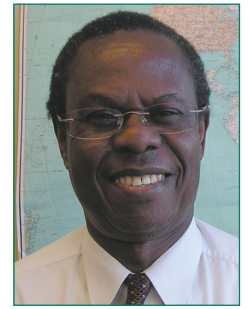


Working for an accessible, motivated and supported health workforce



Dr Francis Omaswa
Executive Director, Global
Health Workforce Alliance

One of the most important health goals was articulated by Lee Jong-wook: “Access to a motivated and supported health worker for every person in every village everywhere.” Whether one is ill, in need of urgent care but denied access to essential services due to the absence of a health worker – or looking from the perspective of an over-stretched health worker who is inadequately equipped and supported, and brings barely poverty-level wages back to the family – the crisis in human resources for health (HRH) is an old problem which has developed right in front of us, and has now been exposed and accentuated by fresh forces. Yet two to three decades ago, as a health worker in Africa, I enjoyed decent wages and good working conditions; and this was the case in many other sub-Saharan African countries.

The growth of a global momentum aiming to remedy the lack of trained health workers has meant that HRH is getting much more attention now than at the beginning of the decade. As many African leaders began to realise how the dismal state of health services and infrastructure, HIV/Aids and other major diseases, financial bottlenecks and brain drain issues were compounding one another and creating a vicious circle of lower health delivery, they began to take the problem to heart. These setbacks compound the pre-existing health burdens of poverty and weak health systems and intensify new fears, such as avian flu, sparking growing political imperatives to respond effectively.

The problem may be most acute in Africa, but the whole world has been affected one way or another.

Recognising that this crisis is also jeopardising the Millennium Development Goals (MDGs), three consecutive World Health Assemblies produced resolutions on several aspects of the HRH crisis (WHA57.19, 58.17 and 59.23 in 2004, 2005 and 2006 respectively). These resolutions were mostly tabled by African countries, but received unanimous support: the problem may be most acute in Africa, but the whole world has been affected one way or another.

Strategies for overcoming the workforce crisis were unanimously recommended by over 100 global health leaders in the landmark report of the Joint Learning Initiative: *Human Resources for Health: Overcoming the*

Crisis. The Oslo Consultation in February 2005 brought together key global stakeholders to achieve consensus around a ‘common global platform of action’. Three high-level forums for the health-related MDGs in Geneva, Abuja and Paris identified the challenges and endorsed the creation of a global alliance to oversee the implementation of a worldwide plan of action in November 2005.

As a part of this momentum, many global health initiatives (such as the GAVI Alliance or the Global Fund to fight Aids, TB and Malaria) and international agencies (such as the World Bank or UNAIDS) are focusing on this crisis, as it is seriously affecting their ability to fulfil their mandates. Consequently, the danger now lies in the multiplication and fragmentation of channels of action, which may lead to duplication of work as well as gaps in the response.

GHWA and its structure

A truly comprehensive response to the global HRH crisis calls for concerted, coordinated and sustained action from the multiple key players within sectors and institutions and across sectors, disciplines, countries and world regions. The Global Health Workforce Alliance (GHWA) represents the collective recognition of responsibility by national, regional and global leaders to address this complex yet central and essential component of health sector performance and social development.

Launched in May 2006, GHWA has a major role to play on the new HRH scene: that of a convener, a watchdog, an open partnership inclusive of all stakeholders. To avoid the pitfalls of patchy (though well-meant) responses to

alleviate the crisis, GHWA seeks to involve all the interested parties: governments, civil society, global health initiatives and partnerships, professional associations, academia, UN and other intergovernmental agencies, as well as foundations and other donors – although GHWA is not a funding entity as such.

GHWA's structure is akin to other partnerships: it has a Board, chaired by Dr Lincoln Chen, whose membership seeks to include GHWA's stakeholder categories and the major world regions. The Secretariat, which is housed at and administered by the World Health Organization (WHO) in Geneva, is led by the Executive Director and is the operational arm of GHWA. Task Forces and Working Groups are being set up to deal with specific challenges such as migration, financing, access to HIV treatment and care, or advocacy. Membership of these Task Forces and Working Groups usually comes from GHWA member bodies, whose numbers are in constant growth. GHWA members are convened once a year for the Forum, the first of which is to take place in September.

The priority countries

The WHO, GHWA's partner and host, identified 57 countries – 36 of which are in Africa – in which the HRH crisis was so acute as to have a major detrimental impact on key indicators such as immunisation and maternal mortality, in its landmark *World Health Report 2006 – Working Together for Health*. The report further identified a ten-year plan of action to turn this situation around, thus providing GHWA with a blueprint from which to come up with its detailed plans.

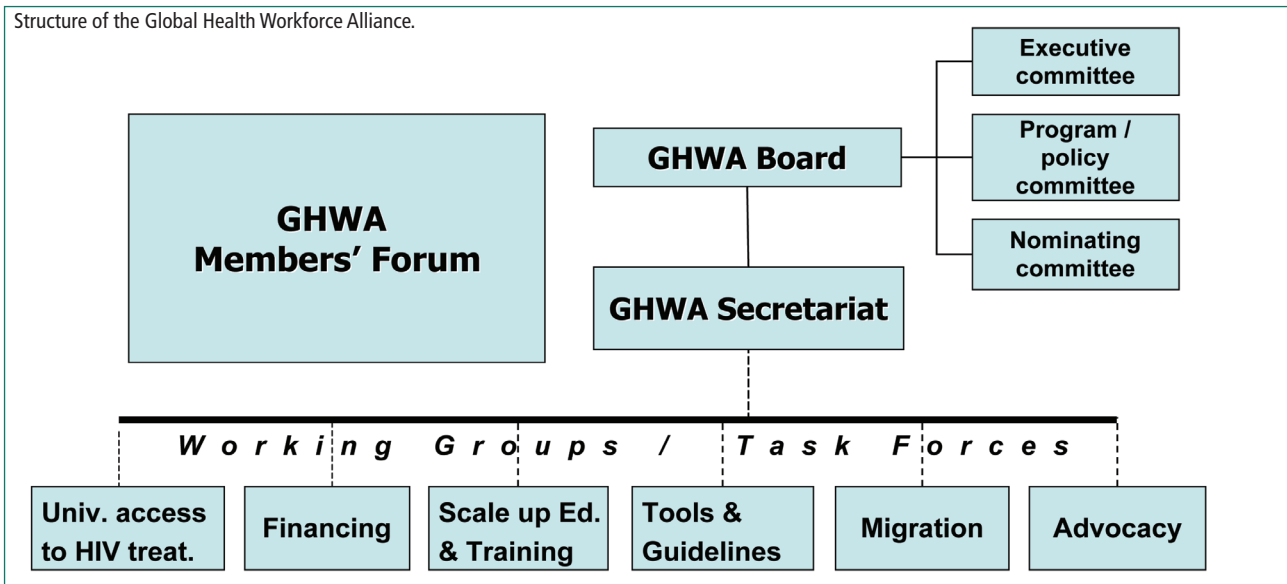
The challenge we must face in this multi-faceted and cross-sectoral issue is that, to be successful, action must take place on two levels: country and global. This fundamental strategy of GHWA has guided our plans and thoughts, for we understood that action must take place in countries first and foremost. At the same time, global action is needed based on the recognition that country work can be hampered by international issues.

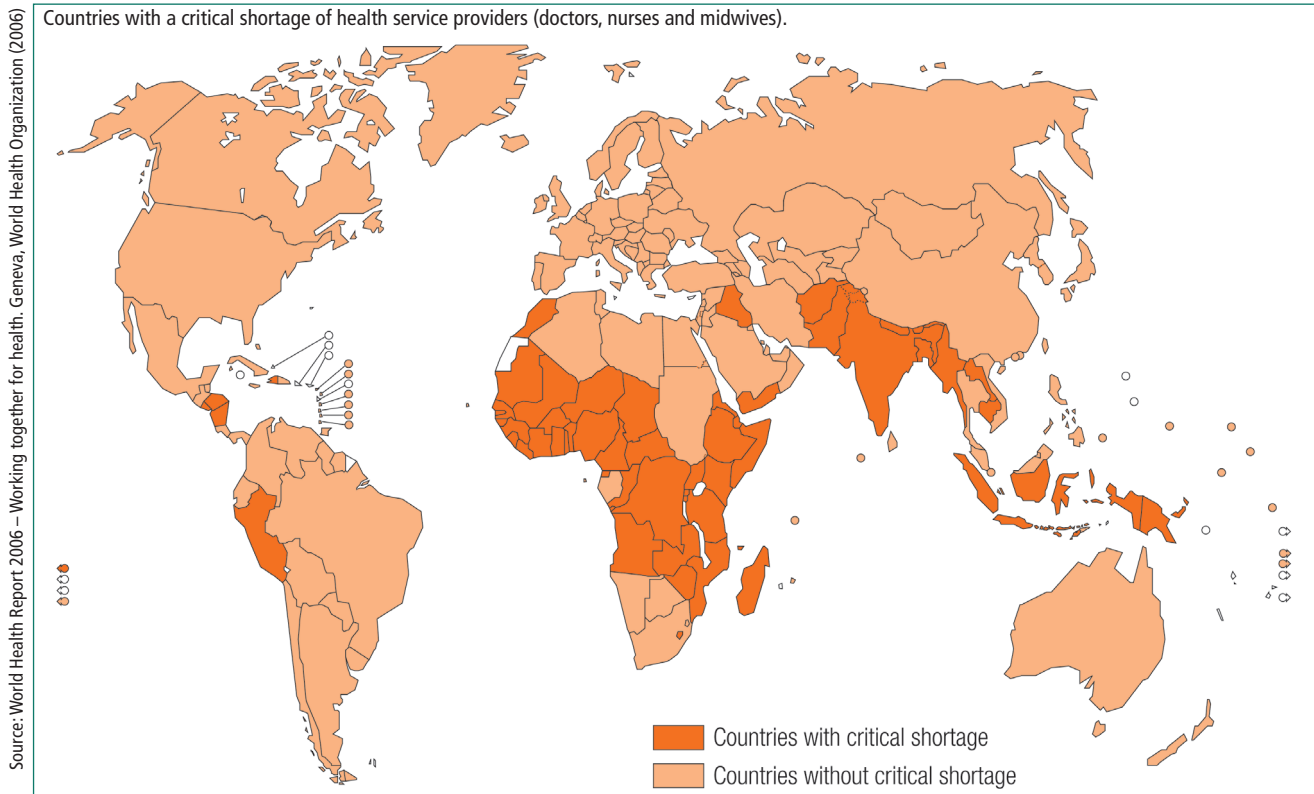
Country-level work: tackling 57 crises

GHWA's country-level operations have a phased programme, and Country Action Teams are getting started. These teams are composed of nationals from relevant stakeholders across sectors such as health, labour, finance, management, civil society, professional associations and the private sector. GHWA is not prescriptive in forming these teams, as needs and methods in countries vary significantly from one to another. Indeed, it could be said that the 57 crisis countries represent 57 different crises.

Every country should either have or develop domestic capacity to devise strong national workforce plans, policies and management systems. This need is greatest in those countries that must be able to do more with limited resources. In interested countries, GHWA is developing partnership arrangements – both directly with countries as well as in conjunction with regional bodies – to improve national planning, policies and management and the development of country and regional capacity in HRH planning.

Such in-country work entails both technical components and political interaction. Technically, GHWA is linking national leaders to information, technical cooperation, tools, guidelines and best practices, so that national actions are not isolated and fragmented, but comprehensive and informed by a strong evidence-base of what works, why, and how. Politically, GHWA can promote in-country stakeholder consultations and engagements, especially for multi-sectoral information. In both technical and political engagement, data and information are of utmost value in informed negotiations and action; and as the foundation for managing country processes, such as debt relief, the medium-term expenditure framework, sectoral planning, and other integrative processes within countries. However, technical assistance for planning will not be sufficient unless it is simultaneously aimed at developing local planning and managing capacity.





GHWA's role is catalytic, not displacing existing mechanisms. Seed grants may be useful for consultations and commissioned studies. For effective work in Africa, GHWA is networking African and external resources together to advance HRH development in specific countries and with regional platforms. The modality of work should be seen as experimental, with high adaptability to local circumstances, needs and opportunities. Pilot country programmes will be tested over an initial two years to refine a working model for expansion and extension.

Global-level challenges: building consensus, advocating change

Some global issues have been identified as requiring sustained action, to which GHWA has responded by using its convening role to form several working groups and task forces.

The task force on scaling up education and training has begun work on several fronts: convening experts to define and recommend action on scaling up HRH education, a framework for North-South twinning at institutional level, and a revamping of curricula to better fit today's and tomorrow's health priorities.

The task force on health workforce migration has started looking into this issue's multi-faceted factors and is to draft an international code of practice. This was specifically asked for by resolution WHA57.19, which states the need for a "code of practice on the international recruitment of health personnel, especially from developing countries."

On the subject of funding, a pre-existing task force on health systems financing has been approached by

GHWA to focus a more significant part of its attention to the specific matter of health workers. Indeed, adequate financing is an issue which can be addressed by a handful of countries on their own, but in a globalised world, this is the exception rather than the rule.

One problem which the *World Health Report 2006* identified was the lack of statistical and diagnostic tools essential for HRH planning and evaluation. The working group on HRH tools and guidelines, which is headed by WHO, is coming up with innovative and interactive solutions to this question. Pilot-testing of a revolutionary web-based tool has already begun, refining an approach which is as complex for the programmers of this tool as it is simple for the user.

The task force on health workforce migration has started looking into this issue's multi-faceted factors and is to draft an international code of practice.

GHWA has always emphasised the importance of combating HIV/Aids, which burdens health workers in a substantial way in most crisis countries. A working group on universal access to HIV prevention, treatment and care is being formed, but GHWA is also very much part of other strong programmes, such as the WHO/UNAIDS *Treat, Train and Retain* campaign (TTR), which aims to help HIV-positive health workers to stay alive and at work.

Advocacy is perhaps one of the most effective ways the crisis can be addressed: a great majority of the

policy levers which can make an impact lie in the hands of governments. All of the aforementioned working groups have a strong advocacy element, but GHWA has gone one step further and put together a special evidence-based advocacy working group, whose sole task is to influence decision-makers towards an increase in health workforce awareness and more efficient HRH planning and implementation. Keeping the health workforce on the agenda of national governments, regional and international bodies is, in the end, GHWA's primary function as the global HRH focal point.

To achieve specific objectives, GHWA will itself raise money to jump-start country processes and fund specific GHWA functions as well as its core operations.

Funding: not reinventing the wheel

The Global Health Workforce Alliance is made up of partners committed to pulling together in support of fundable approaches for HRH at country level, funded through a mix of domestic and external contributions. To achieve specific objectives, GHWA will itself raise money to jump-start country processes and fund specific GHWA functions as well as its core operations. The alliance will also mobilise and advocate for country investments in health systems and HRH, and for increased and harmonised donor support directly to countries.

Developing nations, if this term is taken literally, must put their efforts into their health workforce. Developed nations, if this term is taken literally, should aim at self-sufficiency in terms of health workers.

While substantial funding for country HRH plans is required over a long period (a minimum of 10 years), no new funding mechanism is to be anticipated. Financing HRH plans should as much as possible be integrated in broader health system investments and support priority interventions identified by countries.

For country-level HRH support, the availability of country-level funding mechanisms that can flexibly meet funding gaps will be critical for an HRH plan that includes both public and non-state actors. Global health initiatives and other project or programme funding for scaling up health and HIV/Aids response must carry a shared responsibility for financing the associated HRH costs and ensure that countries are informed of this option in applications.

Conclusion

The litmus test of GHWA's efforts in human resources for health will be the evidence that countries across the world are addressing their health workforce issues as a political and social priority and are allocating the requisite resources. In short, we are looking for evidence to show that the health workforce is recognised as a key part of development.

Developing nations, if this term is taken literally, must put their efforts into their health workforce. Developed nations, if this term is taken literally, should aim at self-sufficiency in terms of health workers. The Global Health Workforce Alliance does take these terms in their most literal sense. Its efforts at country, regional and global level to address the HRH crisis are therefore inextricably linked to the wider development context: poverty reduction, global trade, economic and social development cannot be achieved without investment in the health of the people.

Dr Francis Omaswa is Executive Director of the Global Health Workforce Alliance (GHWA) that was officially launched in May 2006. Before joining GHWA in June 2005, he was the Director General for Health Services in the Ministry of Health in Uganda for a period of seven years, during which he was responsible for coordinating major reforms, including the introduction of the Swaps and decentralisation. Prior to that he was the Chief Surgeon, Head of the Quality Assurance programme and Director of the Uganda Heart Institute, in the Ministry of Health and Makerere University in Uganda. He has a keen interest in cost-effective approaches for increasing access of the poor to quality health care. At the global level he was closely involved in the establishment of the Global Stop TB Partnership and was Vice-Chairman of its Coordinating Board. He was one of the architects of the Global Fund to Fight Aids, TB and Malaria and served as Chair of the Portfolio and Procurement Committee of its Board.

*The **Global Health Workforce Alliance** is a partnership 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 secretariat is provided by the World Health Organization.*

Global Health Workforce Alliance (GHWA)
World Health Organization
20 Avenue Appia
CH-1211 Geneva 27
Switzerland

Tel: +41 22791 1616
Fax: +41 22791 4747
Email: ghwa@who.int

Website: www.who.int/workforcealliance