4. Addressing the health workforce crisis

“We have to work together to ensure access to a motivated, skilled, and supported health worker by every person in every village everywhere.”

Dr LEE Jong-wook, Director-General, WHO (high-level forum, Paris, France, November 2005)

The problem

The Global Plan to Stop TB 2006–2015 urges a dramatic scale-up of MDR-TB diagnosis and treatment. A 2007 addendum calls for the treatment of 1.6 million MDR-TB patients by 2015. Currently, about 20,000 MDR-TB patients per year (less than 5% of the estimated incident MDR-TB cases) are being treated within NTPs. To effectively manage and treat 1.6 million MDR-TB patients by 2015, a significant amount of additional skilled staff will be needed.

Not only the scale up of effective MDR-TB management, but also the effective prevention of MDR-TB, will depend on sufficient attention being given to human resource development (HRD). DOTS has been expanded rapidly in many countries. However, the expansion has not always been accompanied by adequate and continuous efforts to ensure sufficient training of staff, supervisory capacity and collection of essential human resource management information. This has had a severe effect on the quality of some programmes. In a survey of the 22 TB high burden countries (HBC), 17 out of 22 NTP managers identified inadequate human resources as the most important constraint for reaching TB control targets. Evidence from programme reviews in many HBC have shown that there is often inadequate central and peripheral level human resource capacity to ensure basic TB service quality, let alone capacity for expanding services into new interventions such as the diagnosis and management of MDR-TB.

The additional threats to the workforce posed by the HIV/AIDS epidemic, the increased demands on already overstretched health systems, and the stigmatization of some healthcare related occupations, have had a devastating effect on the availability of health workers in many countries. WHO estimates that 57 countries are facing a critical shortage of health service providers, and 15 of those countries are TB HBCs. The health

3 TB Control in the South-East Asia Region. Report of the annual meeting of NTP managers 2005 and 2007. SEA-TB-276 and SEA-TB 310 resp
Fourth Review of the NTP in Thailand 2007 SEA-TB-306
workforce crisis in TB control is therefore very clearly linked to wider health systems constraints.

The shortage of staff is exacerbated in many low-income countries by active recruitment for health-care workers on the part of the industrialized countries.

The solution

An imperative step to improve basic TB control and scale up of MDR-TB control is for ministries of health, NTPs and partners to urgently give the highest priority to HRD for the implementation of all components of the Stop TB strategy. An increased financing of HRD activities is a necessary part of that commitment. There are no simple solutions to the health workforce crisis. Whatever the circumstances however, effective short and long term workforce strategies to prevent MDR-TB and scale up MDR-TB control focus on addressing the three core challenges in HRD:

- improving recruitment;
- helping the existing workforce to perform better (including quality training);
- slowing the rate at which health workers leave the health workforce.  

Experience from a number of countries has shown that HRD is possible with determined and sustainable action and support from internal and external technical and financial partners:  

- Indonesia, for example, used a strategic approach to HRD from 2000 onwards. It included assigning a dedicated focal point for HRD within the NTP, the systematic review of existing competences based on task analysis and functions, the revision of existing training programmes and training material and the development of task and level specific training material for skills development; regular supervision to identify staff turnovers and performance problems; and organization of continuous education. External funding was used to recruit additional staff at central and provincial levels. These HRD steps were associated with a more than three-fold increase in case notification of new smear positive TB, from 52,000 to 175,000 cases between 2000 and 2006. Treatment success rates were sustained at over 85% and reached 91% in 2005. Although it is not possible to determine how much of the incremental success can be attributed to HRD, these key HRD steps were essential to ensure effective service delivery.

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Other countries (e.g. Bangladesh, Ethiopia, India, Kenya, Myanmar, Philippines, the United Republic of Tanzania) have used external funding to implement activities aimed at addressing key challenges. Resources have been allocated for: “top-up” of salaries; effective and increased supervision; organization of regular review meetings at all levels; strengthening collaboration with NGOs and the private sector; improving the working environment; and by contracting staff to fill critical gaps in the health system.

Broader health-system wide HRD initiatives, such as the Emergency Human Resources Programme (EHRP) in Malawi, have been used as a basis for improved human resources for TB control. There is already evidence that the EHRP, which focuses on retention, deployment, recruitment, training and tutor incentives for 11 priority cadres, has resulted in a reduction in nurse emigration, increased enrolment in training programmes, and increased numbers of health staff: 40% more doctors, 50% more clinical officers and 30% more nurses in post in 2007 than in 2003.

Scaling up of pre-service training is a longer term goal, as the impact is not felt immediately due to training lag-time, and because expanding training capacity requires investment in people and infrastructure that itself takes time.

**Urgent action needed**

- Ensure that HRD needs for basic TB control and needs for scale up of MDR-TB control are included in overall health workforce planning and development.
- Revise/update strategic HRD plans (including private health-care providers) to improve basic TB control and to scale up of MDR-TB control.
- Collaborate and coordinate with other public health programmes, with other departments and services in the ministry of health (especially hospital and diagnostic services administration) and with other units in the provincial/district health services.
- Develop medium-term implementation plans to enable alignment with general HRD strategies and plans.
- Collaborate with HRH planning units/departments of MOH, donors and technical support agencies in long term HRD within health system development for staffing and retention.
- Include resources for technical assistance for revision/updating of the HRD in proposals to GF and other donors.