

Human Resources for Universal Health Coverage: a template for eliciting commitments.

Background

The last decade has seen an increased recognition of the central role of human resources for health (HRH) in the drive towards the health MDGs and Universal Health Coverage. The Joint Learning Initiative and the World Health Report 2006 identified challenges and proposed solutions. The launch of the Global Health Workforce Alliance and two Global Forums on HRH (in 2008 and 2011) have been milestones within the wider political momentum for HRH, which has culminated in the adoption of a WHO Global Code of Practice on International Recruitment of Health Personnel (the WHO Code), in HRH-specific commitments made in the context of the UN Global Strategy for Women's and Children's Health, and in the recognition of HRH in a UN General Assembly resolution on Universal Health Coverage (UHC). A number of other high-level political and technical processes and events (on maternal and child health, HIV, non-communicable diseases, aid effectiveness, etc) have also highlighted the critical role of HRH. In spite of this, and notwithstanding some encouraging examples of progress, shortage, maldistribution, quality and performance challenges remain, hindering delivery of essential health services.

Universal health coverage is the goal that all people obtain the health services they need without the risks of financial hardship linked to paying for them. It concerns two inter-related types of coverage: needed health services of good quality (promotion, prevention, treatment, rehabilitation and palliation) and financial risk protection. The latter ensures that people are not required to make unaffordable out-of-pocket payments for the services they obtain. Universality is a third component – coverage should be for everyone. The health workforce plays a critical role in making progress towards UHC, especially in the provision of services to all people who need it.

Reasons why health workforce problems persist are diverse, but a key factor is that often only fragmented or simplistic solutions and quick fixes have been tried, whereas HRH development continuously changes and evolves under the pressure of a variety of factors and forces. However, evidence and years of lessons learned show that integrated and coordinated approaches are required that pay adequate attention to every critical step in the “supply chain” of health workers and that recognize the role that different sectors within government and different constituencies in society play. The WHO Code itself urges Member States to “consider adopting and implementing effective measures aimed at strengthening health systems, continuous monitoring of the health labour market, and coordination” and to “adopt a multisectoral approach to addressing these issues in national health and development policies.”

Thus, there is a need to apply a “systems approach” to HRH. This entails addressing capacity, management and working conditions, as well as a solid understanding of the health labour markets dynamics that affect HRH production, deployment, absorption into the health system, retention, performance and motivation. There is a great opportunity to harness innovations in many HRH areas, from service delivery to training, intersectoral collaboration and the use of information technology.

Countries and the global health community are increasingly embracing the aspiration for UHC; translating this into reality will require adapting HRH production and management to the evolving health needs (extending population coverage, expanding the services offered, and improving quality) and adopting innovative models of care. Rigorous action to improve the HRH situation is required in order to move towards UHC by adopting policy, regulatory and fiscal actions required to match health workforce supply, demand, affordability and sustainability, in order to equitably meet population needs. This constitutes the investment case: health workers are the means through which UHC will be achieved.

Understanding challenges and findings solutions

Against this background, the Global Health Workforce Alliance (GHWA), the Government of Brazil, the World Health Organization (WHO), and the Pan-American Health Organization (PAHO) will convene the Third Global Forum on Human Resources for Health Recife, Brazil, in November 2013.

- First, it will be critical to take stock of what has happened following the Kampala declaration and other commitments. Since countries have very different issues and different pathways to solutions it will be essential to reflect the richness of issues and approaches to solve them. In addition, it will be important to assess common challenges to the implementation of the goals of the Kampala declaration and individual country commitments especially those made in the context of national HRH or health sector plans.
- Second, the Forum provides a unique opportunity to learn from each other on a global scale. Countries are at very different stages on the road to UHC and on achieving their HRH goals and targets. Solutions and innovations often differ - providing the platform to learn from each other will be a primary goal of the forum.
- Third, in the lead-up to the event, countries, development partners, international agencies, and all national and international actors with a stake in health workforce development are invited to make new HRH commitments to advance the health workforce agenda (see annex 1). Effective strategies that address in a sustainable manner deep-seated challenges require a long-term perspective, and multi-stakeholder and multi-constituency collaboration. This in turn can only be guaranteed by high-level political commitment to align the efforts of different line ministries and other constituencies in society, and ensure their sustained focus over a long timeframe. *The challenge is not lack of evidence on effective policies: it is to mobilize political will and catalyse action for a contemporary HRH agenda instrumental to achieving UHC.*

Scope of this template

This template is intended to assist countries and other stakeholders to identify relevant HRH commitments to be brought to the Forum; it does so by mapping out the most effective interventions and their interrelatedness to improve the situation of HRH. It draws on the WHO Code, and the different policy documents that Member States have endorsed that call for action on HRH. However, this template identifies systemic pathways of interventions along the Universal Health Coverage Framework of AAAQ (availability, accessibility, acceptability and quality). The advantage of the AAAQ model (whose concept originates from WHO operations research on health systems performance in the 1960's, and again in 1978 in the era of *Health for All*¹) is that it offers a fitting matrix to systematize action, is easily understood by different stakeholders and actors, and can serve as a bridge between the HRH and UHC agenda.

AAAQ (availability, accessibility, acceptability and quality)²

The International Covenant on Economic, Social and Cultural Rights (1966) states in article 12 the steps required for the realization of the right to health, which include the reduction of child mortality, public health measures, the prevention, treatment and control of epidemic and other diseases, and creating conditions to ensure access to health care for all.

Within this context, the UN Committee on Economic, Social and Cultural Rights, which monitors compliance with the Covenant adopted General Comment N 14 on the right to the highest attainable standard of health (2000).³ General Comment 14 recognizes the importance of both healthcare and the underlying determinants of health, stating that the right to health entails four elements:

- *Availability*: functioning health care facilities; health workers, goods, services and programmes in sufficient quantity;
- *Accessibility*: health facilities, health workers, goods and services accessible to everyone; this entails four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility (affordability), information accessibility;
- *Acceptability*: health facilities, health workers, goods and services must be respectful and culturally appropriate, as well as sensitive to gender and life cycle requirements;
- *Quality*: health facilities, goods and services provided by health workers must be scientifically and medically appropriate and of good quality

It is important to highlight that, while they have been categorized according to the AAAQ framework for illustrative purposes, in reality often different HRH actions are and should be linked with one another and can have effects on multiple dimensions. The different interventions that are linked in the “pathways” described in the template (see figures 1.1 to 1.6) need to be pursued in conjunction in order to be efficient.

Situations and needs vary across countries. This is why the template offers different pathways, or sets of interventions, that have proven to be interrelated. Commitments will need to be based on national priorities as reflected in national health strategies and HRH plans.

Relevant HRH actions and examples of HRH commitments have been identified drawing upon evidence, policy and normative guidance which emerged over the course of the HRH “decade of action”. They include:

- evidence from systematic reviews^{4,5,6,7,8, 9,10,11,12,13,14} and peer-reviewed studies,^{15,16}
- guidance documents from WHO (such as guidelines, the WHO Global Code of Practice on the International Recruitment of Health Personnel, relevant World Health Assembly resolutions), and other international agencies,^{17,18,19,20,21,22,23,24,25}
- reports produced by high-level and expert task forces,^{26,27, 28}
- other policy documents such the Kampala Declaration and Agenda for Global Action, the outcome statement of the Second Global Forum, and the UN Global Strategy for Women’s and Children’s Health.^{29,30,31}

The interventions described in the template are not fully comprehensive, but as a whole they address the bulk of the problems. The identified interventions, if taken up as “pathways”, have all proven to be highly efficient. However, as outlined above, such interventions if taken up as “stand-alone”, might not be equally effective and sustainable. It is therefore not advisable to identify only one initiative, without linking this to the required additional interventions along the AAAQ dimensions. For instance, investment in training new health workers might be lost, if a parallel effort is not made to ensure that adequate resources, management systems and incentives are put in place to ensure that the new graduates can find employment in the health sector, and ideally to work in less served areas.

The aim of the template is therefore to foster dialogue and debate in Member States and other key health sector stakeholders and partners in the preparation for the 3rd Global Forum on HRH. Member States, other national constituencies, and international agencies and development partners are invited to announce at Recife their pathway of commitments, which are based on their prior situation analysis and planning. The GHWA and WHO Secretariat will be responsible for future follow-up and monitoring of implementation of the commitments, including through collaboration with regional networks and organizations.

For ease of reference, the different pathways are colour coded so that the interrelations are easily visible through connecting lines and brackets; individual pathways are also shown separately to highlight more clearly which interventions are more directly related to one another and should be jointly pursued. Cross-cutting actions, such as ensuring a sound leadership of HRH development, informed by information and evidence, and supported by adequate levels of investment, underpin progress across all four AAAQ dimensions, leading to improved access to a quality workforce, increased service coverage, and improved health outcomes (see dotted vertical red arrows in the diagram). Example of relevant commitments are provided for illustrative purposes. The identification of relevant HRH commitments should be tailored to an individual country’s context and needs. The framework templates also suggest some measureable indicators, in order to provide a basis for tracking progress and increasing opportunities for accountability.

Such domestic, country-specific sets of commitments will be complemented by those actions that no country could possibly address alone . Such commitments that are of truly global nature, such as global migration, improved aid effectiveness with regards to health workforce development, the

existence of mechanisms for mutual accountability and review of progress, will be identified in a global declaration to reflect the collective will for convergent action of the HRH community, revisiting lessons learned of the last decade and proposing a forward looking vision inspired by the UHC vision.

Affordability

Some of the proposed HRH interventions (such as increasing the production of health workers and/ or their absorption in the health sector through adequate remuneration and incentives) have significant resource implications, whose affordability should be evaluated in the context of the country's macroeconomic situations and in relation to its political priorities. Other recommended interventions, however, (of regulatory and policy nature) don't necessarily entail the investment of large amounts of new resources, but rather to redefine workflow processes, introduce administrative and management changes (such as allowing health workers to perform a broader scope of tasks for which they were trained; updating and enforcing the implementation of curricula for enhanced competencies; enter international agreements to coordinate health workforce migration, etc). And yet other interventions have the potential of resulting in net savings, such as excising ghost workers from the public sector payroll, or re-orienting the skills mix towards a more balanced composition, including cadres which are less costly to educate and remunerate, such as community-based and mid-level health workers.

Also with regards to external resources, some interventions (such as increased development assistance for health) would have resource implications, while others might focus on improving the efficiency of current spending (for instance by shifting the focus away from short-term disease-specific in-service training towards mainstreaming the required additional competencies in the scale-up of pre-service training, and investing more in HRH motivation and performance through improved remuneration).

The issue of affordability from a health system and public policy perspective, the related fiscal space discourse, as well as the financial accessibility of health services by the population through avoidance of out of pocket payments, are fundamental factors in the pathway towards UHC, which are best examined through a health financing lens,³² and therefore fall outside the scope of this template, whose primary focus is HRH.

Overview of the figures below:

Figure 1.1 gives an integrated overview of different HRH action areas, and of how these are inter-connected, through color-coded pathways; cross cutting actions that are relevant to multiple areas of HRH development are also illustrated through the red vertical dotted arrows. Figures 1.2 to 1.6 each focus on specific pathways that are in the overview figure 1.1. Figure 1.2 illustrates more specifically the commitment pathway related to health workforce education. Figure 1.3 focuses on the pathway related to financial and non-financial incentives. Figure 1.4 details the pathway for the retention of health workers. Figure 1.5 demonstrates the skills mix pathway. Figure 1.6 shows the inter-connectedness of different strategies relating to shaping health labour market forces.

Figure 1.1
A template for HRH commitments

Color code Key
 Education pathway
 Incentives pathway
 Retention pathway
 Skills mix pathway
 Labor markets pathway
 Cross cutting actions

Accelerate progress towards health MDGs, progressive realization of UHC

Increased and more equitable coverage of quality health services

Governments across different sectors and partners across different constituencies collaborate to ensure that all people, everywhere have access to a skilled, motivated health worker, within a robust health system

Ensure an adequate stock and equitable distribution of health workers, responsive to the population's socio-cultural needs, fit for purpose and fit to practice
 (e.g. Government X commits to increase its HRH production by 10% per year over next 5 years, to absorb in the health system and deploy new workers preferentially to underserved areas through appropriate incentives, and to ensure appropriate gender balance and quality standards of new HRH graduates)

Availability indicators

Accessibility indicators

Acceptability indicators

Quality indicators

Scale up pre-service education and training to meet population needs (e.g. Min of Health from country X commits to increase annual training output of midwives from 300 to 1000 by 2015)

Secure adequate supply qualified entrants (e.g.: Min of Education from country X commits to target by 2015 entrants with a wider range of competencies in addition to academic qualifications)

Ensure adequate absorption of HRH graduates (e.g. Min of Health from country X commits to increase annual vacancies for midwives from 300 to 1000 by 2015)

Address HRH loss due to out-migration through WHO Code (e.g. gvt. X commits to enact laws to stop active recruitment from crisis countries by 2014)

Adopt education policies favouring rural retention (e.g. government Y commits to train and recruit locally the majority of rural health workers by 2015)

Provide incentives for retention and equitable deployment (e.g. Civil Service Commission from country X commits to roll out incentive scheme for rural deployment across every district of the country by 2015)

Enhance professional/ personal support in rural areas (e.g. Min of Planning X commits to develop housing and schooling facilities in every district of the country by 2015)

Enable health workers to operate within full scope of profession (e.g. prof. council Y to allow midwives to administer all basic EMOC functions by 2014)

Develop HRH responsive to population cultural (ethnicity language) needs, (e.g.: university X commits to recruit Y% of trainees among vulnerable socio-economic groups/ ethnic minorities by 2015)

Adopt appropriate skills mix to increase service uptake (e.g.: Min. of Health X commits to introduce by 2014 a cadre of community-based health workers as an integral part of its health workforce and health system)

Strengthen HRH oversight and accountability mechanisms (e.g.: prof. ass. X and gvt. Y commit to jointly and regularly conduct by 2015 performance appraisal of clinical staff)

Minimize unethical behaviours (absenteeism, ghost workers) (e.g.: gvt. Y commits to reduce HRH absenteeism in public health facilities by half over the next 3 years)

Enhance quality of education through accreditation (e.g.: university or training institution X commits to fully implement the requirements for certification of new graduates by 2015)

Develop and maintain HRH competences through updated/ improved curricula (e.g.: Min of Education Y commits to revise national pre-service training curricula - e.g. to include NCD competencies - for all health workers by 2015)

Enhance performance through supportive supervision, adequate work environment, management, incentives (example: Min of Health X commits to introduce standard job descriptions by 2014)

Ensure regular update/ further development HRH competencies through in-service training (e.g.: gvt. X ensures that Y% of public sector HRH access relevant continuous professional development opportunities in 2014)

Cross-cutting actions (national leadership, evidence-informed response, and additional and more productive investment):

- Develop, implement, monitor and evaluate comprehensive, costed health plans addressing HRH strategies (example: Min of Health from country X commits to add and include by mid-2014 a HRH module in its national costed health strategy); (example: country Y commits to establish an HRH unit within its ministry of health) indicators
- Ensure capacity for informed HRH response based on evidence, joint learning and mutual accountability (example: professional council Y commits to registering and managing all its members in a modern HR information system by 2015) indicators
- Allocate and spend more productively an adequate proportion of health sector funding to the health workforce (example: Min of Finance and health from country X commit to increase its HRH spending by 10% over the baseline value by 2015 to improve remuneration in public sector) indicators
- Ensure external funding is predictable, effectively harmonized and aligned with national priorities within the context of integrated support to the health sector (example: donor Z commits to re-programme by 2014 50% of its HRH aid away from in-service training towards funding into improved health workforce management and expanding pre-service training) indicators

Figure 1.2: focus on education

Accelerate progress towards health MDGs, progressive realization of UHC

Increased and more equitable coverage of quality health services

Governments across different sectors and partners across different constituencies collaborate to ensure that all people, everywhere have access to a skilled, motivated health worker, within a robust health system

Ensure an adequate stock and equitable distribution of health workers, responsive to the population's socio-cultural needs, fit for purpose and fit to practice
 (e.g. Government X commits to increase its HRH production by 10% per year over next 5 years, to absorb in the health system and deploy new workers preferentially to underserved areas through appropriate incentives, and to ensure appropriate gender balance and quality standards of new HRH graduates)

Availability [indicators](#)

Accessibility [indicators](#)

Acceptability [indicators](#)

Quality [indicators](#)

Scale up pre-service education and training to meet population needs (e.g. Min of Health from country X commits to increase annual training output of midwives from 300 to 1000 by 2015)

Secure adequate supply qualified entrants (e.g.: Min of Education from country X commits to target by 2015 entrants with a wider range of competencies in addition to academic qualifications)

Adopt education policies favouring rural retention (e.g. government Y commits to train and recruit locally the majority of rural health workers by 2015)

Develop HRH responsive to population cultural (ethnicity, language) needs, (e.g.: university X commits to recruit Y% of trainees among vulnerable socio-economic groups/ ethnic minorities by 2015)

Enhance quality of education through accreditation (e.g.: university or training institution X commits to fully implement the requirements for certification of new graduates by 2015)

Develop and maintain HRH competences through updated/ improved curricula (e.g.: Min of Education Y commits to revise national pre-service training curricula - e.g. to include NCD competencies - for all health workers by 2015)

Ensure regular update/ further development HRH competencies through in-service training (e.g.: gvt. X ensures that Y% of public sector HRH access relevant continuous professional development opportunities in 2014)

The return on investment in education can be improved if the quantitative scale-up is matched by corresponding improvements in competencies, through the revision of curricula, quality assurance of training institutions, and appropriate continuous professional development strategies to ensure that skills gained through pre-service training are maintained and further developed over the professional life span of the health worker through in-service training

Cross-cutting actions (national leadership, evidence-informed response, and additional and more productive investment):

- Develop, implement, monitor and evaluate comprehensive, costed health plans addressing HRH strategies (example: Min of Health from country X commits to add and include by mid-2014 a HRH module in its national costed health strategy); (example: country Y commits to establish an HRH unit within its ministry of health) [indicators](#)
- Ensure capacity for informed HRH response based on evidence, joint learning and mutual accountability (example: professional council Y commits to registering and managing all its members in a modern HR information system by 2015) [indicators](#)
- Allocate and spend more productively an adequate proportion of health sector funding to the health workforce (example: Min of Finance and health from country X commit to increase its HRH spending by 10% over the baseline value by 2015 to improve remuneration in public sector) [indicators](#)
- Ensure external funding is predictable, effectively harmonized and aligned with national priorities within the context of integrated support to the health sector (example: donor Z commits to re-programme by 2014 50% of its HRH aid away from in-service training towards funding into improved health workforce management and expanding pre-service training) [indicators](#)

Figure 1.3: focus on incentives

Accelerate progress towards health MDGs, progressive realization of UHC

Increased and more equitable coverage of quality health services

Governments across different sectors and partners across different constituencies collaborate to ensure that all people, everywhere have access to a skilled, motivated health worker, within a robust health system

Ensure an adequate stock and equitable distribution of health workers, responsive to the population's socio-cultural needs, fit for purpose and fit to practice

(e.g. Government X commits to increase its HRH production by 10% per year over next 5 years, to absorb in the health system and deploy new workers preferentially to underserved areas through appropriate incentives, and to ensure appropriate gender balance and quality standards of new HRH graduates)

Availability [indicators](#)

Accessibility [indicators](#)

Acceptability [indicators](#)

Quality [indicators](#)

Scale up pre-service education and training to meet population needs (e.g. Min of Health from country X commits to increase annual training output of midwives from 300 to 1000 by 2015)

Ensure adequate absorption of HRH graduates (e.g. Min of Health from country X commits to increase annual vacancies for midwives from 300 to 1000 by 2015)

Address HRH loss due to out-migration through WHO Code (e.g. gvt. X commits to enact laws to stop active recruitment from crisis countries by 2014)

Provide incentives for retention and equitable deployment (e.g. Civil Service Commission from country X commits to roll out incentive scheme for rural deployment across every district of the country by 2015)

Enhance professional/ personal support in rural areas (e.g. Min of Planning X commits to develop housing and schooling facilities in every district of the country by 2015)

A well-designed package of financial and non-financial incentives has the potential to positively impact health workforce availability (more people will join HRH training and then the HRH labour market), accessibility (through incentives for deployment in rural areas), acceptability (by linking incentives to appropriate citizens' feedback mechanisms, or by reducing the need for informal payments as a coping strategy), quality (by improving health workers' motivation and performance)

Strengthen HRH oversight and accountability mechanisms (e.g.: prof. ass. X and gvt. Y commit to jointly and regularly conduct by 2015 performance appraisal of clinical staff)

Minimize unethical behaviours (absenteeism, ghost workers) (e.g.: gvt. Y commits to reduce HRH absenteeism in public health facilities by half over the next 3 years)

Enhance performance through supportive supervision, adequate work environment, management, incentives (example: Min of Health X commits to introduce standard job descriptions by 2014)

Cross-cutting actions (national leadership, evidence-informed response, and additional and more productive investment):

- Develop, implement, monitor and evaluate comprehensive, costed health plans addressing HRH strategies (example: Min of Health from country X commits to add and include by mid-2014 a HRH module in its national costed health strategy); (example: country Y commits to establish an HRH unit within its ministry of health) [indicators](#)
- Ensure capacity for informed HRH response based on evidence, joint learning and mutual accountability (example: professional council Y commits to registering and managing all its members in a modern HR information system by 2015) [indicators](#)
- Allocate and spend more productively an adequate proportion of health sector funding to the health workforce (example: Min of Finance and health from country X commit to increase its HRH spending by 10% over the baseline value by 2015 to improve remuneration in public sector) [indicators](#)
- Ensure external funding is predictable, effectively harmonized and aligned with national priorities within the context of integrated support to the health sector (example: donor Z commits to re-programme by 2014 50% of its HRH aid away from in-service training towards funding into improved health workforce management and expanding pre-service training) [indicators](#)

Figure 1.4: focus on retention

Accelerate progress towards health MDGs, progressive realization of UHC

Increased and more equitable coverage of quality health services

Governments across different sectors and partners across different constituencies collaborate to ensure that all people, everywhere have access to a skilled, motivated health worker, within a robust health system

Ensure an adequate stock and equitable distribution of health workers, responsive to the population's socio-cultural needs, fit for purpose and fit to practice
(e.g. Government X commits to increase its HRH production by 10% per year over next 5 years, to absorb in the health system and deploy new workers preferentially to underserved areas through appropriate incentives, and to ensure appropriate gender balance and quality standards of new HRH graduates)

Availability [indicators](#)

Accessibility [indicators](#)

Acceptability [indicators](#)

Quality [indicators](#)

Adopt education policies favouring rural retention (e.g. government commits to train and recruit locally the majority of health workers in rural areas by 2015)

Provide incentives for retention and equitable deployment (e.g. Civil Service Commission from country X commits to roll out incentive scheme for rural deployment across every district of the country by 2015)

Enhance professional/ personal support in rural areas (e.g. Min of Planning X commits to develop housing and schooling facilities in every district of the country by 2015)

The challenge of retaining HRH in rural areas, which affects low-, middle- and high-income countries alike, can be best tackled if complementary strategies (focusing on education policies, regulation, incentives, management and community support) are jointly implemented

Cross-cutting actions (national leadership, evidence-informed response, and additional and more productive investment):

- Develop, implement, monitor and evaluate comprehensive, costed health plans addressing HRH strategies (example: Min of Health from country X commits to add and include by mid-2014 a HRH module in its national costed health strategy); (example: country Y commits to establish an HRH unit within its ministry of health) [indicators](#)
- Ensure capacity for informed HRH response based on evidence, joint learning and mutual accountability (example: professional council Y commits to registering and managing all its members in a modern HR information system by 2015) [indicators](#)
- Allocate and spend more productively an adequate proportion of health sector funding to the health workforce (example: Min of Finance and health from country X commit to increase its HRH spending by 10% over the baseline value by 2015 to improve remuneration in public sector) [indicators](#)
- Ensure external funding is predictable, effectively harmonized and aligned with national priorities within the context of integrated support to the health sector (example: donor Z commits to re-programme by 2014 50% of its HRH aid away from in-service training towards funding into improved health workforce management and expanding pre-service training) [indicators](#)

Figure 1.5: focus on skills mix

Accelerate progress towards health MDGs, progressive realization of UHC

Increased and more equitable coverage of quality health services

Governments across different sectors and partners across different constituencies collaborate to ensure that all people, everywhere have access to a skilled, motivated health worker, within a robust health system

Ensure an adequate stock and equitable distribution of health workers, responsive to the population's socio-cultural needs, fit for purpose and fit to practice
(e.g. Government X commits to increase its HRH production by 10% per year over next 5 years, to absorb in the health system and deploy new workers preferentially to underserved areas through appropriate incentives, and to ensure appropriate gender balance and quality standards of new HRH graduates)

Availability [indicators](#)

Accessibility [indicators](#)

Acceptability [indicators](#)

Quality [indicators](#)

Scale up pre-service education and training to meet population needs *(e.g. Min of Health from country X commits to increase annual training output of midwives from 300 to 1000 by 2015)*

Enhance quality of education through accreditation *(e.g.: university or training institution X commits to fully implement the requirements for certification of new graduates by 2015)*

The positive potential of cadres such as community-based and mid-level health workers can be maximized if the expansion of their training is accompanied by a deliberate planning of a skills mix that emphasises a team-based approach to the delivery of care, supported by regulatory interventions that authorize health workers to operate within the full scope of their profession, the enhancement of quality standards safeguarded by regulatory and accreditation mechanisms, and a strengthening of referral systems

Adopt appropriate skills mix to increase service uptake *(e.g.: Min. of Health X commits to introduce by 2014 a cadre of community-based health workers as an integral part of its health workforce and health system)*

Enhance performance through supportive supervision, adequate work environment, management, incentives *(example: Min of Health X commits to introduce standard job descriptions by 2014)*

Similarly, the skills mix can be more efficient if health workers (including nurses and midwives) are authorized to operate within the full scope of their profession, and enabled to do so through supportive supervision and an adequate work environment and management

Enable health workers to operate within full scope of profession *(e.g. prof. council Y to allow midwives to administer all basic EMOC functions by 2014)*

Cross-cutting actions (national leadership, evidence-informed response, and additional and more productive investment):

- Develop, implement, monitor and evaluate comprehensive, costed health plans addressing HRH strategies *(example: Min of Health from country X commits to add and include by mid-2014 a HRH module in its national costed health strategy); (example: country Y commits to establish an HRH unit within its ministry of health)* [indicators](#)
- Ensure capacity for informed HRH response based on evidence, joint learning and mutual accountability *(example: professional council Y commits to registering and managing all its members in a modern HR information system by 2015)* [indicators](#)
- Allocate and spend more productively an adequate proportion of health sector funding to the health workforce *(example: Min of Finance and health from country X commit to increase its HRH spending by 10% over the baseline value by 2015 to improve remuneration in public sector)* [indicators](#)
- Ensure external funding is predictable, effectively harmonized and aligned with national priorities within the context of integrated support to the health sector *(example: donor Z commits to re-programme by 2014 50% of its HRH aid away from in-service training towards funding into improved health workforce management and expanding pre-service training)* [indicators](#)

Figure 1.6: focus on labour markets

Accelerate progress towards health MDGs, progressive realization of UHC

Increased and more equitable coverage of quality health services

Governments across different sectors and partners across different constituencies collaborate to ensure that all people, everywhere have access to a skilled, motivated health worker, within a robust health system

Ensure an adequate stock and equitable distribution of health workers, responsive to the population's socio-cultural needs, fit for purpose and fit to practice

(e.g. Government X commits to increase its HRH production by 10% per year over next 5 years, to absorb in the health system and deploy new workers preferentially to underserved areas through appropriate incentives, and to ensure appropriate gender balance and quality standards of new HRH graduates)

Availability [indicators](#)

Accessibility [indicators](#)

Acceptability [indicators](#)

Quality [indicators](#)

Scale up pre-service education and training to meet population needs (e.g. Min of Health from country X commits to increase annual training output of midwives from 300 to 1000 by 2015)

Secure adequate supply qualified entrants (e.g.: Min of Education from country X commits to target by 2015 entrants with a wider range of competencies in addition to academic qualifications)

Ensure adequate absorption of HRH graduates (e.g. Min of Health from country X commits to increase annual vacancies for midwives from 300 to 1000 by 2015)

Address HRH loss due to out-migration through WHO Code (e.g. gvt. X commits to enact laws to stop active recruitment from crisis countries by 2014)

Provide incentives for retention and equitable deployment (e.g. Civil Service Commission from country X commits to roll out incentive scheme for rural deployment across every district of the country by 2015)

The WHO Code of Practice on the International Recruitment of Health Personnel provides clear guidance: countries should strive for self-sufficiency in terms of health workforce production, but also put in place the incentives required to retain their own health workers

A scale up of training alone will not be sufficient to address HRH shortage, because if the absorption capacity of the health sector is insufficient, or if adequate incentives, including fair remuneration across health cadres, or support systems are not in place, many of the new graduates might fail to find a job in the health sector, and migrate overseas or work in other sectors; therefore an understanding of the health labour market dynamics is required, providing the basis for matching supply-side (i.e. education of health workers) interventions with others that ensure an adequate demand for their services (including a sufficient fiscal space and adequate pay and work environment)

Enhance performance through supportive supervision, adequate work environment, management, incentives (example: Min of Health X commits to introduce standard job descriptions by 2014)

Minimize unethical behaviours (absenteeism, ghost workers) (e.g.: gvt. Y commits to reduce HRH absenteeism in public health facilities by half over the next 3 years)

Cross-cutting actions (national leadership, evidence-informed response, and additional and more productive investment):

- Develop, implement, monitor and evaluate comprehensive, costed health plans addressing HRH strategies (example: Min of Health from country X commits to add and include by mid-2014 a HRH module in its national costed health strategy); (example: country Y commits to establish an HRH unit within its ministry of health) [indicators](#)
- Ensure capacity for informed HRH response based on evidence, joint learning and mutual accountability (example: professional council Y commits to registering and managing all its members in a modern HR information system by 2015) [indicators](#)
- Allocate and spend more productively an adequate proportion of health sector funding to the health workforce (example: Min of Finance and health from country X commit to increase its HRH spending by 10% over the baseline value by 2015 to improve remuneration in public sector) [indicators](#)
- Ensure external funding is predictable, effectively harmonized and aligned with national priorities within the context of integrated support to the health sector (example: donor Z commits to re-programme by 2014 50% of its HRH aid away from in-service training towards funding into improved health workforce management and expanding pre-service training) [indicators](#)

Table 1: Examples of relevant indicators to monitor progress on specific HRH actions and commitments

<p><u>Availability</u></p> <p>Total number of HRH (and density per 1,000 population), by cadre Number and % of accepted applicants who register for training, per cadre Number of students graduating each year, per cadre % of students graduating from primary/ secondary school out of all children of primary/ secondary school age Proportion of graduates entering the health sector Proportion of nationally trained health workers Ratio of exits from the health workforce Existence of ethical norms with respect to the international recruitment of health care workers</p>	<p><u>Accessibility</u></p> <p>Distribution of HRH by geographical location Ratio of density of HRH for rural areas / density of HRH for urban areas of the country Ratio highest: lowest HRH densities by region HRH salary level in comparison to per capita GDP Percentage of health workers whose current primary health care practice setting is the same geographic location as their own community. Treatment of pneumonia with antibiotics by community health workers authorized Midwifery personnel authorized to administer core set of life-saving basic emergency obstetric care interventions</p>
<p><u>Acceptability</u></p> <p>Distribution of HRH by gender Distribution of HRH by occupation, specialization or other skill-related characteristic Existence of inter-professional training strategies in the school of health sciences Ratio of primary care physicians/ total number of physicians Existence of enrolment programs (selective candidate recruitment, affirmative action) to include students from underserved population Percentage of specific training programs for students from indigenous populations, or with a low socio-economic status or that live in geographically inaccessible areas Relative no. of specific tasks performed among health workers (productivity) Days of absenteeism among health workers Proportion of HRH currently unemployed Number/ percentage of newly graduated health workers who are employed in the health labour market within 3 months of graduation (or other nationally defined time period), per cadre</p>	<p><u>Quality</u></p> <p>Existence of an accreditation agency of health education and training institutions Number and % of health training institutions meeting accreditation and reaccreditation standards Inclusion of PHC contents in the curricula Existence of inter-professional training strategies in the schools of health sciences % of facility staff who received in-service training, by cadre and type of training % of facility staff participating in continuous professional development, by cadre % of facility staff with a performance improvement plan</p>
<p><u>Cross-cutting</u> (national leadership and investment)</p> <p>Existence of a costed operational national strategy with explicit objectives, indicators and targets to address HRH planning and management Existence of a HRH unit and its level of development Existence of a functional national coordinating mechanism for the HRH information and monitoring system Timeliness, validation, consistency and disaggregation of data in the HRH information and monitoring system HRH expenditure, total and per capita HRH expenditure by category Government expenditure on HRH as a proportion of recurrent general government expenditure on health Government expenditure on health vocational training, per cadre Proportion of official development assistance for health allocated to HRH</p>	

Note: these indicators are mostly drawn from the WHO Handbook on Monitoring and Evaluation of HRH, which provides further specificity on how to calculate them, relevant data sources and complementary considerations on measurement and comparability issues. A few of the indicators were taken from the PAHO Handbook for measuring and monitoring HRH or from the Countdown to 2015 analytical framework

Annex 1 – Submission form for HRH commitment pathways

1) Name of your institution or country

2) What constituency do you represent? (highlight or circle the one that applies)

National Government	Professional association	Not-for-profit NGO/ civil society	Private for-profit sector
Development partner	International/ multilateral agency	Academia/ research institution	Other (please specify)

3) Contact person (please indicate the name, e-mail and phone number of the focal point in your institution / country for communications on HRH commitments)

Name	E-mail	Phone Number
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4) What human resources for health (HRH) -related actions and pathways can your country/ institution commit to? (Please include responsible organization, targets and expected completion dates)

5) How will you monitor progress towards achievement of your commitment pathways (What indicators will you track? What data sources will you use)?

6) Would you or a representative of your country/ institution be available to announce your HRH commitment pathways at the Third Global Forum on Human Resources for Health in Recife, Brazil, on 10-13 November 2013? (Yes/No)

7) Would you accept being contacted by the GHWA or WHO Secretariat after the Third Global Forum to follow up on the implementation of the HRH actions that you commit to? (Yes/ No)

For any necessary clarifications, further information about HRH commitment pathways, to request the submission form in Word format, and to submit your commitments please write to: globalforum2013@who.int with "commitments" in the subject line. Please submit your commitments before 10 November 2013 (earlier submissions are encouraged to facilitate inclusion in the Forum programme)

References

- ¹ Tanahashi, T. (1978). Health service coverage and its evaluation. *Bulletin of the World Health Organization*, 56(2), 295–303.
- ² WHO and OHCHR (2007) The Right to Health – Joint fact sheet 323
- ³ General Comment N 14 of the Committee on Economic, Social and Cultural Rights
- ⁴ Chopra M et al Effects of policy options on human resources for health: an analysis of systematic reviews. *Lancet* 2008; 371: 668-74.
- ⁵ Callaghan M, Ford N, Schneider H. A systematic review of task- shifting for HIV treatment and care in Africa. *Hum Resour Health*. 2010 Mar 31;8:8
- ⁶ Lewin S, Munabi-Babigumira S, Glenton C et al. Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases. *Cochrane Database Syst Rev*. 2010 Mar 17;3
- ⁷ Global Health Workforce Alliance (2010). Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals - A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems. Geneva, Switzerland. <http://www.who.int/workforcealliance/knowledge/themes/community/en/index.html>
- ⁸ Dolea C, Stormont L, Braichet JM. Evaluated strategies to increase attraction and retention of health workers in remote and rural areas. *Bull World Health Organ*. 2010; 88(5):379-85.
- ⁹ Rowe AK, de Savigny D, Lanata CF, Victora CG. How can we achieve and maintain high-quality performance of health workers in low-resource settings? *Lancet* 2005; 366: 1026–35.
- ¹⁰ Coomarasamy A, Khan KS What is the evidence that postgraduate teaching in evidence based medicine changes anything? A systematic review. *BMJ* 2004; 329: 1017.
- ¹¹ Grimshaw J, Thomas RE, MaLennan G, et al. Effectiveness and efficiency of guideline dissemination and implementation strategies. *Health Technol Assess* 2004; 8: 1–72.
- ¹² Jamtvedt G, Young JM, Kristoff ersen DT, O'Brien MA, Oxman AD. Audit and feedback: effects on professional practice and health care outcomes. *Cochrane Database Syst Rev* 2003; 3: CD000259
- ¹³ Thomson O'Brien M, Freemantle N, Oxman AD, Wolf F, Davis DA, Herrin J. Continuing education meetings and workshops: effects on professional practice and health care outcomes. *Cochrane Database Syst Rev* 2001; 2: CD003030.
- ¹⁴ Wensing M, Wollersheim H, Grol R. Organizational interventions to implement improvements in patient care: a structured review of reviews. *Implement Sci* 2006; 1: 2.
- ¹⁵ Dovlo D Using mid-level cadres as substitutes for internationally mobile health professionals in Africa. A desk review. *Human Resources for Health* 2004, 2:7
- ¹⁶ Vujcic M, Weber SE, Nikolic IA, Atun R, Kumar R. An analysis of GAVI, the Global Fund and World Bank support for human resources for health in developing countries. *Health Policy Plan*. 2012 Dec;27(8):649-57.
- ¹⁷ WHO, 2012. WHO recommendations. Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting. Available from: http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/978924504843/en/
- ¹⁸ WHO (2008). Mid-level health workers The state of the evidence on programmes, activities, costs and impact on health outcomes A literature review. Geneva, Switzerland. http://www.who.int/hrh/MLHW_review_2008.pdf
- ¹⁹ World Health Organization (2010). Increasing access to health workers in remote and rural areas through improved retention - Global policy recommendations. Geneva, Switzerland. http://whqlibdoc.who.int/publications/2010/9789241564014_eng.pdf
- ²⁰ World Health Organization (2007). Task-shifting – global recommendations and guidelines. Geneva, Switzerland. Available from: http://data.unaids.org/pub/Manual/2007/ttr_taskshifting_en.pdf
- ²¹ World Health Organization Models and tools for health workforce planning and projections. Available from: <http://www.who.int/hrh/resources/observer3/en/index.html>
- ²² World Health Organization (2010). WHO Global Code of Practice on the International Recruitment of Health Personnel. Geneva, Switzerland. Available from: http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R16-en.pdf
- ²³ World Health Organization 2010. Framework for action on interprofessional education and collaborative practice. Available from: http://www.who.int/hrh/resources/framework_action/en/index.html
- ²⁴ WHO, 2011. WHA resolution WHA 64.7 Strengthening nursing and midwifery Available from http://www.who.int/hrh/nursing_midwifery/en/
- ²⁵ World Bank, 2013 Soucat A, Scheffler R, Ghebreyesus TA Labor Market for Health Workers in Africa: A New Look at the Crisis. Available from <http://www.hrhresourcecenter.org/node/5032>
- ²⁶ Global Health Workforce Alliance. Task Force for Scaling Up Education and Training for Health Workers, (2009) http://www.who.int/workforcealliance/documents/Global_Health%20FINAL%20REPORT.pdf
- ²⁷ Taskforce on International Financing for Health Systems (2009). Constraints to scaling up and costs. Available from: http://www.internationalhealthpartnership.net/CMS_files/documents/working_group_1_report_constraints_to_scaling_up_and_costs_EN.pdf
- ²⁸ Bhutta ZA, Chen L, Cohen J, Crisp N, Evans T, Fineberg H et al (2010). Education of health professionals for the 21st century: a global independent Commission. *Lancet*;375(9721):1137-8.
- ²⁹ Global Health Workforce Alliance. Health workers for all and all for health workers. An agenda for global action; 2008. http://www.who.int/workforcealliance/forum/1_agenda4GAction_final.pdf
- ³⁰ Global Health Workforce Alliance 2011. Outcome statement of the Second Global Forum on Human Resources for Health. Available from: <http://www.who.int/workforcealliance/forum/2011/Outcomestatement.pdf>
- ³¹ United Nations Secretary General (2010). Global Strategy for Women's and Children's Health. New York, USA. Available from: <http://www.who.int/pmnch/activities/jointactionplan/en/index.html>
- ³² WHO 2010. The world health report - Health systems financing: the path to universal coverage. Available at <http://www.who.int/whr/2010/en/index.html>