Fund

³³ *Using mid-level cadres as substitutes for internationally mobile health professionals in Africa*. Delanyo Dovlo, June 2004

³⁴ *Health Sector Reform and Deployment, Training and Motivation of Human Resources towards Equity in Health Care : Issues and Concerns in Ghana*, Dr Delanyo Dovlo, 2009

affected by HIV/AIDS. Studies have shown that CHWs are valuable in expanding health services and mobilising communities around health and development – but that they should not be given a role to replace professionals³⁵.

Studies have shown that there are several advantages to using SHWs as this is a very attractive way of securing health care at feasible costs. However, there are also disadvantages to using less-trained workers and sometimes resistance from the existing cadres (see Annex 5).

8.2 Country experiences with task-shifting

Task-shifting occurs when tasks carried out by for example physicians are taken up by another cadre, for example nurses. Several countries have tried this type of substitution; in **Malawi, Ghana, Tanzania and Zambia** nurse anaesthetists have provided anaesthesia for surgical operations. This type of substitution enhances the roles of existing cadres.

However, evidence suggests that significant informal substitution often occur without any training; nurses and other mid-level health workers in rural areas often perform procedures that are not in their scope of work and not allowed by the regulations. Nurses in rural areas in Ghana, for example, delivered breech presentations even without additional training and despite restrictions that these tasks be performed by physicians or under physician supervision³⁶.

Sweden has been supporting task-shifting efforts for a number of years with the aim of improving access to maternal care and reducing maternal mortality through task-shifting of obstetric surgery and emergency obstetric care interventions by using mid-level cadres. Successful experiences have been made (programmes in **Mozambique, Tanzania, Zambia**, discussions on-going in **Uganda**)³⁷. Issues that have been raised as challenges are maintaining quality, supervision and career paths for these mid-level but specially trained cadres.

With gaps in certain cadres, task-shifting can play a critical role. There is international consensus that not enough health workers are trained to provide adequate surgical services in specialist or district hospitals. Although some surgical procedures require highly skilled staff, a specialist surgeon is not needed to perform many of the procedures undertaken at a district hospital for example. An audit of eight district hospitals in Zambia concluded that non-surgeons could have been trained to provide 86% of all operations performed.

Some countries, such as Senegal, prefer to generate sufficient specialist surgeons to operate on patients in well-equipped tertiary referral hospitals as well as district hospitals. Other countries are training general physicians to perform basic surgery, for example in Niger, and some, like Malawi train non-physicians to perform specific surgical procedures. It is crucial that non-specialist health workers are properly supervised and that their training programs are carefully evaluated. The so called Bellagio Essential Surgery Group suggests that there is sufficient experience with training non-surgeons to establish mechanisms for accreditation and coordination of the training programs within and across countries.³⁸

³⁵ *Moving toward best practice: Documenting and learning from existing community health/care worker programmes*, Health Systems Trust 2007

³⁶ *Using mid-level cadres as substitutes for internationally mobile health professionals in Africa*. Delanyo Dovlo, June 2004

³⁷ *Consultancy report on workshop "Enhancing maternal and neonatal survival through task-shifting by training of non-physician clinicians for emergency obstetric care: Zambian and regional African experiences"* Staffan Bergström, April 25-May 6, 2010 and *Human Resources to Enhance Maternal Survival, travel report to Uganda*, Staffan Bergstrom, August 2009

³⁸ *Increasing Access to Surgical Services in Sub-Saharan Africa: Priorities for National and International Agencies Recommended by the Bellagio Essential Surgery Group*, PLoS Med. 2009 December; 6(12): e1000200

There also evidence that task-shifting programmes have to be carefully implemented. With the additional burden of HIV/AIDS, Mozambique introduced a programme where so called *tecnicos the medicina* were given two-weeks of in-service training focussing on anti-retroviral therapy. The Ministry of Health evaluated the effects of the programme and concluded that the training was not sufficient for quality services. In fact, only around 10 per cent of the patient encounters were managed correctly. The programme was suspended and a new re-training and mentoring programme was launched.³⁹

A recent analysis⁴⁰ show that there is substantial evidence that task-shifting is an important policy option to address workforce shortages and skill mix imbalances. However, even as task-shifting is promising, it has its challenges. Experiences with task-shifting in HIV/AIDS in sub-Saharan Africa have been mixed and raised quality and safety concerns as well as professional and institutional resistance. There are also challenges in relation to sustaining motivation and performance. The analysis also concludes that more studies are needed, the present studies almost exclusively compare the results of the new cadre with the traditional cadre. Studies also need to compare the new cadre's results to the results from the care that would have been provided had task shifting not occurred.

8.3 Other country examples

Malawi is one country that was particularly hard hit by the HRH crisis. In 2005, the Malawi government initiated a six-year Emergency Human Resources Programme to alleviate the HR crisis in the health sector with the support of its development partners. The key components are; salary increase for health professionals, measures to enhance the capacity of training institutions and short-term recruitment of expatriate volunteer doctors and nursing tutors.

The majority of health workers in Malawi are mid-level providers or cadres of health workers who have shorter training times and who provide services that were originally the preserve of specialists (task shifting). Evaluation is limited, although a few studies of the effectiveness have been positive⁴¹. As these cadres tend to be paid less than fully qualified doctors and nurses, therefore there are potential economic benefits. If they are not adequately motivated, however, they may migrate out of the health sector or seek employment with NGOs and private sector providers.

In Malawi, studies have found that health workers are particularly dissatisfied with what they perceived as unfair access to continuous education and career advancement opportunities, as well as inadequate supervision. A particularly worrying finding is that many health workers often considered leaving their jobs. Contrary to the belief that many of these workers will stay within the health system because their qualifications are not internationally recognized (this is the case for enrolled nurses, clinical officers and medical assistants), findings indicate that NGOs are an attractive option for these health workers because of the higher salaries being offered.

Afghanistan: despite on-going conflict and instability, Afghanistan has managed to increase the number of skilled birth attendants from 467 in 2007 to 2200 in 2008⁴². A decision was made to make midwives the backbone of the reproductive health workforce and empower them with the skills to provide basic emergency obstetric care. The task-shifting to midwives was not seen as a temporary

³⁹ *Task-shifting in Mozambique, cross-sectional evaluation of non-physician clinician's performance in HIV/AIDS care.* Paula E Brentlinger et al, Human Resources for Health October 2010.

⁴⁰ *Health workforce skill mix and task shifting in low income countries: a review of recent evidence,* Brent D Fulton et al. Human Resources for Health 2011 9:1 11 January 2011

⁴¹ *Retention of health workers in Malawi: perspectives of health workers and district management,* Ogenna Manafa' Eilish McAuliffe' Fresier Maseko, Cameron Bowie, Malcolm MacLachlan' Charles Normand, 2009

⁴² *All mothers matter: Investing in health workers to save lives in fragile states,* Merlin, 2009, p 11

solution - although it began as an emergency approach it was developed into a development strategy with the Afghan Ministry of Public Health in the lead⁴³. The Ministry defined what was needed and who would provide care and took steps to ensure that the midwifery schools maintained legitimacy and received formal accreditation. The midwifery schools made efforts to recruit individuals from the provincial level, teaching specific life-saving skills applicable in the field. This framework has successfully retained 86% of its graduates⁴⁴. The Afghan Ministry of Public Health also implemented a number of other longer term reforms with a focus on training and capacity building of various categories of staff in order to improve quality. Several development partners and organisations have been involved, including the London School of Hygiene and Tropical Medicine working together with the University of Kabul⁴⁵.⁴⁶ Afghanistan has also been known for achieving results through elevating the HR function in the Ministry of Health and for establishing mechanisms for interdepartmental work on HR⁴⁷. However, although services have improved in terms of access, there are still challenges as many services are provided by NGOs, coordination is still a challenge as well as standardisation across funders, providers and regions.⁴⁸

Rwanda: decentralisation of funding to health workers and/or de-linkage from the overall government payroll/wage bill have been tried in several countries with different levels of success. In Rwanda, basic health worker salaries are paid from the overall wage bill, but 0-supplementary performance-based allowances are paid from block grants provided to the district level authorities and facilities (and not accounted in the wage bill). This has led to greater control at district and facility level and facilities are able to fund incentives to improve health worker retention and performance.⁴⁹

United Republic of Tanzania (and Thailand): partial devolution of the recruitment process for junior-level health workers to the district level has decreased the burden at the central level which has led to improved efficiency and shorter recruitment times. The Retired, but not Tired program⁵⁰, which started as a pilot in 2007, is another Tanzanian initiative to re-employ retired clinicians and nurses to provide HIV treatment and care. The initiative helps filling staffing gaps created by the increase in HIV patients and a decrease in number of newly trained nurses and clinicians.

Kenya: decentralised financing systems can improve use of donor assistance. In Kenya, the Emergency Hiring Programme was funded by donors to hire staff on three-year contracts in underserved areas. This programme allowed for a better match of candidates with the posts and led to improvements in staffing levels in underserved areas. However, the issue of sustainability when the government is taking over the wage bill for these workers is a continued challenge.

In Chad donor funds have been used to successfully guarantee timely payment for health workers.

In **Ethiopia**, nearly 34,000 health extension workers have been trained since 2003 and sent out to rural areas to advise women that free medical help is available. In tandem about 15,000 health posts have been set up throughout the country. At the core of Health Extension Program implementation

⁴³ Jhpiego, website on work in Afghanistan, January 2011

⁴⁴ Jhpiego, WHO websites, January 2011

⁴⁵ Reconstruction of the Health System in Afghanistan – *Capacity Building in Primary Care and Public Health Report on Workshop of 10 April 2003*, London School of Hygiene and Tropical Medicine

⁴⁶ Report of the Health System Review Mission- Afghanistan Challenges and the Way Forward, WHO 2006

⁴⁷ *The role of leadership in HRH development in challenging public health settings*, Judith Schiffbauer et al, Human Resources for Health 2008 6:23

⁴⁸ Bulletin of the World Health Organization Towards sustainable delivery of health services in Afghanistan, WHO volume 85 September 2007

⁴⁹ *Emerging Opportunities for recruiting and retaining a rural health workforce through decentralized health financing systems*, Bulletin of WHO (BLT), Volume 88:2010, May 2010, p 2

⁵⁰ Supported by Family Health International/PEPFAR funding

is a new cadre of Health Extension Workers (HEWs), who are trained to implement a Health Extension Package of 16 healthcare activities at the kebele (village) level. Results show that the programme has significantly increased the proportion of fully immunised children as well as increased the proportions of children and women using bed-nets for malaria protection. However, the effect on preventive maternal care is rather limited and there is no reduction of the incidence and duration of diarrhoea and cough among under-five children.⁵¹ (See Annex 6).

9. Conclusions and Recommendations

From the international evidence, it is clear that each country has to develop HRH policies and strategies that are suited to the specific country context as part of the human rights core obligations. While there are international recommendations, standards and frameworks that can be used, there is no blue print and no one-fits-all solution.

The conclusion is that each country has to be supported to define its own model and that there are certain areas where development partners, such as Sweden can be of assistance. This entails “doing no harm” which focuses on trying to harmonise as much as possible with other donors as well as trying to align with the country systems. In HRH this is particularly important and much more can be done to ensure that workshops, short courses and trainings are not undermining service delivery. It also entails supporting government (and in fragile states or conflict situations possibly other interim organisations) to take a long term perspective, to work with the education sectors to ensure sufficient training capacity and to advocate for the inclusion of gender, human rights and socio-cultural sensitivity in the development of strategies and plans as well as in the resource allocation for HRH.

During the desk review, some points have emerged which Sweden could consider in the continued support for human resources for health:

1. Sweden should continue to work towards the implementation of the Paris Declaration and the Accra Agenda. The need for increased harmonisation and alignment of systems, working through Sector-Wide Approaches (SWAps) and joint planning, implementation and monitoring frameworks are mentioned in a majority of the documents on human resources for health as key to success. These efforts will facilitate coordination of resources for recurrent staff cost and relieve key staff in central ministries of additional donor administration and pressure. Sweden should continue to take a leading role and actively promote:
 - Country level harmonisation – or abolishment – of per diems and allowances (part of larger civil service reform and needs to be coordinated with other donors)
 - Promoting on-the-job-training instead of workshops/short courses and assisting ministries of health to ensure that all development partners (and their implementing agencies!) adhere to agreed guidelines
2. Sweden can assist ministries of health to advocate for sufficient resources for HRH, including sufficient training resources through other ministries such as education.
3. Sweden can promote the WHO framework for planning the work force, paying particular attention to the need for investment in training and the need to promote gender, human rights and socio-cultural aspects in the workforce.

⁵¹ Impact evaluation of the Ethiopian Health Services Extension Programme, Assefa Admassie et al, Econpapers 2009

4. Sweden can – if the country context allows – provide separate funding of staff to fill a gap or to support certain under-served areas in the short term. However, there then needs to be guarantees that this staff will be included on the normal payroll/wage bill at the end of the support.
5. Sweden’s policy on promoting the role of the midwife is solid and could be expanded, in particular through institutional strengthening and institutional collaboration with training institutions in partner countries. While research show that it is important to develop country policies for (nurses and) midwives, these policies have not been enough to have a positive change in working conditions. Institutional frameworks are important, such as regulatory bodies that monitor the working conditions and set standards – and Sweden could support and promote such institutions, possibly through institutional collaboration with Swedish organisations.
6. It is notable how little research is done on the gender aspects of the health work force. Even in the WHO documents, only limited attention is given to gender roles, how different staff category input is valued and how gender influences the system responses to different gender needs. Sweden could take a strong role in promoting more research in this field, and in continuing to build institutional capacity both in international organisations (such as WHO) as well as at country level.
7. Little space is also given in the literature on the possibilities of using private-public partnerships to make the most out of the existing health work force. Although again it is something that has to be explored within each country context, Sweden could encourage looking into unused capacity in the private sector in the human resources field.

In humanitarian situation/fragile states/transition to development:

1. When Sweden is supporting training in humanitarian situations it will be important to try to take a combined humanitarian and health systems approach – and assist Swedish supported humanitarian NGOs to also see the longer term perspective.
2. With regards to training of staff, it should be on-site as much as possible and delivered through local institutions. While this may not be possible in certain circumstances, it would be important for Sweden to ensure that investing in local institutions is a priority as soon as it is feasible.
3. Sweden should attempt to support early investments in national staff as part of the emergency response. Where dialogue with the Government is established, both staff capacity (numbers and skills) and management capacity should be supported.
4. In fragile states as well as in transition countries, Sweden can advocate for the establishment of a high-level focal point for human resources (like in Afghanistan) which can be used for stewardship in a conflict and post-conflict situation.
5. In an active conflict phase, Sweden should promote maintaining and protecting what works. This includes funding still functioning structures in order to keep them adequately supplied and maintained with staff. Sweden should ensure that humanitarian organisations are involved and have joint short-term planning horizons (for example the 90 day cycles in Sudan/Darfur and Liberia) and focus on getting funds to institutions to enable staff to feed themselves. Paying local workers is both cheaper and more sustainable than bringing in foreign volunteers.

6. In the post-conflict phase, the first measure should be on correcting distortions in the labour market and to embark immediately on the long term investments in pre-service training and human resource planning for the sector with a focus on the underserved areas and needs of particularly hard-to-reach and vulnerable groups (see also Annex 2 on retaining staff in remote areas).

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ANNEX 1 Improving health worker performance⁵²

Some possibilities for countries and providers to improve health worker performance are:

- Introduce shift and time flexibility to ensure better meeting of patient demands
- Undertake management and/or system assessment to ensure that the right cadre of staff undertakes the right tasks (hire non-clinical managers for management tasks)
- Donor harmonization and alignment with joint missions and aligned reporting formats can go a long way in reducing the administrative burden on some cadres of staff.
- Skills delegation or task shifting: this has been explored in several countries as a way to increase overall workforce productivity. Most experiments have involved substitution of doctors by nurses for some specific tasks. However, experiences are mixed so far.
- Supportive supervision: supervision coupled with audit and feedback to staff has been found to improve the performance of many types of health workers. It is particularly important to build this in for workers who often work alone, such as community health workers, and it is important to ensure that it also happens in the private sector.
- Improve basic support systems:
 - Ensuring appropriate remuneration is a key strategy to quality services. Unfortunately, low and/or much delayed salaries force many public sector health workers to invent coping strategies that undermines performance and affects the patients (dual employment, absenteeism, informal payments and referral to the private sector are some examples).
 - Donor support to salaries is a difficult topic that is also related to the overall civil service reform agenda. There has been an increasing acceptance though by international agencies that salary support will be needed in very low income countries for the medium term. Some examples are available of successful interim support by development partners to health worker salaries
 - De-linking health workers from the civil service has been tried in some countries with mixed results. In Zambia it did not work due to resistance by professional groups, in Ghana tax-collectors have been de-linked but not health workers.
 - Introducing performance-based related pay
 - Allowances, loans and other benefits: many countries have tried to introduce special benefit packages and supplements in order to attract staff

⁵² World Health Report 2006

to under-served areas. Examples are bonuses, education, transport and child care subsidies, remote area and/or shift allowances etc. The success of such measures depends on how they are designed and implemented. In some cases the incentives become seen as entitlements and sometimes they also lead to the wrong outcome, such as in Ghana where the additional duty allowance for doctors and nurses was resented by nurses as unfair and contributed to the increased migration of nurses.

- An important point is the informal payments which provide a major source of income for many health workers. This issue needs to be dealt with in the wider health financing and health system context.

ANNEX 2: Recommendations for increasing access to health workers in remote and rural areas (WHO Global Policy Recommendations 2010)

A. EDUCATION RECOMMENDATIONS

1. Use targeted admission policies to enrol students with a rural background in education programmes for various health disciplines, in order to increase the likelihood of graduates choosing to practise in rural areas.
2. Locate health professional schools, campuses and family medicine residency programmes outside of capitals and other major cities as graduates of these schools and programmes are more likely to work in rural areas.
3. Expose undergraduate students of various health disciplines to rural community experiences and clinical rotations as these can have a positive influence on attracting and recruiting health workers to rural areas.
4. Revise undergraduate and postgraduate curricula to include rural health topics so as to enhance the competencies of health professionals working in rural areas, and thereby increase their job satisfaction and retention.
5. Design continuing education and professional development programmes that meet the needs of rural health workers and that are accessible from where they live and work, so as to support their retention.

B. REGULATORY RECOMMENDATIONS

1. Introduce and regulate enhanced scopes of practice in rural and remote areas to increase the potential for job satisfaction, thereby assisting recruitment and retention.
2. Introduce different types of health workers with appropriate training and regulation for rural practice in order to increase the number of health workers practising in rural and remote areas.
3. Ensure compulsory service requirements in rural and remote areas are accompanied with appropriate support and incentives so as to increase recruitment and subsequent retention of health professionals in these areas.
4. Provide scholarships, bursaries or other education subsidies with enforceable agreements of return of service in rural or remote areas to increase recruitment of health workers in these areas.

C. FINANCIAL INCENTIVES RECOMMENDATION

1. Use a combination of fiscally sustainable financial incentives, such as hardship allowances, grants for housing, free transportation, paid vacations, etc., sufficient enough to outweigh the opportunity costs associated with working in rural areas, as perceived by health workers, to improve rural retention.

D. PERSONAL AND PROFESSIONAL SUPPORT RECOMMENDATIONS

1. Improve living conditions for health workers and their families and invest in infrastructure and services (sanitation, electricity, telecommunications, schools, etc.), as these factors have a significant influence on a health worker's decision to locate to and remain in rural areas.
2. Provide a good and safe working environment, including appropriate equipment and supplies, supportive supervision and mentoring, in order to make these posts professionally attractive and thereby increase the recruitment and retention of health workers in remote and rural areas.
3. Identify and implement appropriate outreach activities to facilitate cooperation between health workers from better served areas and those in underserved areas, and, where feasible, use telehealth to provide additional support to health workers in remote and rural areas.

4. Develop and support career development programmes and provide senior posts in rural areas so that health workers can move up the career path as a result of experience, education and training, without necessarily leaving rural areas.
5. Support the development of professional networks, rural health professional associations, rural health journals, etc., in order to improve the morale and status of rural providers and reduce feelings of professional isolation.
6. Adopt public recognition measures such as rural health days, awards and titles at local, national and international levels to lift the profile of working in rural areas as these create the conditions to improve intrinsic motivation and thereby contribute to the retention of rural health workers.

ANNEX 3: Managing migration

At the global level, two main responses are taking place:

- A growing number of middle income countries are training health workers for international export (for example the Philippines)
- Professional agencies are more actively sourcing for staff abroad

In order to manage migration, action in three areas is necessary:

1. Action in so called source countries (where workers depart from):
 - a. Training that is focused on local conditions can help limit workforce attrition, such as training that leads to credentials that do not have international recognition. However it necessitates other incentives for the workers and support by the training institutions and from the professional associations to function.
 - b. Expansion of training to meet shortfalls. In low income countries this would mean support from donors or involvement of the private sector to meet the financing gap of such increased training. Training can also be tailor-made to meet export demands, such as in the Philippines, Cuba, China, Indonesia and Viet Nam. Such strategies have not been evaluated but indications are that it requires establishment of institutional capacity for training, accreditation and careful management.
 - c. Improve local conditions is one measure that may remove some of the push-factors for worker migration.
 - d. Bonding is a method where the education of the health workers is paid by the prospective employer and the health worker is under obligation to work for the employer for a set minimum period of time after graduation. Experiences of bonding are mixed - it does ensure coverage but it seems to be strongly associated with low performance and high turnover rates.
 - e. Surveys show that many migrant workers want to return home after a period of time, brain gain. Active institutional management of migration can help ensure that migrants are taken care of both during their time away and once they return.
2. Action in receiving countries:
 - a. Ensure fair treatment of migrant workers
 - b. Adopt responsible recruitment policies
 - c. Provide support to human resources in source countries through development assistance: as many of the countries which are providing pull-incentives for the migration are also providing development assistance, this mechanism can be used to expand the workforce in source countries. Apart from direct support to strengthen the workforce, twinning and capacity development through exchange are ways to ensure that source country institutions are strengthened.
3. Action at the international level
 - a. Over the last decade a number of ethical codes and guidelines for recruitment have been developed and implemented. An example is the bilateral agreement between South Africa and the UK in which a Memorandum of Understanding outlines opportunities for time-limited education or practice in both countries and includes other measures such as exchange on professional regulation, strategic planning, revitalization and training of hospitals and training in health care management.

ANNEX 4: National Health Workforce Strategies

Each country needs to define its workforce strategy for the health sector based on local conditions, there is no blue print or magic bullet. Key ingredients in national strategies are:

- Building trust and managing expectations; in order to have an impact on the health of the people, citizens must trust that the health workforce is doing the right thing. This relates to performance, quality of services and quality of training and staff attitudes. In many countries in particular in Africa, women fear delivering babies in health institutions due to poor staff attitudes and even beating of women who scream or moan when in pain. This does not go well with targets of increasing skilled deliveries to prevent maternal and neonatal deaths.
- Fair and cooperative governing; Quality standards must be set similar for both public and private sectors. Professional organisations decide who and what type of care different cadres can provide. This self-regulation can be useful provided there is a balance between protecting the staff and the interest of the patients. Professional organisations can also be supported/strengthened to enhance professionalism and commitment. Patient's rights and Watchdog organisations can also be a way of enhancing transparency and accountability in the health sector from health workers.
- Strong leadership; while strong leadership of the health sector is key to success, it is unfortunately not possible to develop through training. Developing leadership skills depends on leadership structures and tactical capacities. However, it is difficult to develop, evidence from developing training courses for leadership have shown little or no effects⁵³. However, individual tactical capacities can be built through for example coaching and mentoring programmes.
- Strengthening strategic information; countries need to ensure that the strategies for the health workforce is based on research and evidence from its country – but at present this information is rarely there. However, as was shown in Malawi, proper understanding of local health worker problems can be immensely useful in developing successful policies and strategies.
- Investing in workforce institutions; while policy-making is normally the job of the government, not all ministries have the capacity to undertake evidence-based human resource policy development. One way of assisting the government has been developed in Latin America through special human resources for health observatories. Each country has its own design but the common denominator is the network organisation which includes government/health ministries and academic institutions together with the World Health Organization (WHO).

⁵³ World Health Report 2006 p 125

ANNEX 5: Substitute Health Workers (SHW)

Many African countries have created country-specific cadres to carry out tasks that are internationally recognized as those of other professionals. Examples include substitution for doctors using "clinical officers", "medical assistants", "assistant medical officers" and "surgical or obstetric technicians". There are two subtypes:

- Partial substitutes, who carry out only limited and circumscribed tasks of doctors and refer other tasks to doctors. Medical assistants in Ghana and clinical officers in Zambia are examples of such substitutes.
- Full substitutes, who carry out significant segments of the scope of practice of doctors. Assistant medical officers in Tanzania and surgical/obstetric technicians (*tecnicos de cirugía*) in Mozambique independently perform surgery and are examples of this type of substitution.

The training of substitute cadres varies between countries in terms of entry qualifications, training duration and content of training. In most countries, the ministries of health are directly responsible for the training. The training time also varies but seems to be around three years – the Kenyan Medical Training Centre's clinical officers are trained for three years and registered after a year's "internship". Malawi's College of Health Sciences (MCHS) graduates clinical officers with certificates in "clinical medicine" after three years' training.

Scopes of practice of substitute cadres varied with each country, especially at the "specialized" cadre level found in Tanzania, Malawi and Mozambique, where "surgical technicians" are given a more extensive scope of practice. But some curricula show that the most basic-level substitutes perform tasks limited to consultation, writing prescriptions and basic treatment.

Limiting the scope has implications for how useful such cadres can be in areas where quick referrals are not possible. Bergstrom (1998) proposes that certain types of services are crucial for patients at the first point of contact and suggests basic emergency obstetric functions at "first referral level".

If clinical officers are unable to provide these services, they may simply become a transit referral point, another bottleneck in emergency care.

The cost-effectiveness of the substitute cadres are still under assessment, for example surgical-technician training in Mozambique was estimated to be "10 times cheaper" than training doctors. The Kenya KMTC estimated that training of clinical officers was cheaper and further suggested that costs to the clients were lower. Clinical officers were also less likely to order lots of tests, which further reduced costs to clients.

Travel costs for the client are expected to be lower, as medical assistants based in rural centres are likely to be closer for clients than having to go to district hospitals. However this should be interpreted with caution about the influence of skill levels and the effects of lack of drugs and equipment in remote locations, which may still drive clients to go to hospitals.

However, there has been resistance in several countries from the already existing professional cadres to create a less-educated cadre. In **Ghana, Malawi, Zambia, and Kenya**, nurses' lobbies have succeeded in banning the training of "enrolled nurses" despite increased migration and shortages of registered nurses.

Possible advantages and disadvantages of substitute health workers⁵⁴

Possible advantages	Possible disadvantages
<p>Substitutes are country-specific, not internationally "tradable", and are more easily retained within the country</p> <p>2. Emoluments and incentives for such cadres are significantly lower than for cadres substituted for</p> <p>3. Pre-service training costs are also much lower</p> <p>4. Academic entry requirements into technical training are less problematic and training is accessible to a wider range of entrants from all segments of society</p> <p>5. All training is local and practical</p> <p>6. Substitute cadres accept postings into rural/hardship areas and are retained there</p> <p>7. Substitutes may reduce other service costs by requiring fewer diagnostic tests and less sophisticated equipment and by prescribing generic medications</p> <p>8. They may relate better with communities by being less elitist and more integrated</p>	<p>1. Quality of care may suffer with poor clinical decision-making or poor supervision of their practice (they still require supervision by a professional)</p> <p>2. Ethical considerations may be less strong in new cadres who don't have existing traditions and norms. Practice regulation is absent for many such cadres</p> <p>3. The perceived low costs may be offset by poor treatment results and outcomes to patients and high morbidity</p> <p>4. Scaling up the numbers of substitutes to achieve higher coverage will mean similar expansion in the numbers of professional cadres required for supportive supervision</p> <p>5. Eventually cadres carrying out similar tasks want remuneration and incentives similar to those of the original cadres. Inter-professional conflict and demotivation may ensue</p>

⁵⁴ Dovlo, Human Resources for Health, 2004 2:7

ANNEX 6 Health Extension Workers in Ethiopia

In Ethiopia, nearly 34,000 health extension workers have been trained since 2003 and sent out to rural areas to advise women that free medical help is available. In tandem about 15,000 health posts have been set up throughout the country.

The aim is to halve Ethiopia's maternal mortality rate. At the core of Health Extension Program implementation is a new cadre of Health Extension Workers (HEWs), who are trained to implement a Health Extension Package of 16 healthcare activities at the kebele (village) level.

All HEWs are women, at least 18 years of age, with a minimum of 10th grade education and recruited from the communities in which they will work. HEWs must complete a one-year course of instruction and field training.

On completion of training, HEWs are assigned, in pairs, to kebeles where they staff health posts and work directly with individual families. Health posts, therefore, are becoming the first level of healthcare for the community, emphasizing preventive care. Services are focused on four areas of care: Disease Prevention and Control, Family Health, Hygiene and Environmental Sanitation, and Health Education and Communication. HEWs spend 75 per cent of their time visiting families in their homes and performing outreach activities in the community. The remaining 25 per cent is spent providing services at the health posts, including immunizations and injectable contraceptives, among others. To address strong community demands for basic curative care, HEWs are trained to provide first aid; treat malaria, dysentery, intestinal parasites, and other ailments; and to refer cases to the nearest health centre when more complicated care is needed.

So far there are very few studies of the impact of the programme. One study with data from 3095 households from both programme and non-programme villages in rural Ethiopia indicate that the programme has significantly increased the proportion of children fully and individually vaccinated against tuberculosis, polio, diphtheria-pertussis-tetanus, and measles. The study finds heterogeneity in childhood immunisation coverage as a result of differences in terms of the number of health extension workers, in the quality of health posts and in terms of the educational achievement of mothers across programme villages. The proportions of children and women using insecticide-treated bed-nets (ITNs) for malaria protection are significantly larger in programme villages than in non-programme villages. The effect on preventive maternal care is rather limited. Whereas women in the programme villages appeared to make their first contact with a skilled health service provider significantly earlier during pregnancy, very little effect is detected on other prenatal and postnatal care services. Moreover, the programme has not reduced the incidence and duration of diarrhoea and cough diseases among under-five children.⁵⁵

⁵⁵ Impact evaluation of the Ethiopian Health Services Extension Programme, Assefa Admassie et al, Econpapers 2009