PRIORITIES FOR ACTION

1. EDUCATING AND TRAINING HEALTH WORKERS

Rapid advances in medicine, technology and case-management approaches are changing the mixture of skills required to respond to current and emerging health needs. Matching the skills-mix of health workers with the needs of diverse populations is a key requirement of successful health education and training.

The first requirement for an effective health workforce is to have sufficient numbers of skilled workers equipped with the necessary technical and other competencies. They must also be accessible and able to reach diverse clients and populations. Achieving this first step will need:

- **Comprehensive planning** — to guide the training of a sufficient pool of health workers with the appropriate mix of skills. Such planning needs to focus on optimizing public and private investments in education and training, and on managing labour markets. Recruitment and placement policies should aim to ensure the acceptability and accessibility of health workers, especially in terms of gender, language and ethnic compatibility.

- **Public sector investments in education and training** — to ensure a broad range of graduate skills and an emphasis on prevention. This is especially true where market-driven “curative” services are not providing the full range of skills required. The key to successful financing in this area will be to harness the growing private sector in health training while continuing to allocate sufficient public funds to ensure comprehensive skills training and fair coverage.

- **Building strong and responsive Institutions** — to produce health graduates of the right type and number. The world’s 1600 medical schools, 375 schools of public health, 880 schools of pharmacy and 6000 nursing schools are not

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training sufficient numbers of the right type of workers to meet patient needs. Faced with accelerating erosion of the workforce, these institutions are only providing a slow “drip” of graduates into a leaking bucket. The training of health workers requires capable and motivated teachers, using innovative teaching approaches to reach students from different sociocultural backgrounds.

- **Strengthening professional regulation** — through accreditation (licensing, certification and registration) and wise investment of public funds. Governments must ensure the competency and quality of professional bodies, backed up by regulatory enforcement, if widespread trust in health services is to be achieved.

What can countries do to educate, train and deploy health workers?

All countries, poor or rich, should develop updated comprehensive national plans to identify health workforce shortages and bottlenecks, and develop a consensus for joint action. Plans should respond to health needs and personnel requirements, as well as the changing nature of labour markets and the new skills mixes required. In all these areas, rational and innovative new approaches will be needed.

Approaches that have already yielded good results in many countries include:

- adapting education and training curricula to fit national health priorities;
- improving coordination and planning between the health, education and finance sectors;
- continued training and support for health professionals;
- diversifying the roles of health workers and maximizing their functional capacities; and
- creating new health worker categories, along with new education programmes.

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**The public health movement in South-East Asia – regional initiatives and new schools**

Although almost one third of the world’s population lives in south-east Asia, the region has less than 5% of the world’s public health schools. Efforts to rapidly increase public health training for health professionals are urgently needed. In response, national, regional and international stakeholders are now aligning the resources and political will required to develop new and innovative approaches. In 2004, the South-East Asia Public Health Initiative to strengthen public health planning was launched in order to:

- position public health high on regional and national agendas;
- strengthen public health education;
- enhance technical cooperation in the development of national public health training institutions;
- establish a public health education institutions’ network; and
- help countries to define an appropriate package of essential public health functions.
Building an appropriate skill-mix in health providers in Samoa

Samoa is an independent island nation in the South Pacific comprising a land area of 1800 square kilometres with a population of over 180,000. In Samoan society, the level of women’s participation in the paid labour force is relatively high, and their access to education and achievement in the formal educational system is virtually equal to men. Strong democratic traditions and social systems based on village communities and extended family ties and churches greatly influence public opinion and policy-making.

The government, community leaders, health leaders and other stakeholders have long recognized a persistent shortage of doctors in rural areas, where much of the population lives. As a result, nurses and other front-line primary health care workers were often providing care beyond the scope of their training. Traditional chiefs (matai) and community leaders strongly voiced the need for trained nursing personnel in villages.

In 1987, the Ministry of Health officially endorsed strategies to upgrade the skills-mix of selected senior nurses. With the support of consulting physicians located in central hospitals, nurses could now provide the full range of curative and preventive health services in communities. In 1990, a five-year nursing strategic plan was developed. This was based on a primary health care model and included key activities to develop and sustain appropriate nursing and midwifery skills to meet the projected health needs.

The overall goal of the nursing strategic plan was the provision of high quality health services to rural areas in a cost-effective manner. The approach is now considered to be an effective and efficient way to deliver health services to vulnerable and under-served rural groups.
Health education and training capacity and the frequent lack of specialized training facilities contribute to the global shortage of health workers. While the opening of new training institutions has become a priority in some settings, so have efforts to maintain educational standards and academic quality assurance and accreditation mechanisms.

Figure 3: Inequities in the distribution of health workers worldwide

Source: WHO 2006

However, training health workers does not always require expensive investments. Successful innovations have frequently been demonstrated in pilot and other small-scale studies that can be brought to national scale. In the case of health workforce development, success has been demonstrated in many settings. Examples include delegating tasks to community workers, establishing new cadres of health workers, such as mid-level and nurse practitioners, implementing new training approaches and supervisory techniques, and using modern information technologies.
Nurse Practitioners in Fiji – practice patterns and community acceptance

The impact of nurse practitioners in the remote areas of Fiji is considered positive and they play key roles in providing health care to rural and remote communities of the country. The nurse practitioners currently perform many functions in Fiji’s health centres, including: assessing and managing acute and chronic illnesses; managing health centre activities; conducting health screenings and community education sessions; making field visits to surrounding villages and settlements; performing surgical procedures, including tooth extractions and circumcisions; and delivering babies. The nurse practitioners prescribe medications deemed necessary to treat minor or common medical complaints through the use of national protocols.

A survey of the relationship between nurse practitioners and the communities they serve was conducted in collaboration with WHO. Comments from community members about the work of the nurse practitioners included the following:

“The nurse practitioner has the heart to do house visits and goes when she is needed, rather than waiting in the health centre for patients to come.”

“She travels by sea, river, road, solely to accomplish her duties. She tends to every call during working hours and after working hours and even on Saturday and Sunday, with a smiling face. She always offers encouragement to patients.”

“Serious cases no longer always have to be sent to the mainland. Now, some of them are dealt with here on the island.”
2. SUPPORTING AND PROTECTING THE HEALTH WORKER COMMUNITY

In many countries, strict limits have been put on the number of health staff and their salaries. At the same time, government spending on professional education and development has often been severely reduced. As a result, the morale of health workers has plummeted, and wages in many places have fallen well below acceptable levels. Health workers often struggle to provide for their families, and practise privately to supplement their meagre income. Increasingly, health workers are coming under pressure to “vote with their feet” and change jobs or emigrate. In the worst cases, political instability and conflict have further damaged an already insufficient health infrastructure and have seriously overburdened health workers.

Poor pay, poor working conditions

In some developing countries in the Western Pacific Region, salaries of health professionals range from US$25 to US$50 per month, with ongoing shortages of essential working equipment and supplies, as well as a lack of potable water supplies in health facilities and insufficient operating budgets to cover heating and refrigeration costs.

Health workers struggle to meet daily living expenses on insufficient salaries in a number of countries in the Region. In countries with dispersed population groups in rural areas, health workers must also cope with walking distances of 1 to 6 kilometres, to reach some families to provide essential health services.

In Mongolia, health workers and citizens have to overcome road and communication service challenges to reach one another, sometimes walking 3 to 5 kilometres to reach public transportation stations. The provision of emergency and referral services is quite difficult due to long distances, the state of repair of roads, required overland travel and in many cases, migratory people without residential addresses.

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Shortages of basic supplies, sanitation, electricity and water are putting health workers and patients at serious risk of injury and infection. Increasing violence in the health workplace in many parts of the world compounds these problems. Much of this violence is directed against women who comprise a growing proportion of the health workforce. On top of all these, particularly in sub-Saharan Africa, HIV/AIDS further depletes the already limited numbers of health workers.

Some health facilities in the Region lack security, especially at night, with reported incidences of violence against facility health workers. In addition to security problems, there may be improper use of hospital facilities by those living nearby, resulting in accumulation of rubbish in clinical and other areas and the defacing of walls with graffiti. Although nutrition disorders may be quite common in patients admitted to facilities, there may be insufficient food for all patients. Cross infection rates can be very high, in some hospital environments, due to rodents, lack of running water and accumulation of rubbish.

Poor management is now leading to unprecedented levels of frustration among health workers. These workers are now leaving their jobs to either change careers or to emigrate.

**Working conditions and remunerations**

- Unsatisfactory and poor in most countries – very low pay / remuneration
- Lack of / inadequacy of equipment, supplies including drugs, logistics, supervisory support.
- Limited non-monetary incentives such as housing, safety and security, social/family support

→ Low morale; retention and performance problems; and lowered quality of services provided.

**What can countries do to support and protect health workers?**

Supporting and protecting health workers requires competitive salaries and other benefits, good working conditions (including flexible working hours) and a workplace safe from the risks of infection, injury and violence.

In the era of HIV/AIDS, illness among individual health workers, their colleagues and family members seriously threatens the viability of health care systems. All health workers should therefore be protected against HIV infection. This includes providing protective gloves, safe disposal of sharp materials, procedures to prevent needle stick injuries, as well as proper environmental cleaning and waste management. HIV-positive health workers should be accorded the highest priority for antiretroviral treatment.
Capacity-building to support and protect health workers and the people they serve

In China, there has been insufficient formalized preparation of nurses in China, especially those practising in high impact areas. Similarly, nursing programmes have not consistently integrated HIV information into nursing curricula. Increasing knowledge regarding HIV transmission and prevention will enhance nurses’ ability to provide confident, competent care for infected and affected individuals and families and to reduce their own risk of exposure. Over 1000 nurses have been trained in essential HIV/AIDS knowledge, attitudes and skills in China’s HIV/AIDS Nursing Leadership Initiative, a multi-partner project aimed at strengthening the capacity of nurses to effectively respond to the needs of patients, family members and communities affected by HIV/AIDS.

In Viet Nam, nurses are addressing the leadership capacity-building needs of provincial and district chief nurses. They are also working to reduce needle and sharp-instrument injuries among nurses, as well as strengthening nursing education to better meet service delivery needs.

Mongolia’s nurses are building nursing capacities to safely use technologies in the delivery of injections and intravenous fluids, revising and standardizing nursing curricula, developing nursing human resource policies, raising nursing care documentation standards, and delineating continuing education requirements.

In addition to the risks associated with infection and workplace accidents, health workers face the added threat of violence. A shift towards a “zero-tolerance” approach to violence against health workers and its systematic reporting is one of the most important issues in protecting health workers, and one that needs to be addressed now.

Successfully mobilizing support from both the public and private sectors will also be a key part of retaining health workers. Building up the capacity for ongoing training, encouraging career advancement, and providing managerial support are all urgent priorities. Not all strategies for supporting and protecting health workers require large-scale financial investment or infrastructure.
Incentives and allowances valued by health workers

- contract signing bonuses;
- reimbursement of job-related expenses (such as uniforms or petrol);
- education, accommodation, transport or childcare subsidies;
- health insurance;
- access to loans (including subsidized mortgages);
- remote area allowances;
- out-of-hours allowances (such as for overtime and night shifts); and
- specific performance incentives (for example, for high immunization rates).

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On the ground today teams of health workers are deploying their collective ingenuity to address critical health challenges. We must harness this know-how more systematically, critically evaluate it and share lessons more broadly.

Dr Tim Evans, WHO

As health care changes, so do the demands placed on health workers. In particular, the HIV/AIDS pandemic and increased levels of chronic disease have placed great strain on health systems. At the same time, advances in technology have allowed the focus of care to shift towards community-based and home-based models. The opportunity to manage patients as outpatients minimizes over-reliance on hospitals.

Health care delivery is now increasingly the domain of family members, community health workers with minimal training and patients themselves. In order to respond to the challenges of the changing health environment, health workers must be helped to become more effective, and health systems management must become more supportive. At present, those providing care at the grassroots level can feel isolated, unsupported and let down by the formal health care system.

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Good evaluation does not equate to promotion.

Nurses are assessed every six months, yet nurses often do not get promotion or increment for more than 10 years. Unless you are in the ‘Good Book’ or know someone upstairs, you are destined to remain a staff nurse for your entire career – no matter how hard you’ve worked and how well you have performed.

1 World Health Organization Regional Office for the Western Pacific. The migration of skilled health personnel in the Pacific Region [quotation from a Pacific Island nurse]. Manila, 2004, p. 30

What can countries do to enhance health workforce effectiveness?

Strategies to enhance the effectiveness of the health workforce must initially focus on existing staff because of the time lag in training new health workers. In the short-term, one challenge will be improving health worker performance and impact by matching skills to health needs while maintaining professional standards and codes of conduct. In the longer term, sustained improvements are only likely if they are accompanied by improved working conditions, salaries and management as well as workplace policies that support life-long learning.

A team approach to patient care should be encouraged. Innovative approaches to turn individual health workers into members of health teams, backed by effective and supportive supervision, should be implemented. Recognizing the contribution of all health workers and finding efficient ways for them to contribute will be vital if significant gains are to be made.

But it is not just the formal workforce that can be better managed for improved performance. For example, in Thailand, village health volunteers perform primary health care and disseminate health information in their communities. In return they receive non-financial incentives, such as social recognition and continuous training. Such innovative and cost-effective ideas can enable informal health workers worldwide to carry out basic yet life-saving functions such as drug distribution, health surveillance and outreach programmes.

If implementing these and other approaches is to be successful, it will be vital to gain trust. Without trust, health systems cannot be fully effective. Fighting corruption in all its guises must therefore be a priority if trust in state health systems is to be regained. A lack of transparency and accountability, limited enforcement of rules, and lax fiscal controls has led to serious abuses. Corruption may also take the form of “ghost workers” who are only ever seen on the payroll. Such widely known abuses at all levels of the health system have led to a damaging loss of public trust over the past decade. These abuses must be addressed if trust is to return and the full beneficial impact of the health workforce is to be harnessed.

In conclusion, increasing consultation with communities and patients on their health service needs and introducing policies that strengthen the effectiveness of health workers within communities must become prime objectives of local and national health planning. If the considerable challenges that exist can be overcome, there is an enormous opportunity to enhance the effectiveness of health workers and health systems worldwide.
Innovating for greater impact

• **Delivering health**¹ – Drugs may be important, but for their impact to be really broad, health workers must be there in person to bridge the gap between technology and the patient. In Egypt, infant mortality decreased by 15% when oral rehydration solution was made available in pharmacies. But when community health workers were able to bring the solution to people’s homes, infant mortality decreased by 40%.

• **Cooperation brings success**² – In Nepal, health expert Ram Shrestha realized that he could distribute life-saving vitamin A pills to a wider community by going to the grandmothers. They have the time to distribute the pills and the authority to see that children take them. Today there are 49,000 grandmothers distributing vitamin A to 3.5 million Nepalese children every year. The same programme is now getting vitamin A to pregnant women as well, to prevent eye disease.

• **Using personal experience to bring hope**³ – Helen is the administrative clerk at an HIV/AIDS clinic in rural Uganda. As a person living with HIV/AIDS who started antiretroviral therapy (ART) nine months ago, she has gained considerable knowledge about treatment. As an expert patient, she can answer many questions from other patients visiting the clinic. As an activist of the national organization of women living with HIV/AIDS, she is involved in organizing nutritional support to patients on treatment. She is also a member of the local AIDS drama group and is involved in group education within the community. Helen is in an excellent position to link service providers, patients and community members.

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¹ Bhattacharyya K et al. (2001). Community health worker incentives and disincentives: how they affect motivation, retention, and sustainability. Arlington, Virginia, USA, Basic Support for Institutionalizing Child Survival Project (BASICS II), United States Agency for International Development.


Maximizing the contributions of faith-based and non-governmental organizations – Anglicare StopAIDS Papua New Guinea is a nurse-led national non-governmental organization founded by the Anglican Church of Papua New Guinea. Anglicare’s principal focus is its response to the HIV/AIDS crisis facing the country. Anglicare provides both prevention and care services. The prevention component comprises awareness, peer/community education, condom distribution, drama performances and training of trainers in HIV/AIDS education and behaviour change. Because the HIV epidemic is generalized in Papua New Guinea, Anglicare’s target audiences range from out of school youth to church groups, people living in settlements, building sites, city offices and sports groups.

Anglicare’s care component – counselling, treatment and support – is emerging as vitally important to the response and Anglicare’s nurses are playing a pivotal role. Working alongside their counsellor and positive advocate colleagues, they are conducting Voluntary Counselling and Testing, managing the drop-in centre for people living with HIV/AIDS, offering treatment for opportunistic infections, and facilitating training in home-based care. As more people living with the virus come forward, the nurses’ role becomes increasingly more critical in providing and developing a comprehensive service of care and support.
4. TACKLING IMBALANCES AND INEQUITIES

Access to health care remains very uneven and very unfair. In many places, this is contributing to the dwindling level of public trust in health systems. Health workers are disproportionately lacking in countries and regions with the highest relative need (TABLE 1).

Table 1: imbalances in health

<table>
<thead>
<tr>
<th>The Americas</th>
<th>Sub-Saharan Africa</th>
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<tbody>
<tr>
<td>14% of the world’s population</td>
<td>11% of the world’s population</td>
</tr>
<tr>
<td>10% of the global burden of disease</td>
<td>24% of the global burden of disease</td>
</tr>
<tr>
<td>37% of the world’s health workers</td>
<td>3% of the world’s health workers</td>
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<tr>
<td>&gt;50% of global health expenditure</td>
<td>&lt;1% of global health expenditure</td>
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The global shortage of health workers is currently estimated at 4.25 million. The World Health Report 2006\(^2\) has shown that in general, countries with fewer than 2.3 doctors, nurses and midwives per 1000 people fail to achieve an 80% coverage rate for measles immunization, or the presence of skilled birth attendants during childbirth. This has a demonstrable impact on people’s lives and deaths. Fifty-seven countries fall below this minimum threshold, mainly in sub-Saharan Africa and Asia. For these countries to reach the required threshold, an additional 2.36 million health service providers would be required. Add to this the other types of workers needed to support health care providers and the total shortfall is estimated at 4.25 million. Effective delivery of health services also requires that workers be equipped with the essential skills, drugs and equipment and have supportive transportation and referral systems.

This global workforce shortage is made even worse by imbalances within countries. There is a general lack of adequate staffing in rural areas compared to cities. However, systematic monitoring of imbalances within many countries is lacking, due to inadequate health information systems. Setting policies without information and with no means of measuring progress is not a recipe for success.

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Demographic trends are also making health imbalances and inequities worse. As the populations of the developed world and its health workforce get older, ever more people are needed to provide care. This “pulls” health workers from developing countries. At the same time, as working conditions in developing countries become intolerable, health workers there feel “pushed” to move away. For example, for every 100 African doctors working at home, there are 23 working in 8 OECD countries, while for every 100 nurses and midwives working in Africa, there are about 4 working in these OECD countries\(^1\). Driven by these “pull-and-push” forces, migration brings mixed consequences – positive for some but detrimental to health for many.

The accumulated effects of migration, premature death, illness, and career changes can lead to significant losses of health workers. In some regions, the losses may be large enough to undermine the ability to provide effective health services. When a country has a fragile health system, the loss of its workforce can bring the whole system close to collapse and the consequences can be measured in lives lost. While freedom of movement is a basic human right that must not be constrained, managing the causes and consequences of migration must be tackled responsibly by national governments and the international community.

**What can countries do to tackle imbalances and inequities?**

Strategies must be developed to manage internal and international migration, and make health work a safer and more attractive occupation. Where appropriate, the statutory age of retirement should be re-considered and made more responsive to an era of ageing workforces. Whatever approaches are adopted there should be a focus on protecting health in the poorest countries while ensuring individual freedom of movement.

Countries must work both individually and together to find solutions. Governments should invest in their health systems, particularly the workforce, in order to attract and retain sufficient health personnel to meet the health needs of their populations.

In order to manage international migration and minimize inequities, action will be required in source countries, receiving countries, and internationally.

Source country strategies

Source countries can employ a wide range of strategies for managing migration, including:

- **Adjusting training to needs** – Training that is focused on local conditions can help to retain health workers. Success here will depend upon a wide range of on-the-job incentives and support, and the involvement of key institutions such as universities and professional associations.

- **Improving local conditions** – Improving the employment conditions of workers helps to remove the “push” factors that induce workers to migrate.

- **Making it easy for health workers to return home after working abroad** – Surveys show that many migrant workers eventually want to come back home, either to work or to retire. Mechanisms to make proper use of their skills and knowledge should be sought.

Receiving country strategies

Receiving countries should demonstrate concern for the rights and welfare of migrant health workers by:

- **Adopting responsible recruitment policies** – Receiving countries have a responsibility to recognize that significant investments were made in source countries in training health care professionals, and their absence may have immediate and adverse effects. Discussions and negotiations with ministries of health, workforce planning units and training institutions will help to avoid claims of “poaching” and other disreputable recruitment behaviour.

- **Providing support to human resources in source countries** – Many receiving countries are also providers of overseas development assistance for health. Support could be more directly targeted at expanding the health workforce, thus stemming the impact of outgoing migration.

- **Ensuring the fair treatment of migrant workers** – Migrant workers should be recruited on terms and conditions equal to those of locally recruited staff.

International strategies

From an international perspective, the need to balance the rights of migrant health workers while ensuring an adequate health workforce in source countries has led to the development of ethical international recruitment policies, codes of practice and various guidelines. Although not legally binding, these do set important norms for behaviour among the key actors involved in the international recruitment of health workers.