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HUMAN RESOURCES FOR HEALTH DOSSIER

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Introduction

The 2006 World Health Assembly (WHA) and the publication of the 2006 World Health Report, **Working together for health**, constitute the most important events in human resources for health (HRH) of the last decade and have brought global HRH issues to the top of the international agenda. From the first meeting of the High Level Forum in Geneva and the launching of the Joint Learning Initiative in Mexico , there have been a series of international events looking specifically at HRH. These events culminated with the adoption of important resolutions on HRH by the WHA: Resolutions **WHA59.23** and **WHA59.27**, and the presentation of a ten years plan to tackle the health workforce problems at global level.

The **World Health Report 2006** assesses the current crisis in the global health workforce, highlighting an estimated shortage of almost 4.3 million doctors, midwives, nurses and support workers worldwide. This shortage is most severe in the poorest countries, especially in sub-Saharan Africa , where health workers are most in demand. Focusing on all stages of the health workers' career lifespan, including entry to health training, job recruitment, professional development and retirement, the report outlines a ten-year action plan in which countries can build their health workforces, with the support of global partners.

The **World Development Report 2006: Equity and Development** identifies poor service delivery as a major factor contributing to increase inequities in health and to hinder development. According to the report, poor service delivery is related to weak management and incentives within public health systems, ineffective technical and structural backup, lack of professional career structures and inadequate financial incentives.

The **Global Health Watch Report 2005**, an alternative health report from civil society organisations, details the global health worker crisis. The authors illustrate the importance of the health workforce within health systems and highlight the history of neglect that the issue has suffered in the last decades. The report shows that, although maternal, child and infant survival rates increase with density of health workers, it is not only the right number of workers that is important. The distribution of health personnel is often inequitable. Developing countries bear the highest burden of disease but have the lowest access to health professionals, and the brain drain of health workers from low-income to more industrialised countries contributes to this. Within countries, the most deprived areas tend to have fewer health professionals than more affluent areas. The distribution of human resources between private and public services is also imbalanced, as there is often a higher concentration of private health services, which are generally not accessible to the poor. The report suggests a range of positive policies to address shortages of HRH in poor countries. It recommends redefining professional roles, improving the motivation of health workers and coordinating these efforts with effective ethical recruitment policies.

In the paper **Human resources for health policies: a critical component in health policies**, Gilles Dussault aims to sensitise decision and policy-makers and their advisers to the role of workforce policies in supporting health sector reform. It argues that the production and the management of the workforce play a determinant role in achieving the objectives of reforms.

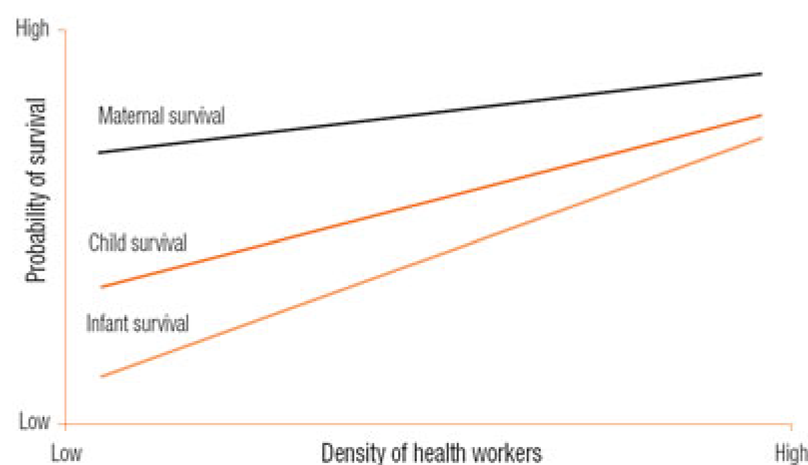
Intelligence is paramount in tackling workforce problems. Information availability constitutes one of the main hindering factors for monitoring and decision-making in HRH. The WHO Department of Human Resources for Health gathers information on the number of health workers and their employment status, gender and age, among other characteristics. **The Global Atlas of the Health Workforce** presents the estimate of numbers and densities – the ratio per 100 000 population – of health workers.

Why are human resources important?

The essential role of HRH in advancing global health

Global resources are available to tackle existing health threats. Yet many health systems are unable to deliver adequate health care to ensure a healthy population. Health care is a labour-intensive service industry and human resources are essential in realising global health goals. The World Health Organization (WHO) argues that health workers represent the human face of health systems: they represent its values and are essential for the use of its available resources. New evidence about strategies to fight against diseases and to promote health can only be put in practice through the skilled intervention of health workers. The number and skills of health workers are positively related to improvements in health such as infant, child and maternal survival.

"Health workers save lives"



Source: **World Health Report 2006** (figure 1, p. xvi)

The role of HRH in consolidating and scaling up health systems

The WHO recognised in 2005 that shortage of human resources for health is a major constraint in scaling up the response to HIV and AIDS and the achievement of the other health MDGs. Countries most affected by shortages in HRH, particularly in sub-Saharan Africa, are those where advancement towards the MDGs has been most limited.

Health workers as gatekeepers of health systems

The quality and quantity of health care workers has been shown to significantly impact on the health of a population. The quality of doctors and the density of their distribution have been linked with positive outcomes in cardiovascular diseases. Child malnutrition has worsened with staff cutbacks during health sector reform.

Health workers also play a key role in improving and maintaining effective and efficient health systems. The WHR 2006 argues that cutting-edge quality improvements in health care are best initiated by workers themselves because they are in the best position to identify opportunities for innovation. Health workers can function as gatekeepers and navigators for the effective, or wasteful, application of all other resources such as drugs, vaccines and supplies.

Health workers are at the frontline during health crises

The **Joint Learning Initiative on Human Resources for Health** has shown that HRH mobilisation and strengthening is central to combating health crises and to building sustainable health systems. Nearly all countries are challenged by worker shortage, skill mix imbalance, maldistribution, poor work environments, and weak knowledge base. In poorer countries, the workforce is also under assault by HIV and AIDS, out-migration of skilled health workers, and inadequate investment.

Effective country strategies need to be backed by international support. The JLI task force argues that the crisis in human resources is a shared problem that requires a shared responsibility for cooperative action. Alliances for action are needed to strengthen the performance of all existing actors while expanding space and energy for fresh actors.

Human resources contribute to keep a healthy and productive population

Poverty Reduction Strategy Papers (PRSPs) are the major aid instrument in tackling poverty. They provide a mechanism for countries to have a clear focus on this central objective. The link to debt relief for heavily indebted poor countries (HIPC countries) provides real incentives for those very poor countries to make progress. In a World Bank publication, **Review of the Poverty Reduction Strategy Paper (PRSP) approach: main findings**, the authors recognise that there has been widespread acceptance of the PRSP approach and that PRSPs are leading to better informed decision-making. But they also recognise that strategies alone are not sufficient—they must be followed up by actions. The implementation of PRSPs cannot realistically be achieved without clear human resource plans.

To find out more visit the **Eldis guide to the Poverty Reduction Strategy process**.

An analysis of PRSP and HIPC documentation illustrates the problem. Most of the country based documentation, interim PRSPs, PRSPs and progress reports refer to human resource problems but few indicate how these problems are to be addressed. HIPC documentation is even weaker in this respect.

Of course it can be argued that PRSP documents and HIPC documents are not designed to address these issues. But the fact remains that without complementary human resources strategies and plans; few PRSPs will achieve the improvements they envisage.

A Bank review of the HIPC/PRSP process in 18 African countries, **Enhancing human development in the HIPC/PRSP context: progress in the Africa region during 2000**, observes that it is important to take advantage of the specific opportunities presented by the HIPC initiative to strengthen the link between debt relief and improvements in social services and eventually, progress in poverty reduction. As well as the human resource issues of increasing coverage of services to poor people, there is an emphasis on improving efficiency of human resource utilisation. Often civil service reform has focused on reducing staffing numbers but the sustained improvements have been elusive. **Civil Service Reform: a review of World Bank assistance** provides recommendations on how the implementation of World Bank supported civil service reforms can be improved.

Planning for human resources

Planning the supply of and demand for human resources in healthcare is a neglected topic with little consensus on how it should be done. To inform the design and development of improved workforce planning, Canadian policy-makers conducted a **review of healthcare systems** in five countries: Australia, France, Germany, Sweden and the United Kingdom. The main finding is that workforce planning is inefficient because it ignores crucial economic issues.

As part of a series of ten papers commissioned by the World Health Organization (WHO) in 2000 for the Workshop on Global Health Workforce Strategy, researchers examined the possibilities of integrating shorter term service planning and longer term human resource planning. This involves determining the numbers, mix, and distribution of health providers that will be required to meet population health needs at some identified future point in time. The authors conclude that there needs to be a focus on outcomes and integrated planning in order to provide an efficient and effective health service for future generations. See **Integrating workforce planning, human resources, and service planning**, in **Towards a global health workforce strategy**.

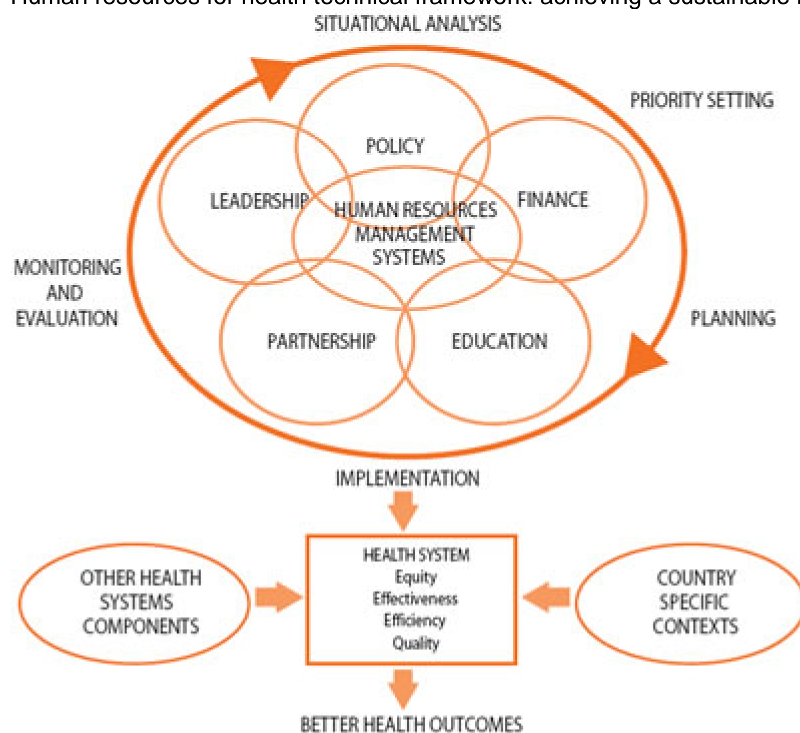
Many decision-makers readily point to human resource problems as the chief bottleneck they face in attempting to scale up health systems. Yet time and again the reform agenda avoids the sensitive and difficult issues involved—not least because there are major gaps in the knowledge base required for a realistic workforce strategy. An editorial of the Bulletin of the World Health Organization, Human resources impact assessment, suggests that policy-makers and donors may want to request those proposing a major new project or policy to make a systematic and formal 'human resource impact assessment' during its preparation.

See also **Addressing the health workforce crisis: avenues for action**.

Institutional and system considerations

The lack of a common approach has been one of the obstructive factors to tackling the Human Resources for Health (HRH) crisis. HRH policy and decision makers are often lost in an overwhelming number of complex problems in this area. The WHR 2006 suggests a **technical framework** that is intended to guide planning and strategy development at the country level and to raise awareness among donors and multisector organisations outside ministries of health.

Human resources for health technical framework: achieving a sustainable health workforce



Source: World Health Report 2006 (p. 137)

The framework outlines areas of technical competence necessary to establish a strategy for human resources. It will also help to: prevent simplistic approaches to complex issues; avoid duplication by harmonising the HRH agenda; and promote sharing among stakeholders. At country level the framework will help decision makers see a broad picture of the health workforce and avoid fragmentation. In particular, the framework can support governments in establishing a comprehensive strategic agenda and invite donors to define their agendas accordingly.

Many HRH experts see the lack of focus on human resource issues in the wider context of sector reform as the single most important reason for human resource problems faced by developing countries, and cite it as the reason for the failure to successfully implement reform. The public health system needs to be seen as both part of the wider public system and also part of the overall health system.

Because those managing the public health system do not usually have total authority over the human resources working within the system, then HR can only be satisfactorily addressed if actions are considered not only within the public health system but also:

- within the public service generally

- within the health system generally.

Therefore, if health workforce management is to be fully and effectively addressed in the public health system then issues related to good governance, civil service reform, and education need to be addressed. This requires a wider embracing of health sector reform within government and an acceptance that reform beyond the health sector is needed as well, if the aims of health sector reform are to be fully realised.

Equally, policy change in the public health system may be affected or indeed thwarted by change in the private or not-for-profit sector. Policy implementation needs to address the human resource implications across the health sector as a whole. Regulation of the private health sector is one route for addressing the issues. The issue of **gender** is also important and a cross-cutting issue.

This analysis applies equally well to other sectors, for example education, as it does to health. The importance of the human resource issue is therefore cross-sectoral, and linked closely to global initiatives and approaches. This includes not only disease specific issues, such as the **Global Fund to Fight HIV/AIDS, TB and Malaria (GFATM)**, but also cross-cutting initiatives such as **PRSPs** and **HIPC**.

Principles

Arriving at clear, universal principles to guide workforce management in all health sectors can be difficult: health systems vary widely, and models of HR practice tend to focus on individual firms rather than complex national systems like health provision. However, three general principles can be arrived at to guide the development of effective HR strategy:

Ownership: an effective HR strategy must be owned by key stakeholders, including ministry officials, trade unions and staff. The use of widely agreed mission statements and corporate values, and clear messages about the goals of HR strategy can help foster ownership.

External fit: HR strategy should be in line with the external health policy environment if it is to be effective. Crucially, HR strategy should be developed as part of the organisation's overall policies and agendas, rather than as a separate means of quantifying the numbers of staff needed at different levels.

Internal fit: personnel policies need to be internally consistent if they are to be effective. Competency frameworks can help ensure 'internal fit', by linking HR needs to the attitudes and behaviour of staff.

Financial crises have triggered reforms which affected health systems in different ways. Narrow approaches to these problems, which underestimate the importance of the health workforce as part of the solution, have led to health systems failing to achieve their established health goals. Decentralising decision-making without first increasing the capacity of health managers at peripheral level and reducing health workforce size driven exclusively by financial criteria rather than health needs are two examples of this.

The combination of failing health systems and donor pressure has led to an increased vertical or disease specific health programmes. This has resulted in a loss of health workers in primary care and contributed to the overall depletion of human resources across health systems. Apart from these

systemic problems, individual health workers have to accept low pay, an inadequate work environment and a lack of supervision and support.

Insufficient HRH supply for a growing demand is at the root of the existing crisis. On one hand, demand is increased due to factors such as the ageing of the population, increasing in chronic ailments requiring longer term assistance, new and re-emerging diseases that require long term care, and advanced technology whose operation requires skilled professionals. On the other hand, supply is being reduced by migration and brain drain, decrease in number of new professionals due to low capacity of the educational system, and increasing turnover among health professionals.

The paper **Health human resources demand and management: strategies to confront the crisis** proposes eight recommendations for policy, management and migration. At policy level the report recommends increased political commitment with increased financial support to HRH, increasing the capacity at peripheral level, and defining the role of the private sector and its contribution. At managerial level the report advises improved strategic HRH planning and proposes the establishment of a global HRH intelligence body. To manage the problems posed by migration, the authors recommend improving the production and retention of resources in destination countries and establish a global crises response strategy to help source countries to overcome the effect of the crises.

Understanding the labour market

Understanding the dynamics of labour market is key to tackling health workforce imbalances, shortages and to facilitate policymaking and planning. International mobility of health professionals has increased substantially in the last decades. The globalisation of the labour market significantly impacts upon the mobility and rights of workers, as well as the efficiency of health systems. See **Imbalance in the health workforce**.

The paper **Not enough there, too many here: understanding geographical imbalances in the distribution of the health workforce** explores the geographical dimensions of the availability of qualified health personnel. The authors examine the determinants of these imbalances and attempt to identify and assess strategies to overcome these barriers. The authors argue that the geographical distribution of the health workforce cannot be dealt with in isolation. The response must take into account factors residing outside the domain of the Ministry of Health and must be multifaceted, integrated and coordinated in relation t the health sector and its environment. One major factor is the emergence of the private sector, both for-profit and not-for-profit, which has resulted in major changes on the environment in which HRH issues are to be addressed.

Further reading

- **Nursing workforce planning: mapping the policy trail**
- **The nursing workforce in sub-Saharan Africa**
- **Overview of the nursing workforce in Latin America**
- **The impact of the aging population on the health workforce in the United States**

Gender

If the most is to be made of human resources and the interests of poor people are to be fully taken into account then issues of social development and gender need to be considered. The challenge is to develop innovative human resource strategies that take into account the particular needs of women and men.

In **Equity, equal opportunities, gender and organization performance in the health sector**, commissioned by the WHO Global Health Workforce Strategy, Hilary Standing and Elaine Baume present a review of gender, equal opportunities and organisation performance in the health sector. It highlights the fact that employment equity debates and policies largely refer to high-income countries and that even in these countries there remain few instances where there is clear evidence of successful outcomes. The review provides a series of instances where there has been some general agreement regarding the implementation of better practices and also sheds illumination on the areas where there remain gaps in knowledge between current practices and the evidence.

This article **Gender: a missing dimension in human resource policy and planning for health reforms** by Hilary Standing takes up the relatively neglected issue of gender in human resources policy and planning (HRPP), with particular reference to the health sector in developing countries. Current approaches to human resources lack any reference to gender issues. Meeting the health needs of women as major users and potential beneficiaries of health services is a key international concern.

In the article Gender dimensions of AIDS in Zambia from the Journal of Gender Studies, Abrahamsen argues that within the poor urban households of Kitwe in Zambia, the impact of AIDS affects women disproportionately due to their subordinate status and the numerous roles that they traditionally undertake. The paper asks whether home-based AIDS care threatens to overload the coping capabilities of women and suggests that any improvement in the situation will require a broad based solution that aims to empower and improve women's economic independence.

In a Health Policy and Planning paper Gender and equity in health sector reform programmes: a review Hilary Standing reviews literature and debates relating to Health Sector Reform (HSR) in relation to women's health and gender equity. The paper attempts to provide an analysis of gender and women's health issues most likely to be associated with HSR in order to outline an agenda for further research. The premise of the article is that gender cuts across poverty.

Further resources

- **Imbalance in the health workforce**
- **Improving female recruitment, participation, and retention among peer educators in the Geração BIZ program in Mozambique**
- **The perceptions of rural women doctors about their work**
- **Increasing health systems performance: gender and the global health workforce**
- **On the front line of primary health care: the profile of community health workers in rural Quechua communities in Peru**
- **The global dimensions of female migration**
- **Women and international migration in the health sector**

Financial and non-financial incentives

Incentives must be viewed in a broad context in order to understand the constraints and success factors of health systems. HRH needs to be seen as a complex and interrelated system where incentives aimed at one group of professionals will impact on the entire system.

In many developing country settings, and particularly in rural areas, the implementation of anything more than very rudimentary contracts for medical care providers, including public employees, is virtually impossible. Produced by the World Bank and George Town University, **Designing incentives for rural health care providers in developing countries** examines the kinds of policy levers that governments might conceivably have available to induce physicians to serve in rural areas. It assumes that sophisticated performance-based contracts are difficult to enforce in poorer countries.

Pay and non-pay incentives, performance and motivation (in **Towards a global health workforce strategy**) is an overview of the current evidence on the effect of pay and non-pay incentives on health workers' performance and motivation. Incentives must be viewed in a broad context in order to understand constraints and success factors that affect their prospects of success. Health human resources should be seen as a complex and interrelated system where incentives aimed at one group of professionals will impact on the entire system.

Health sector workers respond to inadequate salaries and working conditions by developing various individual ''coping strategies''—some, but not all, of which are of a predatory nature. Van Lerberghe et al in the **Bulletin of the World Health Organization** article **When staff is underpaid: dealing with the individual coping strategies of health personnel** review what is known about these practices and their potential consequences (competition for time, brain drain and conflicts of interest). By and large, governments have rarely been proactive in dealing with such problems, mainly because of their reluctance to address the issue openly. The effectiveness of many of these piecemeal reactions, particularly attempts to prohibit personnel from developing individual coping strategies, has been disappointing.

Gerry Bloom et al in **How health workers earn a living in China** observe that under the command economy all government health workers in China earned similar salaries. Twenty years of transition to a socialist market economy, including liberalisation of the labour market, has led to growing income differences. This Institute of Development Studies working paper explores how this has affected health workers. The study suggests that the government needs to establish new payment systems and a regulatory framework that encourages health workers to provide effective and affordable health services while enabling them to earn a reasonable income.

The study **Identifying factors for job motivation of rural health workers in North Viet Nam** recommends that both non-financial and financial incentives for health workers should be considered. It describes and reports on the findings of a study that looked at the relation between the implementation of various human resource management tools in Viet Nam and the perception of health workers of these tools on their motivation. It aimed to describe the main factors influencing job motivation at commune and district health centres in rural areas of North Viet Nam and to recommend ways for improving motivation of health workers.

Further resources

- **Can "pay for performance" increase utilization by the poor and improve the quality of health services?**
- **Dual practice of public sector health care providers in Peru**
- **Economic incentive in community nursing**
- **Improving health services and strengthening health systems: adopting and implementing innovative strategies**
- **Payment of lunch allowance: a case study of the Uganda Health Service**
- **Polio eradication: mobilizing and managing the human resources**
- **The effect of performance-related pay of hospital doctors on hospital behaviour**

Achieving change

A review of the literature shows a surprisingly common view about how human resources for health might be better addressed. Two key themes – the need for a systemic approach and the need to involve stakeholders – are summarised here.

A third theme, **integrating human resources into civil service reform**, is examined in the following section.

Taking a systemic approach to human resources problems

In the section **Institutional and system considerations**, the systemic aspects of human resource management are explored. The following three references give some suggestions about how this aspect of human resources can be addressed.

In response to an identification of weaknesses in human resources in the health sector, a paper **Human resources for health policies: a critical component in health policies** by Gilles Dussault and Carl-Ardy Dubois presents proposals on how the policy process is conducted in the development of human resources for health (HRH). The development of the health workforce is concluded to be a crucial part of the health policy development process. To achieve success, further input is required in order to attain the provision of effective, efficient, accessible, viable and high-quality services by personnel. These services should be present in sufficient numbers and appropriately allocated across different occupations and geographical regions. The proposals to achieve the changes required include:

- to move beyond the traditional approach of personnel administration to a more global concept of human resources management (HRM)
- to give more weight to the integrated, interdependent and systemic nature of the different components of HRM when preparing and implementing policy
- to foster a more proactive attitude among human resources (HR) policy-makers and managers
- to promote the full commitment of all professionals and sectors in all phases of the process.

The paper highlights four crucial conditions that will be required to assist in successful implementation of the proposals: institutional/technical capacities, political feasibility, social acceptability and affordability.

During the Fifty-fifth World Health Assembly, in May 2002, Dr Gro Harlem Brundtland, WHO Director-General at the time, explained that she had established an initiative to improve human resources in national health systems. In accordance with the Health Assembly's recommendations, an integrated framework for human resources for health was proposed. Using this framework, **Human resources for health: developing policy options for change** outlines WHO guidance on human resources policy options that could lead to improvement in health systems performance.

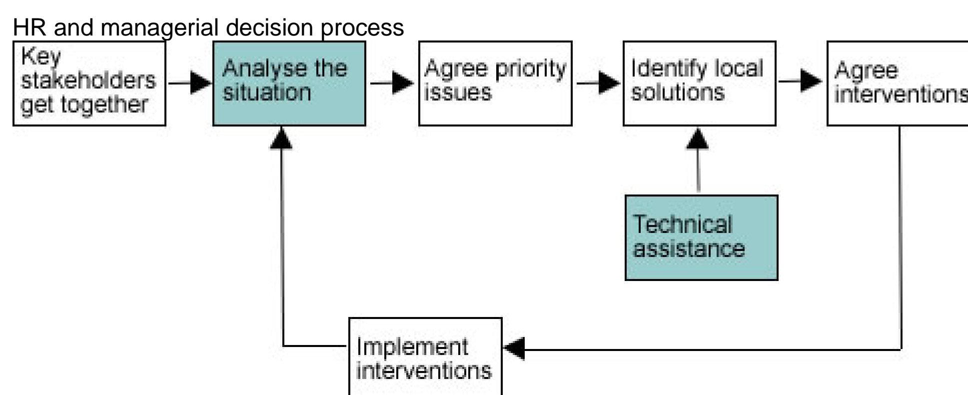
With the multiple objectives of highlighting human resources for health (HRH) policy issues and providing assessment and guidance for countries and their policy-makers this draft WHO Discussion Paper aims also to integrate HRH policy issues with indicators to assess and monitor HRH performance as part of the WHO initiative. Recognising that HR is linked with health services provision and with the performance of health service providers in a relationship of mutual dependence, the paper argues that a better understanding of the outcomes of this relationship should be the basis for the development of policy options with countries for countries.

Produced to provide support and guidance on human resource issues for the UK Department for International Development (DFID), Key issues in human resource management in low and middle-income countries argues that human resource issues in the health sector can only be effectively addressed when a more joined up approach is taken involving other sectors, particularly those working on governance and education. It further notes that the problems in managing human resources are not unique to the health sector, and are widespread across low and middle-income countries. Based upon actual experience working in the health sector in low and middle income countries the paper intends to provide a basis for deciding how best to tackle the issue of human resources. The paper concludes that a more holistic approach will be required in future.

Involving stakeholders in addressing human resources issues

The ideal process for addressing human resources can best be summarised by considering the following diagram.

HR and managerial decision process



Key stakeholders get together – The stakeholders will depend on local circumstances but might include, the Ministry of Health, the Ministry of Finance, the Ministry of Education, the Civil Service Commission, representatives of professionals and other staff, and academic institutions.

Analyse the situation – understanding the situation in the context of the system is important and helps determine what needs to be done

Agreeing priority issues – there will often be too many issues to address all at once and it will be important therefore to address those considered to be most important

Identify local solutions – this is where experience from elsewhere might help Government decide what approaches might be adopted.

Agree interventions – the solutions have to locally determined and designed

Implement interventions – a plan for implementation will help

Feedback to analyse the problems - This feedback is crucial for two reasons: the system is complex and unexpected results may arise, and secondly because of this it is important to build capacity in the problem solving process itself

The blue boxes in the diagram ("analysing the situation" and "technical assistance") are the activities where the development partners for Government have tended to provide support. It perhaps would be more effective for development partners to support the process itself. The Pan American Health Organization has done just that in its Human Resource Observatories initiative in the Americas, as described in **Development and strengthening of human resources management in the health services**. The initiative now covers 20 countries.

In the WHO discussion paper **Achieving the right balance: the role of policy-making processes in managing human resources for health problems,** the authors propose an explanation for the gap between policy formulation and implementation in human resource for health and uses a WHO framework for correcting what is proposed to be an imbalance between the many complex components and dynamics that form human resources for health policies (HRH). The paper is built upon a hypothesis that countries that successfully implement HRH policies and as a result ameliorate HRH problems are those that:

i. adjust the specific HRH strategies to meet the demands of their country's health sector reforms, the political/macroeconomic context, and government administrative policies

ii. use policy-making processes that are consultative, "owned by the country", based on sound data, and supported by adequate human and financial resources. In other words, to achieve the right balance (number, type, distribution) in a country's health workforce may also require striking the right balance between context-appropriate strategies (content) and organizational change mechanisms (process).

In **HR and new approaches to public sector management: improving HRM capacity**, Stephen Bach reviews HR issues in health sector reform, and explores how new approaches to HR management in health provision can enable reform. The evidence on the impact of HR capacity on health sector effectiveness indicates that:

- HR issues should be treated as central to the reform process, and be taken into account from the outset.
- Attention needs to be paid to the process of reforms as well as to their content; the timing of planned change and the involvement of different stakeholders can be crucial to successful implementation.
- How human resources have been managed in the past, and the institutions and incentives that have developed from these systems, will impact on the success of reform.
- More effective HR management involves going beyond narrow issues of pay and training to considering the broader incentives and systems for encouraging and managing good performance.

Arriving at clear, universal principles to guide HR management in all health sectors can be difficult: health systems vary widely, and models of HR practice tend to focus on individual firms rather than complex national systems like health provision. However, three general principles can be arrived at to guide the development of effective HR strategy:

- Ownership: an effective HR strategy must be owned by key stakeholders, including ministry officials, trade unions and staff. The use of widely-agreed mission statements and corporate values, and clear messages about the goals of HR strategy can help foster ownership.
- External fit: HR strategy should be in line with the external health policy environment if it is to be effective. Crucially, HR strategy should be developed as part of the organisation's overall policies and agendas, rather than as a separate means of quantifying the numbers of staff needed at different levels.
- Internal fit: personnel policies need to be internally consistent if they are to be effective. Competency frameworks can help ensure 'internal fit', by linking HR needs to the attitudes and behaviour of staff.

Civil service reform

Human resource development is gradually being recognised as crucial to future reforms and the formulation of health policy. New information systems at local and regional level will be needed to collect data on human resources. New employment arrangements, strengthening organisational culture, training and continuing education will also be needed.

The introduction of market mechanisms often involves the formation of an internal market within the health sector and market testing of different functions with the private sector. This has immediate implications for the employment of health workers in the public sector, because the public sector may reduce its workforce if services are purchased from other sectors or may introduce more short-term and temporary employment contracts.

Decentralisation of budgets and administrative functions can affect the health sector, often negatively, by reducing available resources and confusing lines of accountability for health workers. Governance and regulation of health care, when delivered by both public and private providers, require new systems of regulation. The increase in private sector provision has led to many health workers moving to the

private sector. For those remaining in the public sector, there are often worsening working conditions, a lack of employment security and dismantling of collective bargaining agreements. **Public sector reform and demand for human resources for health** considers some of the effects of health sector reform on HRH in developing countries and countries in transition by examining the effect of fiscal reform and the

Case studies: the Republic of Karelia (Russia), Zambia and the UK

This paper examines the criticality of HR in healthcare reforms via three case studies; the authors situate the health context for each of the countries and then subject the case studies to the following questions:

- Is HR an integral element of the reform agenda, from pre-planning through to implementation and evaluation?
- Is there sufficient capacity to implement the necessary changes in HR, and to deal with the challenges that will arise?
- Does the health care workforce understand the need for the reforms? To what extent does it support the reform plan?

Read the full report

introduction of decentralisation and market mechanisms to the health sector.

The authors of **Human resources: the Cinderella of health sector reform in Latin America,** describe how World Bank-led reforms, meant to increase equity, efficiency and quality of care in Latin American health systems did not address HRH problems, despite having been identified in multiple health sector assessments. The authors describe how the two most important reform policies, decentralisation and privatisation, impacted negatively on employment conditions and prompted organised opposition on the part of health care workers. Consequently, the workforce became the most important obstacle to successful reform. The authors suggest that solutions determined from within the system are more likely to succeed than those imported from outside.

Emphasising the potentially overlooked importance of managing and administrating human resources (HR) in the health sector in Administrative and civil service reform – health sector issues**,** James Buchan acknowledges that managing HR in health care is a complex challenge and one that has often been underestimated when reform and restructuring has been planned. Overall he suggests that the key to achieving effective HR is to recognise that it has to be an integral element of overall planning and management of the delivery of health services.

More information on **Civil service reform** from the **Governance and Social Development Resource Centre**

Decentralisation

What issues arise when considering human resources and health sector decentralisation programmes in developing countries? Evidence about the impact of decentralisation on efficiency, equity and quality of

health services is based primarily on theoretical and anecdotal evidence, rather than on systematic empirical studies. The impact of decentralisation on HRH decisions made at the local level is well illustrated in a **case study about Ghana, Zambia, Uganda and the Philippines**. The paper outlines how decentralisation impacts upon human resources in four ways: payment of health workers; health systems governance; the political nature of HRH management; and balancing equity and efficiency between the local and national health systems. The authors argue that little information is available on this complex issue and propose a new research agenda

The paper **Decentralization and human resources: implications and impact**, aimed at health leaders considering decentralisation or implementing reforms, analyses the impact of decentralisation on sound human resource development. Two major human resource issues are considered, those that emerge as a part of the process of transferring power to lower management levels and identification of the most important areas of HR where problems arise as a result of the way in which decentralised management systems are structured.

Further reading on decentralisation and HRH

- Decentralization in Kenya
  Health facility committees: the governance issue
- Decentralization in South Africa
  The District Health System in South Africa: Progress made and next steps
- Decentralization in Zambia
  Effectiveness of District Health Boards in interceding for the community

Integrating human resource issues into planning and implementing reform

Most experts recognise the importance of human resource management in the planning and implementation of health sector reform. Professor James Buchan argues in Administrative and civil service reform – health sector issues that human resources must be an integral part of planning and managing health service delivery. Emphasising the potentially overlooked importance of managing and administrating human resources in the health sector in this web document, he acknowledges that managing HR in health care is a complex challenge.

In **The interface between health sector reform and human resources in health** Rigloi and Dussault review evidence on how individual or collective actions of human resources are shaping reforms, by spotlighting the reform process, the workforce reactions and the factors determining successful human resources participation. It attempts to provide a more powerful way of predicting the effects and interactions in which different "technical designs" operate when they interact with the human resources they affect.

Many of the main challenges facing health systems in developing countries are directly or indirectly related to issues of human resources. The WHO report on the **Workshop on global health workforce strategy: Annecy, France 9-12 December 2000** presents a summary of the proceedings and recommendations for action of a workshop held at Annecy, France by the Global Health Workforce

Strategy Group. The workshop was held to inform the work of the GHWSG and to ensure that other stakeholders could participate fully in identifying priority areas for coordinated action to improve human resources for health (HRH) policy and practice. Four main interlinked components of work were identified for an agreed programme of priority action outlining key steps to forward advocacy of HRH issues:

- strengthening HRH in context, through the development of methods for HR impact assessment, and better integration of HR activities in other elements of health sector policy, planning and management
- developing HR competences and structures, through training and development of HR practitioners, the effective use of external "experts" and consultants, identification and application of appropriate knowledge tools, and improvements in HR information and performance management systems
- improving HR advocacy and networking by awareness-raising among stakeholders, sustained support of regional and country-level events, web sites, and other forms of networking
- enhancing the evidence base on HRH through coordinated support for research on the impact of HRH policy, practice and tools; a recognition of the need for country and context specificity; and improved collation and dissemination of available evidence

The editorial of the Bulletin of the World Health Organization, **Human resources impact assessment** provides an overview of the role of human resources within the health sector, regardless of whether it is public or private. The editorial discusses the importance of human resources management within the health sector, and suggests that policy-makers and donors concerned with human resources problems may want to request those proposing a major new project or policy to make a systematic and formal 'human resource impact assessment' during its preparation. Such assessments would examine the likely effects of the proposed project or policy on the health workforce.

Gearing public/civil service reform to the health agenda rather than efficiency

HR and new approaches to public sector management looks at evidence on the impact of HR capacity on health sector effectiveness. It indicates that HR issues should be treated as central to the reform process, and be taken into account from the outset. A **World Bank publication** argues that the highly indebted poor countries (HIPC) initiative presents specific opportunities to strengthen the link between debt relief, improvements in social services, and eventually, progress in poverty reduction – and argues that it is important to take advantage of these opportunities.

As well as the human resource issues of increasing coverage of services to poor people, there is an emphasis on improving efficiency of human resource utilisation. Often civil service reform has focused on reducing staffing numbers but the sustained improvements have been elusive (**Civil Service Reform: a review of World Bank assistance**). Although efforts to improve efficiency cannot be ignored, the main focus has to be on improving effectiveness of service delivery.

Efficient but largely ineffective service delivery wastes most of the expenditure – inefficient but effective service delivery wastes only some of the money. The message for human resources must be to concentrate on effective use of human resources rather than efficient use of human resources.

Arriving at clear, universal principles to guide HR management in all health sectors can be difficult: health systems vary widely, and models of HR practice tend to focus on individual firms rather than complex national systems like health provision. However, three general principles can be arrived at to guide the development of effective HR strategy:

- Ownership: an effective HR strategy must be owned by key stakeholders, including ministry officials, trade unions and staff. The use of widely-agreed mission statements and corporate values, and clear messages about the goals of HR strategy can help foster ownership.
- External fit: HR strategy should be in line with the external health policy environment if it is to be effective. Crucially, HR strategy should be developed as part of the organisation's overall policies and agendas, rather than as a separate means of quantifying the numbers of staff needed at different levels.
- Internal fit: personnel policies need to be internally consistent if they are to be effective. Competency frameworks can help ensure 'internal fit', by linking HR needs to the attitudes and behaviour of staff.

The World Bank supported civil service reforms (CSRs) during the 1980s and 1990s as a means to remove what it saw as institutional impediments to market-led development in client countries. The Bank's own **review** of these reforms suggests that they were largely ineffective in achieving sustainable results in downsizing, capacity building, and institutional reform. Recommendations include re-categorisation of CSR interventions, and increased monitoring and standardisation of CSR performance indicators.

Presenting an analysis of data obtained from a 1999 survey of public officials in Bolivia the authors of **The experience of public officials in Bolivia: what works in a weak institutional environment?** use detailed survey data to map the points of weakness, and to identify the characteristics of organisations within the public sector that seem to be working well. The report draws conclusions regarding targets for reform and lessons that can be learnt. The premise for the surveys is that the performance of public officials depends upon a series of factors. These factors include their institutional environment, the trust that they have in the future, the degree to which they believe that rules will be enforced, belief that resources will be provided, and belief that policies will make a difference.

Health sector workers respond to inadequate salaries and working conditions by developing various individual ''coping strategies''—some, but not all, of which are of a predatory nature. The paper **When staff is underpaid: dealing with the individual coping strategies of health personnel** reviews what is known about these practices and their potential consequences (competition for time, brain drain and conflicts of interest). By and large, governments have rarely been proactive in dealing with such problems, mainly because of their reluctance to address the issue openly. The effectiveness of many of these piecemeal reactions, particularly attempts to prohibit personnel from developing individual coping strategies, has been disappointing.

Tools

Evidence-based information is needed to better understand HRH trends. Although a range of information sources exist that could be used for HRH assessments, there is a lack of any relevant analysis. In order to reflect and address the complexity of HRH issues, a variety of data sources and analytical approaches, each with its own strengths and limitations, is required.

In order to improve and compare understandings of the health workforce across and between countries, data collection needs to follow internationally standardised classifications at the greatest level of detail possible.

The following information and table, taken from the **JLI report**, outlines a range of methods and tools for assessing the health workforce.

Toolkits for appraising health workforce

A proper appraisal of human resource for health needs to be carried out to guide planning, policy, and management. Most appraisals include an assessment of the current workforce and future requirements, including the aims of quality, equity, and efficiency. Where conventional health service providers are in short supply, an analysis of alternative providers might be necessary. And to ensure sustainable solutions, human resource policymaking and systems should be analyzed. A broader understanding of organisational goals, and strengths and weaknesses in areas other than staffing will assist with the development of appropriate and feasible human resource solutions. In addition, an analysis of the policy environment covering stakeholders, opportunities, and threats is needed. The appraisal should identify whether the wider oversight system ensures that human resources are addressed adequately in the health sector.

The JLI conducted a survey of methods and tools currently available for appraising the human resource situation. More than 25 examples of published, unpublished, and web-based materials have been identified. These instruments have been reviewed to identify the purpose and scope, the timeframe, and data requirements. Evidence of their validity has also been sought.

A selection of the instruments:

Instrument	Description	Comments
	Broad diagnostic tools	
Human resources in the health sector: guidelines for appraisal and strategic development	Broad analysis of HR situation including HR functions, key stakeholders and policy context. Suggested questions provided.	Also available in French. Information on usage not known.
Reviewing health manpower	Explains key issues in areas of HR	Case studies included as

development: a method of improving national health systems	planning, production and management, sample questions and possible data sources.	examples of the review; may need updating.
Guidelines for a HRH review	Outline a method for making a review and provide suggestions and template materials that can help with data collection and analysis, and with the presentation of the results.	Information on usage not known.
	HR planning tools	
Simulation models for workforce planning	Computer-based HR planning model capable of sophisticated projections; much training has been provided for users.	In use for over 10 years and applied on a trial basis in at least eight countries. Also available in Spanish and French.
The WPRO/RTC health workforce planning workbook	Provides steps for developing an HR plan; includes simple computer-based planning model.	Extensively used.
	HR management tools	
Achieving the right balance: the role of policy-making processes in managing human resources for health problems	Although designed as study, this contains a framework for analysing HR policy implementation.	Used for 18 countries; methodology provided, so could be adapted as an assessment tool.
Human resource management assessment instrument for NGOs and public sector health organizations	A rapid tool to assess the core functions of a human resource management system. The tool is adapted to be responsive to HR elements resulting from the impact of HIV and AIDS.	Widely used in both the public and private sectors.
	Programme-specific HR tools	
Capacity building for 3 by 5: country fact, planning & monitoring sheet	Pro forma to identify current and potential workforce for delivering ART with guidance on information sources.	Supports the WHO ART programme; currently in use.
Human capital development inquiry (for HIV and AIDS programs)	Inquiry to ensure a comprehensive response to entrenched HR issues. Inquiry includes 4 components: policy; HRM; leadership and partnerships.	Still in introductory stage, but useful as a framework to identify range of HR issues to be included in a sustainable strategy.

Tools for considering policy context and options

Open systems model for institutional appraisal	Situates HR issues in wider organisational context of strategy, culture, management systems, structure, environment, etc.	Would ensure that HR is not forgotten in a broad appraisal exercise.
Decentralization mapping tool	To map out the movement of management responsibilities, including those of human resource management.	An example of a tool for examining the impact of structural reforms; available in Spanish.

Source: Human resources for health: overcoming the crisis, p. 115

Joint Learning Initiative / Global Health Trust, 2004

Strengthening capacity – policy and practice

In this section the most frequently discussed and examined areas of policy and practice in human resource management are listed with links to further information on these topics.

Scaling up production

In its 59th General Assembly in 2006, the World Health Organization (WHO) passed **a resolution** to rapidly increase the health workforce production. New and creative strategies need to be developed in order to bridge the existing demand/supply workforce gap. With a global shortage of health workers, scaling up production in the short term will require new ways of thinking about human resources for health.

Properly trained and supervised Lay Health Workers (LHWs) have been playing an important role in different areas of health care. See **Lay health workers in primary and community health care**. While there is a lack of evidence regarding the impact of LHWs on access, utilisation and health outcomes in developing countries, it has been shown that programmes that integrate LHWs in the existing health system appear to be more effective than non-integrated LHWs programmes. For example, the Lady Health Workers programme in Pakistan trains traditional birth attendants and integrates them in the primary health care network. This approach has proven to be effective in reducing perinatal mortality. See **An intervention involving traditional birth attendants and perinatal and maternal mortality in Pakistan**. However, some argue that evidence on the effectiveness of LHWs is inconclusive as it is based on specific, context-based approaches and, therefore, difficult to assess on a wider scale.

The impact of introducing community-based therapeutic care for severely malnourished children has been shown to reduce the needs of human resources in nutritional emergency settings when compared to the traditional therapeutic feeding centre strategy. See **Emergency Nutrition Network special supplement on community-based therapeutic care**.

In rural Kenya , an initiative to train shopkeepers has improved malaria home management by improving the use of over-the-counter anti-malarial drugs for childhood fever illness. See **The cost-effectiveness of improving malaria home management: shopkeeper training in rural Kenya**

The role of faith-based organisations (FBOs) in the delivery health services is becoming increasingly important. See **Planning, developing and supporting the faith-based health workforce**. **DREAM: an integrated faith-based initiative to treat HIV/AIDS in Mozambique** describes an initiative which integrated community-based and home care services together with mother and child prevention and care, and was integrated within the existing health system.

The **Sangha Metta Project** involves counselling by Buddhist monks to HIV positive patients and provides support for HIV related orphan children in Thailand. **Asia-Pacific faith-based organizations battle HIV/AIDS** describes other FBO initiatives, such as Wat Norea Peaceful Children's Home in Cambodia , Yayasan Dana Islamic Center, Indonesia Mosque Association Mushallah Muttahidah in Indonesia; and Anglicare-StopAIDS PNG in Papua New Guinea.

Also see the role of **community** in delivering health care in the Africa section of this dossier.

Nursing

Nursing shortages in health systems around the world are having negative impacts on the health and well being of populations. They pose unprecedented challenges for policy makers and planners in high and low-income countries alike. Inadequate human resources planning and management, poor deployment practices, internal and external migration, high attrition (due to poor work environments, low professional satisfaction and inadequate remuneration), the impact of HIV and AIDS, and under investment in human resources are just some of the critical issues driving nursing shortages.

The **International Council of Nurses (ICN)** is a federation of national nurses' associations, representing nurses in more than 120 countries. Operated by nurses for nurses, ICN works to ensure quality nursing care for all, sound health policies globally, the advancement of nursing knowledge, and the presence worldwide of a respected nursing profession and a competent and satisfied nursing workforce.

The **International Centre for Human Resources in Nursing**, set up by the ICN in 2006, is dedicated to strengthening the nursing workforce globally through the development, ongoing monitoring and dissemination of comprehensive information, standards and tools on nursing human resources policy, management, research and practice.

ICN (see box) and the **Florence Nightingale International Foundation** undertook a **Global Nursing Review Initiative: Policy Options and Solutions**. This review identified five key areas of intervention. These include: workforce policy and planning; positive practice environments and organisational performance; recruitment and retention, addressing in-country maldistribution, and out-migration; and nursing leadership. The report **The global nursing shortage: priority areas for intervention** emerged from this two year process and looks at key issues in nursing shortages.

The 2006 World Health Assembly **resolution** called for nursing and midwifery skills and services to be strengthened. This resolution recognises the importance of these health professionals in attaining global health goals. It invites countries to put nursing and midwifery in a prominent position within health systems to increase their participation in the decision making process, and commits the WHO to increase the number of nurses and midwives in its own programmes.

Nursing and midwifery services provide a platform from which to scale up health interventions to assist in meeting national health targets. A variety of problems, however, continue to undermine the contribution of nursing and midwifery services. **Nursing and midwifery services: strategic directions 2002-2008** provides an evidence-based framework for action that will be undertaken by WHO and its partners to support countries dedicated to improving the quality of nursing and midwifery services. The document introduces the strategic directions, key result areas and objectives with the expected results to achieve them and discusses how nursing and midwifery services form an integral part of health services.

Also see the **International Centre on Nurse Migration (ICNM) eNEWS Newsletter**.

Medical workforce

Most OECD countries have long term policies to support the training and employment of enough physicians for their population. However, most of these countries also employ physicians trained elsewhere as an interim method to address the short- to medium-term shortages. While this is the case, there is a need for a global framework that enforces ethical migration policies aimed at redressing the balance between home and host country health systems. In the long term, OECD countries need to implement appropriate education and training policies rather than rely on physician migration to address

their future needs. See **Impact, regulation and health policy implications of physician migration in OECD countries**.

The migration of over 5000 doctors from sub-Saharan Africa to the United States (USA) has had a significantly negative effect on the doctor-to-population ratio of Africa. **The migration of physicians from sub-Saharan Africa to the United States of America** reveals that most physicians migrating to the US come from only a few countries and medical schools. They argue that policy interventions in only a few locations could be effective in stemming the brain drain.

Abundant for the few, shortage for the majority discusses medical workforce imbalances in Thailand. The authors describe how there are 23 times more doctors in the capital city than in the lowest doctor per population province. Reasons for this imbalance include: the rapid capitalistic economic growth with rapid expansion of the urban private hospitals, the opportunity for continuing education, the urban origin of the graduates, and the influx of foreign patients.

Post-conflict environments pose a particular challenge to reforming health systems. **The providers of health services in Lebanon: a survey of physicians** considers the supply of physicians in Lebanon in 1998, looking specifically at practice patterns and capacity building. The authors find that there is an oversupply of physicians and not enough of their time is being used for capacity building. They suggest that decision makers need to closely monitor the increasing supply of providers and make appropriate interventions strategies.

Skill mix

Determining and achieving the right mix of health personnel are major challenges for most health care organisations and health systems. Health care is labour-intensive and health care managers strive to identify the most effective mix of staff that can be achieved with the available resources while also taking into consideration local priorities.

Skill mix in the health care workforce: reviewing the evidence by Jim Buchan and Mario Dal Poz reviews publications that examine the skill mix in health care. Much of the literature is based on experiences from the USA , although analyses from other countries are used, where available. The paper gives a brief overview of the determining factors that should be taken into consideration when assessing and adjusting skill mix. It then summarises the main findings from a literature review, highlighting the evidence on skill mix that is available to inform health system managers, health professionals, health policy-makers and other stakeholders.

Coverage and skill mix balance of human resources for health in Myanmar considers the current distribution and balance of skill mix in various townships. The paper explores the expansion of township hospital beds, Rural Health Centres (RHCs) and sub-centres and questions whether the current skill mix is appropriate and cost-effective for the rural areas.

Further resources

- **Task shifting for a strategic skill mix**

- **Skills-mix and policy change in the health workforce: nurses in advanced roles**
- **Imbalances in the health workforce: a briefing paper**
- **Determining skill mix in the health workforce: guidelines for managers and health professionals**
- **Strategies for assisting health workers to modify and improve skills: developing quality healthcare - a process of change**

Migration

Health professionals form the biggest group of skilled migrants. This is facilitated by the fact that within the profession there is a globally shared knowledge base. While some of the world's richest countries benefit from this movement of health workers, it generally has a negative impact on health services in some of the world's poorest countries.

Efforts underway to stem "brain drain" of doctors and nurses outlines actions currently being taken to combat the problem of developing countries losing health care professionals through migration, including codes of conduct and exchange programmes.

However, many have argued that current policy responses to migration of health professionals from low income developing countries underestimate the pressures and miss-identify the reasons for rising migration. The authors of **The 'skills drain' from the developing world** argue that these policies also overestimate the impact of recruitment policies on migration flows and ignore the unintended side effects, and ethical dilemmas involved.

In **Briefing note on international migration of health professionals: levelling the playing field for developing country health systems** the authors attempt to provide increased clarity on the key issues surrounding the international migration of health professionals from developing countries and the resultant impact on health services. Initially providing an overview of the extent of the knowledge base upon the impact of international migration by health workers, the paper then explores contemporary influences on migration and finally examines policy issues relating to different levels and different stakeholder groups.

International recruitment of health workers

International recruitment needs to be managed to avoid negative impact on the health systems of developing countries. However individual freedom and the right to emigrate will always keep a number of migrant nurses and doctors moving across borders. Consequently, issues concerning the welfare of immigrant health workers also need to be addressed.

Health workers are often found to be part of the refugee community in developed countries. In order to tackle the shortage of nurses and doctors in London, the Mayor of London Office in 2002 commissioned a study to identify skilled professional among the refugee population. The main finding of the study was

that a number of refugee nurses and doctors were willing to be employed by the health system. The report calls for an ethical treatment of these professionals and recommend support for these workers to be able to enter the health workforce. See **Missed opportunities**.

Research has demonstrated the vulnerability of overseas staff in health systems. For example, overseas nurses recruited by private agencies or directly by nursing homes in the UK are exposed to exploitation during the recruitment process as well as during their professional practice. See **We need respect**.

The study, **Researching equal opportunities for overseas-trained nurses and other healthcare professionals** explores the experiences of overseas-trained nurses and other health professionals, public and private health services in the UK. The authors found that overseas trained nurses' skills and experiences were generally not recognised, and that they face discrimination in the workplace.

Positive practice environments provides an overview of the influences of international policies and agreements on nurses experiences. It also explores the social and personal benefits and costs of migration for international nurses and outline framework to develop positive practice environments to support long-term integration and the retention.

Two third of the overseas nurses working in the UK are recruited with the support of specialised recruitment agencies. (See **Should I stay or should I go?**) Yet, the role of recruitment agencies in international migration has attracted limited attention in the research agenda. Susan Maybud and Christiane Wiskow in **Merchants of labour** explored how these agents not only facilitate recruitment but also instigate migration of highly needed health professionals from countries facing serious problems of shortages of HRH.

Source (countries from where migrants emigrate) and destination countries need to ensure that the movement of health professionals is guided by ethical rules. John Connell and Barbara Stilwell argue that source countries need to ensure adequate production and retention of their own staff. Destination countries need to improve their recruitment standards ensuring equitable standards and a return of losses incurred by source countries. See **Merchants of labour**.

Codes of practice for international recruitment

Given that international recruitment has been blamed for nursing and doctor shortages in developing countries, some countries which are destinations for migrant health workers, such as the UK, have now introduced codes of practice for ethical recruitment of health personnel. But compliance is purely voluntary, and they do not regulate the private sector, which continues to recruit nurses from overseas. **Ethical international recruitment of health professionals: will codes of practice protect developing country health systems?** reviews the use of codes of practice (and similar instruments), as a means of managing the migration of health professionals from developing countries where staff are in short supply.

See also:

- **Commonwealth Code of Practice for the International Recruitment of Health Workers**

- UK Code of Practice for the international recruitment of healthcare professionals

Retention

Improving retention of health professionals within national health systems is one of the main challenges for HRH managers and policy makers. Interventions at this level require strategic packages rather than single approaches. Often these strategic elements fall under different sectors, increasing the complexity of the process.

Low retention of health professionals in sub-Saharan Africa results in the loss staff with the most experience going abroad for improved professional and economic development. This has left many health systems in the region on the verge of collapse. See **Supporting the retention of human resources for health**.

Retaining health workers in low-income countries needs to be addressed in a number of ways. For instance, increasing the production of health workers will have a limited impact if is not coordinated with good retention. Low-income countries have been adopting policies to improve retention of health workers in the last decade with different results. See **Retention of health care workers in low-resource settings**.

Further resources on retention

- Retention of health care workers in low-resource settings: challenges and responses
- A study identifying factors affecting retention of midwives in Malawi
- Nurse turnover: a literature review

Further reading on international migration

- The migration of physicians from sub-Saharan Africa to the United States of America: measures of the African brain drain
- International nurse mobility: trends and policy implications
- Developing evidence-based ethical policies on the migration of health workers: conceptual and practical challenges
- International migration of health workers: labour and social issues
- Managing the migration of health-care workers
- Migration of highly skilled persons from developing countries: impact and policy responses
- Medical migration: who are the real losers?

Human resource management

Human resource management (HRM) – a major determinant of any system's performance – has been overlooked in the health sector until recently. While the non-health sector has defined and evaluated the effects of HRM interventions, the particular nature of the health sector makes difficult to apply lessons learned from elsewhere. However, one lesson that can be applied to HRM in health is that single or uncoordinated interventions are less likely to achieve performance improvements than strategic packages. See **What difference does (good) HRM make?**

The importance of human resources management in health care: a global context considers the importance of HRM in improving overall patient health outcomes and delivery of health care services. The authors argue that proper management of human resources is critical in providing a high quality of health care. The authors argue that a refocus on HRM in health care and more research are needed to develop new policies. New and effective human resources management strategies are needed to achieve better outcomes from and access to health care around the world.

Defining roles and competencies

Competencies – what a person is capable of doing, rather than what they are doing – help address both behavioural and technical skills needed to define job expectations and requirements. They provide a common language and framework for those critical – but sometimes elusive – aspects of job performance and are an effective tool for communicating about performance because they help people frame expectations and goals in clear terms. See the **generic roles and competencies project**.

Defining and maintaining job descriptions

Job descriptions are the basic organising element in any organisation. They document an employee's tasks and responsibilities, what his or her authority is, and what skills and qualifications are necessary to do the work. They form the basis of the contract an individual holds with the organisation. Definition of appropriate job descriptions contributes to improve efficiency of the workforce. They need to be dynamic and flexible allowing for revision and adaptation to new situations, expanding or focusing the scope of intervention according to needs. Changes in job description should always be accompanied by educational support to ensure appropriate skills. See **The Health and Family Planning Manager's Toolkit**.

Improved supervision

Supervision of staff in health care has two aims: to ensure the quality of program and clinic operations; and to enable staff to perform to their maximum potential. Traditional approaches have focused on 'inspecting' facilities and 'controlling' individual staff performance. However, improving performance and maintaining standards through individual supervision is impractical: most services are complex and the result of coordinated team effort, and are not dependent on the actions of a single individual.

Further resources:

- **Guidelines for implementing supportive supervision: a step-by-step guide with tools to support immunization**
- **Making supervision supportive and sustainable: new approaches to old problems**

Professional development and training

Contemporary specificities of labour in the health care sector: introductory notes for discussion argues that the rapid development of health innovation systems means that knowledge can become out of date. The authors argue that continued education and training of health personnel will help overcome these barriers and improve the labour status of the sector.

Further resources:

- **WHO recommendations for clinical mentoring to support scale-up of HIV care, antiretroviral therapy and prevention in resource-constrained settings**
- **Educating to improve population health outcomes in chronic disease: an innovative workforce initiative across remote, rural and Indigenous communities in northern Australia**

Work environment

The work environment has a strong influence on job satisfaction and turnover. Decisions to emigrate by nurses and doctors are often related to a poor working environment. Low recognition, poor communication, poor supervision and career stagnation are some of the most cited factors. Magnet hospitals, despite being a concept developed in more industrialised countries, is a good example of how a good work environment can increase retention of health workers . See **A lasting attraction? The "Magnet" accreditation of Rochdale Infirmary**

Further resources

- **What makes a good employer?**
- **Perceptions of health workers about conditions of service: A Namibian case study**

Tools for HRH management

- **MSH Improving human resource management**
- **WHO tools and methodologies for the health workforce**
- **HRH Global Resource Centre** Tools
- **HRH Tool Compendium**

Resources from the US and the UK

- **UK Department of Health: human resources and training**
- **UK Chartered Institute of Personnel and Development**
- **Health Care Workforce Toolkit - from the American Hospital Association**

Absenteeism

Absenteeism among health care workers is a barrier to effective health service delivery and is caused by a number of factors.

Governments in developing countries spend substantial amounts of money on public services including publicly supplied health care. Despite this, dissatisfaction is frequently expressed over the performance and quality of these services. One possible reason for this is that not enough money is allocated to them; another is that the money is not spent effectively. The paper **Ghost doctors** attempts to quantify one particular way in which public money may not be spent effectively via a study in which unannounced visits were made to health clinics in Bangladesh with the intention of discovering what fraction of medical professionals were present at their assigned post.

This survey represents the first attempt to quantify the extent of this problem on a nationally representative scale. Nationwide, the average number of vacancies over all types of providers in rural health centres is a very large 26 per cent. Regionally, vacancy rates (unfilled posts) are generally higher in the poorer parts of the country. Absentee rates at over 40 per cent are particularly high for doctors. When separated into level of facility, the absentee rate for doctors at the larger clinics is 40 per cent but at the smaller sub-centres with a single doctor, the rate is 74 per cent. Even though the primary purpose of this survey was to document the extent of this problem among medical staff, we also explore the determinants of staff absenteeism. Whether the medical provider lives near the health facility, has access to a road, and rural electrification, are important determinants of the rate and pattern of staff absentee rates

Also see Wastage in the health workforce.

Dual working

It is quite common in countries where there are both public and private health care systems that many doctors work in both sectors at the same time . There are few studies, however, that analyse the complex relationships that exist between the two sectors and, therefore, the conflicting interests that arise from the doctors' dual activity. Listed below are a number of suggested readings that address this issue.

Dual job holding by public sector health professionals in highly resource-constrained settings: problem or solution? analyses some possible policy options to regulate dual practice in low income countries .

The review **Multiple public-private jobholding of healthcare providers in developing countries**, by Peter Berman and Dexter Cuixon, examines the systemic and individual causes of multiple jobholding and evidence on its prevalence through an analysis of country-level conditions. It proposes more action

in terms of research, innovative implementation and evaluation, and the participation of health workers in a varied strategy of policy development and implementation, in order to identify feasible ways forward.

The article **Who moonlights and why? Evidence from the SIPP** examines the characteristics of moonlighters and the length of their moonlighting episodes with the goal of understanding who moonlights and why. The analysis of data reveals that most moonlighters, in spite of working long hours, tend to be poorer than the average worker.

The dynamics of dual job holding and job mobility presents a model which seeks to explain why and when workers take on second jobs and presents new insights into the economics of dual job holding and labour mobility.

The economics of multiple job holding investigates the determinants of the moonlighting supply function in terms of demographic and market factors and describes the relationship between primary and secondary employment.

Should physicians' dual practice be limited? An incentive approach examines the specific implications that dual activity has for public health authorities. The main objective is to analyze the circumstances under which the health authorities benefit from the doctors' dual practice and those under which they lose. The article finds that physicians will have incentives to over-provide medical services when they use their public activity as a way of increasing their prestige as a private practitioner.

Performance management

Efficient performance of tasks is an essential element to strengthening health systems. Monitoring productivity is well established in the industrial sector and in some areas of public services as well. Analysing performance provides managers and policy makers with important information to make appropriate health workforce decisions.

Productivity among nurses and midwives in Botswana highlights the importance of educational factors over economic incentives in the performance of the nursing and midwifery staff. The study provides information not only about the level of existing performance but also provides guidance on how to carry out further interventions aimed to improve the productivity of health workers.

A study by **Manzi et al**, exploring the influence of workplace trust over health worker performance at primary care level, was conducted in Tanzania and South Africa in 2003. Reasons for poor performance and motivation included staff shortages, low salaries, and poor working conditions. Respondents also cited lack of transparency in human resource management practices, limited supervision and monitoring, weak disciplinary procedures and limited and slow opportunities for promotion. The authors conclude that, although salary levels were seen to be important, they were not necessarily the most important issue.

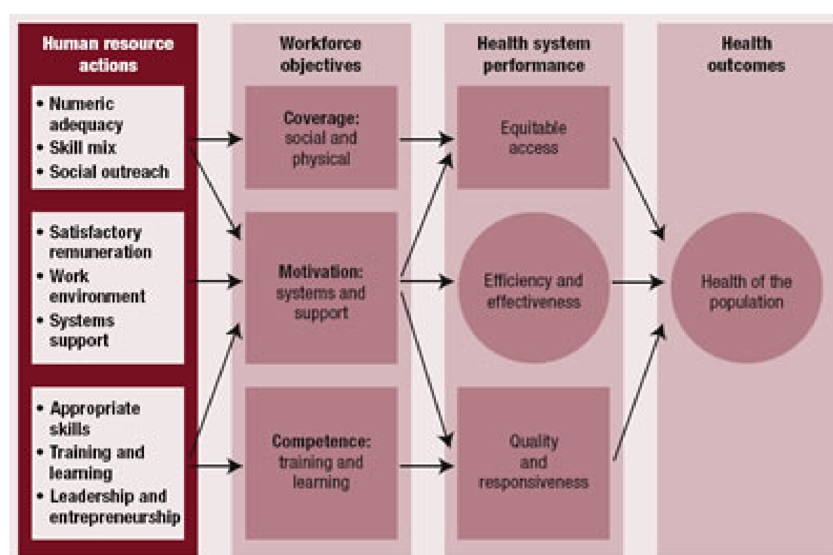
Performance management helps organisations achieve their strategic goals. It reminds us that being busy is not the same as producing results. It also influences the motivation of health workers. In Mali,

operational research was conducted to identify the **match between motivation and the range and use of performance management activities**. The results showed the importance of adapting or improving upon performance management strategies to influence staff motivation.

With the need to improve the operational performance of health systems, there is a growing acceptance that assessing the performance of health systems needs to extend beyond a purely clinical performance focus and include managerial performance. In other words, setting goals for the efficiency, effectiveness and equity of the health system is a legitimate focus for health service policy making. In order for managers to meet these goals methods must be developed to set realistic achievement targets, to measure progress towards these targets and, ultimately, for managers to be held accountable for their actions in achieving targets.

Chapter 3 of the **JLI Report** presents a framework for managing performance. This framework outlines a number of human resource intervention that focus on workforce coverage, motivation and competence. The framework also outlines how these will improve health systems performance and result in better health outcomes.

Managing for performance



Source: JLI Report HRH Overcoming the Crisis, p. 71

The authors of the JLI outline how the elements of the framework are interactive and can be complex. For instance, coverage is determined not just by the number of workers but also by their skill mix, geographic placement, available resources and support, and social compatibility with patients. Many countries that have large numbers of workers are still unable to generate full coverage because of skill misfits or geographic imbalances. Similarly, a lack of health workers may highlight the need for a stronger educational infrastructure for training doctors and nurses. It could also be a sign of inappropriate production targets, where there should be shorter training for more auxiliary workers.

Introducing performance management in national health systems: issues on policy and implementation uses preliminary research results from 15 case studies to examine the prerequisites for successful introduction of performance management systems which are appropriate for developing country situations. The key message and conclusion is that it is important to measure and value staff performance, but that this requires levels of organisational management and an external policy environment that are often not in place in a developing context.

Guidelines for introducing human resource indicators to monitor health service performance, written by Peter Hornby and Paul Forte from the Centre for Health Planning and Management, outlines why and how to develop and use health workforce performance indicators to improve management. It is aimed at policy makers and managers in national health systems.

Further reading on performance management

- **How can we achieve and maintain high-quality performance of health workers in low-resource settings?**
- **The health and family planning manager's toolkit**
- **Validating a work group climate assessment tool for improving the performance of public health organizations**
- **Ghana case study: staff performance management in reforming health systems**
- **Testing how management matters in an era of government by performance management**
- **Recognising, understanding and addressing performance problems in healthcare organisations providing care to NHS patients**

HIV and AIDS

In low-income countries with a generalised HIV epidemic, HIV and AIDS has considerably exacerbated existing human resource problems. It has placed a double burden on an already overstretched and poorly functioning health workforce. Workloads have increased through the growing demand for services such as counseling and testing, diagnosis and prevention and treatment of opportunistic infections, while the supply of health workers has decreased as they themselves have become infected, fallen sick and died. Direct costs to health sector have been in the form of lost productivity due to absenteeism resulting from illness, attending others' funerals and caring for sick relatives, and death.

Human capital and the HIV epidemic in Sub-Saharan Africa (Cohen ILO 2002) outlines how the HIV epidemic not only reduces the stock of those with higher level professional and managerial training and experiences, but also reduces capacity to maintain the flow of those with needed skills and training. Training and educational institutions are themselves losing staff due to HIV and AIDS, reducing their capacity to meet growing demands.

Hospital beds are now dominated by patients with HIV and AIDS related illnesses, such as pneumonia and TB, which are complex to treat and generally require longer hospital stays than other illnesses. Nurses have had to work longer hours due to the growing demand for services but also to cover for staff

shortages resulting from the epidemic. Overall, the AIDS epidemic has weakened staff morale and motivation. Health workers have felt a sense of professional inadequacy in the face of such high mortality, and the perception of occupational risk of infection has remained high.

HIV/AIDS, equity and health sector personnel in Southern Africa (Aitkin and Kemp EQUINET 2003) identifies how increased stress and fear amongst health workers as a result of HIV and AIDS have been important push factors in their leaving the public health sector and migrating overseas. Health worker attrition related to HIV and AIDS has worsened the existing rural urban bias in the distribution of human resources within the sector. The human resource gap is projected to get worse as the disease progresses and a higher number of staff contract HIV.

The recent global movement towards incorporation of antiretroviral treatment (ART) into a comprehensive HIV approach to prevention, treatment and care (see **Treating 3 million by 2005: making it happen, the WHO strategy**) poses new human resource challenges. **Estimating health workforce needs for antiretroviral therapy in resource-limited settings** argues that availability of trained health workers will be the single biggest obstacle to scaling up ART, and estimates that between 20,000 and 100,000 doctors, nurses and pharmacists would be needed to meet the WHO target.

Human capacity-building plan for scaling up HIV/AIDS treatment outlines a strategic plan for WHO to support the development, strengthening and sustaining of the workforce necessary to radically scale up and maintain antiretroviral treatment. **Scaling up HIV/AIDS care** outlines the staffing requirements of different systems of ART delivery and points to existing solutions to the human resources issues that are involved.

Treatment within a continuum of care will require new clinical and management skills, including provision of palliative care, laboratory monitoring and the ability to ensure treatment adherence to prevent development of drug resistance. Demand for ART will be cumulative since it is required for life. **Provision of antiretroviral therapy in resource-limited settings: a review of experience up to August 2003**(Attawell and Mundy, HSRC 2003) identifies human resource shortages as a major constraint to ART scale up affecting the capacity to absorb new resources and provide quality ART, and meet cumulative demand for chronic care.

To help mitigate the HR problem related to prevention, treatment and care, WHO in **A public health approach to antiretroviral therapy: overcoming constraints** (WHO 2003) recommend reducing the reliance on qualified health staff by devolving responsibilities to other less qualified health care workers, such as clinical officers, pharmacy technicians and lay counselors. They also stress the importance of involving communities, particularly in provision of psychosocial support and adherence counseling, and in the selection of who receives ART. **Expert patients and AIDS care** considers how people with HIV themselves could play a greater role in ART provision.

As is the case for treatment of other sexually transmitted infections (STIs), it is likely that private providers will provide a substantial proportion of ART treatment. **Antiretroviral treatment in developing countries: the peril of neglecting private providers** (R. Brugha in BMJ vol 326 2003) outlines some of the poor ART practices already taking place within the private sector, such as provision of incorrect doses and the indiscriminate switching of different therapies. An equally worrying finding

was the belief by some private patients of ART to be a cure for HIV. Clearly, an urgent HR challenge is the improvement of government stewardship of ART provision in the private sector.

Poorly planned HIV and AIDS treatment and care scale up could have a detrimental impact on health systems, by diverting scarce human resources away from other essential health services. Viewed in a positive way, the prospect of substantial new resources for ART can be seen as an opportunity for strengthening health systems broadly and human resources specifically. For this to happen, HR planning for ART needs to be integrated into sector wide HR plans, which in turn need to be part of national level multi-sectoral poverty reduction planning processes. ART resources could then be used to address systemic HR problems, such as low pay and retention, and geographical imbalances.

Suggested further reading

- **The impact of HIV/AIDS on human resources: a literature review**
- **HIV/AIDS, human resources and sustainable development**
- **The impact of HIV/AIDS on the health sector in Sub-Saharan Africa: the issue of human resources**

International initiatives in human resources for health

During the last two years, there has been an increase in the development of new initiatives concentrated in health workforce issues. More than 75 health funds and partnership have been created. See **Mapping Global Health Partnerships**.

The **Global Health Workforce Alliance** (GHWA) is a new international partnership that is dedicated to identifying and implementing solutions to the health workforce crisis. It brings together a variety of actors, including national governments, civil society, finance institutions, workers, international agencies, academic institutions and professional associations. The GHWA draws together and mobilises key stakeholders engaged in global health to help countries improve the way they plan for, educate and employ health workers. The World Health Organization (WHO) will host its secretariat.

The **Joint Learning Initiative on Human Resources for Health and Development (JLI)** was launched in November 2002 by the Global Health Trust in recognition of the centrality of the workforce for global health. The JLI was a consultative process that was intended to increase creativity, innovation and dialogue. The process resulted in the JLI Strategy Report **Overcoming the Crisis.** The report suggests that action based in the community, with leadership at country level and globally supported is the best approach. The report calls for strengthening health systems, mobilising to combat health emergencies in crisis countries and building a knowledge base.

EU strategy for action on the crisis in human resources for health in developing countries sets out the action that the European Union intends to take to help developing countries solve their worsening human resources problems. In May 2006 the EU Council adopted a **package of action oriented decisions**derived from the strategy for action on the crisis in human resources for health in

developing countries. This includes incorporating human resources issues into Poverty Reduction Strategies and health policy discussions, and supporting and financing national human resources plans.

A central theme that runs through many recent initiatives is the importance of leadership at country level. This creates both challenges and opportunities for country HRH policy leaders and advocates. Country leadership:

- reduces dependence on external decision-makers but it increases accountability for action
- provides frameworks for action but it increases the number of stakeholders
- raises visibility and political attention to health but implies greater involvement with actors outside the health sector
- It means that action on HRH will necessitate building new coalitions for analysis and decision-making among the multiple actors who need to be engaged for effective change on HRH matters

For the first time the G-8 (Group of Eight major industrial countries) **summit in April 2006** included a Health Ministers' meeting with participation of the EU, China, Brazil, Mexico, South Africa and representatives from UN agencies for Health. Human resources for health was recognised as one of the main areas in need of support.

By 2002, the secretariat of the **Global Fund to Fight AIDS, TB, and Malaria (GFATM)** was established, reflecting a growing political commitment to health improvement in developing countries. The Fund has already delivered 2 billion USD in the fight against these three major diseases. It now provides some funding for HRH through health systems strengthening interventions. However, few countries have taken advantage of this opportunity as of yet. The authors of **Health workforce issues and the Global Fund to Fight AIDS, Tuberculosis and Malaria: an analytical review** argue that countries should go beyond short-term objectives and link their Global Fund activities to a long-term development of their human resources for health.

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Developing country initiatives

The number of initiatives among developing countries has increased in the past few years. **TOUCH** is a charity that was created in January 2005 to help train more doctors, nurses, pharmacists, dentists, and other health care workers in developing countries.

The **health strategy of the New Partnership for Africa's Economic Development (NEPAD)** manifests a political commitment similar to the GFATM concerning African countries. In 2002 the Council of the African Union (AU) called upon its members to develop realistic plans for Human Resources for Health (HRH) and requested the establishment of an international partnership for HRH.

Private sector involvement

Within the World Trade Organization, the **2001 Declaration on the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement and Public Health** addresses public health issues, especially pharmaceutical policy issues, in connection with the ongoing effort for trade liberalisation. The commitment of many major multinational enterprises to address HIV/AIDS, TB, and malaria is reflected in **Global Health Initiative of the World Economic Forum.**

Actions

The commitment of the international community is also reflected in a wide range of initiatives for policy change, new instruments for providing development assistance, and new tools, all with potential for impact of human resources for health. The list below includes selected actions on individual health-specific conditions and diseases (often known as 'vertical programmes'), and examples of bilateral assistance.

Africa

Health systems have reached the breaking point in many countries in sub-Saharan Africa . With increased commitments from international donors and other global initiatives such as the **Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM)** and the **Global Alliance for Vaccines and Immunization (GAVI)**, more money is available now than ever before to improve health systems in Africa. And there is a growing consensus that human resources are a vital part of improving African health systems and making progress towards the MDGs.

The World Health Organization African Regional Office (WHO-AFRO) highlights the importance of the health worker in **Placing health workers at the heart of health services delivery in Africa**. This brochure outlines how health workers are central to making the best possible use of other resources and investments in the health sector.

The **NEPAD (New Partnerships for Africa's Development) Health Strategy** also highlights the importance of human resources and identifies it as a priority in its strategy. Its action plan aims to strengthen and improve training programmes for health care workers, as well as improving and increasing the capacity of public health training in Africa more generally.

However in the editorial **Human resources for health in Africa**, Adetokunbo Lucas argues that training alone is not enough. Lucas calls for strong African leadership to direct debate and discussions to establish national and local needs for health workers. Lucas also highlights the need for countries to develop human resources for health policies that are relevant, affordable and sustainable, and that are realistic about the migration of trained health workers.

With this increased international, national and regional focus on HRH in Africa comes the need for better HRH data and information. In order to effectively respond to the HRH crisis, information on the key issues such as international migration, international recruitments and trends, distribution imbalances, production of health workers, freezing on recruitment due to Structural Adjustment Programmes (SAPs), impact of HIV and AIDS on the health workforce, scaling up of priority interventions, motivation and retention challenges, among others is needed. This has led to the creation of the **Observatory of Health Human Resources for Africa**. This observatory will be a cooperative network initiative among the countries and different partners of the region promoted by African Regional Office of the World Health Organization (WHO AFRO) . It will produce information and knowledge necessary for improving human resources policy decisions, and sharing the country experiences in order to improve human resource development in the health services.

Human resources for health are not just an issue for Ministries of Health to deal with. Often factors affecting recruitment and retention in the public sector are linked to wider public sector problems and need to be addressed through public sector reform.

Reasons for human resource problems in African health systems are complex. F actors such as the financial cutbacks as a result of structural adjustment, as well as misdirected human resource and training policies, weak institutions, and inappropriate structures all contribute to these problems. Moreover, they vary greatly between and within countries. This means that solutions will be complex and are dependent on the political, economic, historic and social context of each country.

Capacity building and health worker training

Central to the issue of human resources is capacity building and health worker training. Factors such as the shortage of health workers and the need to scale up ARV treatment critically impact upon African countries' capacity to produce enough, properly trained health care workers to deliver adequate health services.

A major joint initiative by the WHO (World Health Organization) and the World Bank - Building strategic partnerships in education and health in Africa - brought together African stakeholders in the development and management of human resources for health from a wide range of interested countries. The collaborative approach between health professionals, government and other stakeholders mirrors the successful PAHO (Pan American Health Organization) initiative of **human resource observatories** in Latin America.

Participants at this consultation identified a lack of information available for health care providers and a lack of reviews of educational institutions and programmes as key issues in the human resource crisis.

Agreed priority areas of action included ensuring relevant education and training for health professionals and forging partnerships between health and education sectors.

The report **Investing in Tanzanian human resources for health** argues that the only effective means of really addressing the HRH challenge in Tanzania is to immediately scale up training capacity. The authors outline how this approach is relatively inexpensive when the long-term benefits are considered.

However, **Human resources for obstetric care in northern Tanzania** argues that there are adequate numbers of suitably trained health care workers in Tanzania to meet the national standards for health care delivery. But most are concentrated in a few centralised locations and the remainder are inefficiently and inequitably distributed in rural areas. The authors conclude that availability of trained staff does not translate into availability of obstetric care due to these distributional problems, and argue that more attention should be paid to quality of care, rather than just coverage.

What is the access to continued professional education among health workers in Blantyre, Malawi? finds that most health care workers had little access to professional journals and internet facilities and few were satisfied with their own knowledge of health matters. The authors recommend improving access to relevant publications and regulating mandatory continuing professional development credits for re-certification.

A model for analysis, systemic planning and strategic synthesis for health science teaching in the Democratic Republic of the Congo: a vision for action looks at which educational, environmental and organisational factors are needed to improve the skills and ability of trained health workers. The authors argue that a global and integrated approach to training, which addresses the complex determinants of health behaviour, is needed. Moreover, this multi-disciplinary approach needs to be integrated within the existing organisational structure of the Ministry of Health.

The capacity of health workers is not only affected by levels of education and training. Organisational changes such as health sector reform need to address the capacity of staff to implement reforms successfully.

Human resources and the success of health sector reform examines the impact of health sector reform on staff in Zambia. The authors found that there was little strategic planning and capacity to implement new personnel management systems at decentralised levels. Moreover, newly created management systems were inadequately staffed to meet the challenges of the new system and became further distanced from high level decisions.

The authors argue that key diagnostic questions need to be asked to help policy makers and planners identify key issues relating to human resources (HR) when developing and implementing health sector reform.

- Is HR an integral element of the reforms agenda, from pre-planning through to implementation and evaluation?
- Is there sufficient capacity to implement the necessary changes in HR, and to deal with the challenges that will arise?
- Does the health care workforce understand the need for the reforms? To what extent does it support the reform plan?

Online training resources

- **Treating HIV & AIDS: a training toolkit**
  This project by aidsmap is intended to support the scaling-up of antiretroviral therapy in resource-limited settings. It was developed with the support of doctors providing training on ARVs in Botswana, Kenya and South Africa.
- **Increasing healthcare professionals' knowledge of HIV/AIDS and reproductive health through an email course**
  JHPIEGO offered two e-mail courses under its Training and Reproductive Health Project, Meeting the Family Planning and Reproductive Health Needs of Clients with HIV/AIDS in Low-Resource Settings.

Africa: migration of health workers

The migration of doctors and nurses from Africa to rich countries has raised fears of an African medical brain drain. But empirical research on the issue has been hampered by lack of data. How many doctors and nurses have left Africa? Which countries did they leave? Where have they settled? A new database of health professional emigration from Africa is now available. This database includes information on the flows of African-born physicians and nurses to nine destination countries. It looks specifically at skilled professionals and is part of the US **Center for Global Development**'s ongoing research between on the links between international labour mobility and global development.

The Africa Regional Office of the World Health Organization (WHO AFRO), in **Migration of health professionals in six countries: a synthesis report**, outlines how the migration of skilled health professionals out of Africa has adversely affected the quality of care offered in health institutions.

However, both the WHO AFRO study and James Buchan and Delanyo Dovlo, in **International recruitment of health workers to the UK: a report for DFID**, find that the migration of African health care workers is not confined to migration out of the region. It takes place within countries from rural areas to urban areas and from poorer countries such as Malawi to richer countries such as South Africa .

With respect to doctors, migration from Africa to the United States (US) is particularly important. In the paper **The migration of physicians from sub-Saharan Africa to the United States of America: measures of the African brain drain,** the authors found that the majority of migrating African doctors to the US came from three countries – Nigeria, South Africa and Ghana. Furthermore, 79 per cent of these doctors were trained at only 10 medical schools. The findings suggest that policy interventions in only a few locations could be effective in stemming the brain drain.

The reasons for migration are often complex. Some developed countries have developed **codes of practice** intended to reduce active recruitment of health workers from countries where migration is a problem. However, there are a number of factors that motivate health workers to migrate.

Is there any solution to the "Brain Drain" of health professionals and knowledge from Africa?
Describes both the "push" and "pull" factors involved in migration of health workers. The pull factors

(factors drawing workers towards developed countries) include better pay and working conditions, job satisfaction, and prospects for further education. Push factors (factors pushing workers away from developing countries) are characterised by poor working conditions, which includes a lack of promotion and other career advancement opportunities.

While the loss of health worker adversely impacts on the local health system, **Buchan and Dovlo** highlight the beneficial effects of migrant workers sending money back to their families. For more on the impact of remittances, see the id21 insights on **Sending money home**.

Stopping health workers from migrating is neither an ethical or viable option, nor does it address the reasons for migration. Many have suggested ways of encouraging health workers to continue working in African health systems.

Adamson Muula suggests that adapting health training curricula to the African context in African medical schools and encouraging the development of specialist training programmes in African medical schools could also help to retain health care workers.

Actively managing migration could also be a way to maximise the benefits and minimise the problems it can cause. **Buchan and Dovlo** suggest that encouraging structured, temporary moves of staff to other organisations could help to build career and personal development opportunities as well as contribute to organisational development.

Ultimately, the work environment and benefits for health workers will need to improve for African health systems to retain staff. The **WHO AFRO study** suggests that African governments need to ensure regular and fair provision of a living wage for health professionals.

Africa: HIV and AIDS

The AIDS crisis is one of the most important factors driving the human resources crisis in Africa. UNAIDS's **most recent update** reports that 25.8 million adults are living with HIV in sub-Saharan Africa, with 3.2 million adults and children infected with HIV in 2005. With sub-Saharan Africa the hardest hit by HIV and AIDS, the impact of the crisis is felt at all levels of society.

Impact

The impact of HIV/AIDS on health systems and the health workforce in sub-Saharan Africa highlights how health systems may lose up to 20 per cent of their employees over the next several years. The demographic make up of the health workforce population is also a significant element when considering the impacts of HIV and AIDS. For instance, the demographic profile of health workers in Botswana is that female health workers outnumber male health workers by almost two to one. The authors argue that human resource plans will need to incorporate staff losses based on demographic, gender and socioeconomic factors.

Challenges confronting the health workforce in Sub-Saharan Africa details the specific health workforce challenges of HIV and AIDS in sub-Saharan Africa. These include: new demands of knowledge and skills, increased burden of work in an already stretched health system, increased safety

risks and increased rates of HIV among health workers. The authors argue that a comprehensive and coordinated approach, across several sectors of government, is needed to tackle these multiple issues.

The impact of HIV/AIDS on the health sector: national survey of health personnel, ambulatory and hospitalised patients and health facilities outlines how the increase in those needing care will also require additional services being made available. These include antiretroviral therapy, food security, improved nutrition, voluntary counselling and testing and home-based care.

It is not only clinical staff that are affected, as loss of workers and capacity impacts upon all levels of health systems. For example, key staff in ministries of health are affected with a loss of capacity to address serious systematic problems, making their ability to tackle the disease more difficult.

Human capital and the HIV epidemic in Sub-Saharan Africa outlines how the HIV epidemic not only reduces the stock of those with higher level professional and managerial training and experiences, but also reduces ability to maintain the flow of those with needed skills and training. Training and educational institutions are themselves losing staff due to HIV and AIDS, reducing their capacity to meet growing demands.

Human resources for health and the global HIV/AIDS pandemic suggests that increased funding is needed immediately to address the growing crisis. The author also suggests that establishing an African Human Resources observatory would promote evidence-based policy, and help policy makers to share experiences.

ARVs

A critical issue in considering the impact of HIV and AIDS on human resources is the ability to deliver ARVs (anti-retrovirals) to those who most need them. **Scaling up access to ART in southern Africa** argues that human, rather than financial, resources represent the main constraint to implementing treatment plans in southern Africa . Yet none of these countries currently has a comprehensive human resource strategy.

In **Scaling-up anti-retroviral treatment and human resources for health: what are the challenges in sub-Saharan Africa?**, Kaspar Wyss outlines how human resources for health issues are an essential component to scaling up ARV delivery in low-income countries in Africa . These constraints include the availability of personnel with clinical, nursing, counselling, pharmaceutical and laboratory skills are critical to the pace of scaling up delivery. The author suggests that increasing training capacity, including investments in institutions, is necessary to scaling up services. However, massive scaling up of ARV delivery may also seriously deplete the provision of other priority services and threaten the strengthening of district based health services.

In **Human resources for health and ART scale-up in sub-Saharan Africa** the authors stress the need to rethink the adequacy of current ART delivery models. They point to context-specific delivery models that rely much less on medical doctors in situations where they are in short supply. They argue that, in order to deal with necessary scale-up requirements, new models should be centred around expert patients and their communities, rather than doctors.

In Mozambique **the DREAM project** is attempting to scale up interventions for HIV and AIDS through an integrated approach to prevention and treatment, drawing on a range of trained health workers and community members.

Tools

- **Human resource management rapid assessment tool for HIV/AIDS environments: a guide for strengthening HRM systems**
  This rapid assessment toolkit aims to help strengthen managerial skills and the ability of human resource managers to respond to HIV and AIDS.

The role of the community

Overstretched health systems due to lack of personnel and increasing demands have led many to consider alternatives to standard health care models.

In the previous section, **Kober and Van Damme** stress the need to establish new models of ARV delivery based on the patient and communities in order to cope with the massive increase in demand. Experience from the International HIV/AIDS Alliance also highlights the important role of the community. **Human resources for health exist in communities** documents the role of community organisations in the provision of ARVs in Zambia and Burkina Faso. It argues that public health systems will struggle to duplicate the same levels of energy, drive and local accountability in community programmes. The authors call for communities to be incorporated into plans to expand access to ARV therapy in resource-limited settings.

It is not only HIV and AIDS services that have begun to use community resources. Non-clinical family planning services in Tanzania have also drawn on community based programmes. **Community-based distribution in Tanzania: costs and impacts of alternative strategies to improve worker performance** describes how the these programmes use community organisations, structures and institutions to promote the use of safe and simple contraceptive technologies.

Another study from Ethiopia, documented in **Teaching mothers to provide home treatment of malaria in Tigray, Ethiopia: a randomised trial**, finds mothers are able to take care of their sick children when taught and supplied with appropriate guidance and drugs for home medication. The authors call for more attention be given to what family and community-based efforts can achieve when properly designed and applied in an appropriate setting.

While the community can play a critical role in filling the gaps left by health worker shortages, it is essential that adequate training and remuneration are considered. **What motivates lay volunteers in high burden but resource-limited tuberculosis control programmes? Perceptions from the Northern Cape province, South Africa** finds that many participants volunteer in the hopes of gaining skills and finding paid work. The authors suggest that incentives such as gaining qualifications while volunteering might lead to a lower drop out rate.

Janowitz et al also suggest that paying community workers more can reduce the costs of programmes by improving the performance of the workers.