Health Workforce Innovation: 
Accelerating Private Sector Responses 
to the Human Resources for Health Crisis

Private Sector Task Force Report
Global Health Workforce Alliance

REPORT SUMMARY
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NOTE: A full length version of this report is also available

March 2012

This piece of work has been commissioned by the Global Health Workforce Alliance (the Alliance), a partnership hosted by the World Health Organization (WHO), as part of its mandate to implement solutions to the health workforce crisis. The views expressed in this report do not necessarily reflect the official views of the Alliance. In preparation of the report the Alliance is grateful to all the members of the Private Sector Taskforce especially, Jeffery Moe,(Taskforce Director), Michael Merson, (Taskforce Co-chair) and Caroline Hope Griffith, (Taskforce Officer).
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<tr>
<th>Acronyms</th>
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<tr>
<td>ACHEST</td>
<td>African Centre for Global Health and Social Transformation</td>
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<td>ACT</td>
<td>artemisinin-based combination therapy</td>
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<td>ADDOs</td>
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<td>Association of Rural Physicians</td>
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<td>antiretroviral therapy information system</td>
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<td>BD</td>
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<td>Community Health Insurance Plan</td>
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<td>CCF</td>
<td>co-ordination and facilitation</td>
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<td>CDC</td>
<td>Centers for Disease Control and Prevention (United States)</td>
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<td>CFWclinic</td>
<td>Child and Family Wellness Clinics</td>
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<td>CHMI</td>
<td>Center for Health Market Innovations</td>
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<td>CHW</td>
<td>community health worker</td>
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<td>COHSASA</td>
<td>Council for Health Service Accreditation of Southern Africa</td>
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<td>Department for International Development (United Kingdom)</td>
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<td>FBO</td>
<td>faith-based organization</td>
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<td>FMPOS</td>
<td>faculty of medicine, pharmacy, and dental medicine</td>
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<td>Health Careers of America</td>
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<td>Health Workforce Incubator</td>
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<td>International Partnership for Innovative Health Care Delivery</td>
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<td>KD-AGA</td>
<td>Kampala Declaration and Agenda for Global Action</td>
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<td>Millennium Development Goals</td>
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<td>Medical Knowledge Institute</td>
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<td>Ministry of Health</td>
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<td>Acronym</td>
<td>Full Form</td>
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<td>NCK</td>
<td>Nursing Council of Kenya</td>
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<td>non-governmental organization</td>
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<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<td>PMTCT</td>
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<td>public-private partnership</td>
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<td>private sector partnership</td>
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<td>Private Sector Task Force</td>
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<td>Standards-Based Management and Recognition</td>
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<td>United States Agency for International Development</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>ZAAI</td>
<td>Zambia Access to ACT Initiative</td>
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A. Introduction

The human resources for health crisis

In 2006, the World Health Organization (WHO) estimated a global shortage of 4.3 million health workers. There are 57 countries with a critical shortage; 36 of these are in sub-Saharan Africa.¹ The insufficient supply and uneven distribution of qualified health professionals severely thwarts efforts to achieve the health-related Millennium Development Goals (MDGs).²

Analysis of the private health sector

The public sector is expected to serve as the primary provider of health services and a steward of the health system. However, the public sector faces many constraints (e.g., growing and changing disease burdens, lack of health personnel, and scarce financing) and must rely on participation from the private sector to assist in health system capacity-building and improvement of health outcomes. For the public sector to leverage the private health sector, it must create an enabling environment that encourages private sector participation and holds the private sector accountable for its contribution. The private health sector spans the entire health value chain, including provision/creation, financing, manufacturing, distribution, and retail. It includes the following stakeholders:

- For-profit organizations
- Social enterprises
- Non-profits, including non-governmental organizations (NGOs) and faith-based organizations (FBOs)
- Privately-motivated individuals and groups of individuals
- Informal sector entities, including traditional healers, birth attendants, and individual medicine sellers³

The role of the private health sector in resource-poor settings

The private sector accounts for more than 50% of health expenditures in resource-poor countries in Africa and Asia.\(^4\) Patients often choose private providers because of perceived higher quality services and accessibility of care. The private sector also provides “much-needed capital, competition among providers, management skills for operating complex systems like hospitals, and innovation and flexibility in health care delivery.”\(^5\) Yet invoking the private sector raises concerns about unregulated commercialization and quality of care, while also inciting ideological conflicts regarding healthcare privatization.\(^6\) There is also a factual basis, in some cases, for patient concerns about the quality of services they receive through the private sector. Financial incentives, limited resources, lack of regulation, and inadequate health worker training can conspire to create circumstances where patients receive sub-standard care from private providers.\(^7\) The international community recognizes the importance of, and challenges associated with, engaging the private health sector. For example, recent private health sector assessments in Ghana, Kenya, and Mali conducted by the World Bank and USAID, as well as a report by the International Finance Corporation (IFC)/World Bank explore how governments can create optimal operating (or enabling) environments to engage the private sector to improve health in Africa, and how the private sector can best prepare for engagement with the public sector. Additionally, the Kampala Declaration and Agenda for Global Action (KD-AGA) advocates for innovative public-private partnerships (PPPs) that leverage the private health workforce to contribute to health goals within country strategic plans.\(^8\)

The Global Health Workforce Alliance (GHWA) Private Sector Task Force (PSTF)

The PSTF was formed under the aegis of the GHWA to understand how the private sector was responding to the human resources for health (HRH) crisis; identify practical and actionable insights to accelerate successful private sector responses; and to actively

engage, within significant resource constraints, with a small subset of private sector innovators to support their activities and increase the PSTF’s insights into successful private health sector responses. Three general questions informed the work of the PSTF:

- How is the private health sector innovating in response to the HRH crisis?
- What is enabling health workforce innovation in the private health sector?
- How can those innovative responses be accelerated?

To examine these questions, the PSTF reviewed 31 initiatives in low-income countries (primarily located in Africa) that increased the supply, improved the effectiveness, and/or slowed attrition and misdistribution of health workers. The PSTF also contributed to the scaling and cross-border implementation of three private health sector initiatives in Kenya, Mali, and Zambia. Based on these experiences, the PSTF has identified critical enabling environment factors that can determine the success or failure of private sector HRH initiatives and proposed actions to facilitate engagement of the private sector in a way that enhances the quality and management of private sector services.

**B. Health workforce innovators**

Researchers have identified a number of private health sector innovators, which have also been described as “disruptive innovators,” that develop simpler and cheaper services or new business models to provide services.\(^9\) Numerous healthcare delivery innovators working in low- and middle-income countries are improving access to care while reducing costs and improving quality.\(^10\) Among these private health sector innovators, the PSTF identified a unique capability: innovation to secure and optimize the health workforce. While these private sector actors developed new models for care delivery, financing, or regulating performance,\(^11\) they also found alternative ways to supply and optimize their health workforce. Specifically, they developed strategies to increase the supply of health workers, improve the effectiveness of existing health workers, and increase health worker retention. These strategies have been identified by the KD-AGA as critical to solving the

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health workforce crisis. The PSTF has named this subset of private health sector actors “health workforce innovators.”

The PSTF identified health workforce innovators that are (1) demonstrating innovative approaches to increasing the supply of health workers (e.g., the Rural Technology Business Incubator, the AMREF eLearning Program), (2) using innovative approaches to increase the effectiveness of existing health workers (e.g., Tulane University Technical Assistance Program, MSH Technical Assistance to COMBASE), and (3) improving retention of health workers (e.g., JHPIEGO Ethiopia, Santé Sud-Mali Rural Physician Initiative).

In a few cases, these health workforce innovators are specifically organized to address the health worker shortage. They are the exception. More frequently, workforce innovators have discovered new approaches to human resource provision in response to the scarcity of health workers needed to pursue their primary organizational goal. While the PSTF found health workforce innovation in the private sector, it is but one part of a comprehensive response to the HRH crisis. The private sector responses (i.e., health workforce innovation) need greater support both internally and from actors in the enabling environment that potentiates and constrains the innovators.

The PSTF report is not prescriptive: the innovators identified in the report are not the only innovators or the best-in-class. In most instances, information regarding the methods and results are self-reported and limited. The report, therefore, is descriptive, and limited by and to self-reported data.

C. Enabling environments

Health workforce innovators observed by PSTF do not fully expand or scale in their existing locale and rarely replicate into other markets or national contexts. For the private health sector, we use the term “enabling environment” to describe a milieu of health and business institutions, capabilities, capital markets, legal systems, and labor markets that allow health-related businesses and organizations to form and grow. The report describes linkages to a set of factors in the social and business environment, the enabling environment, that the workforce innovators report have both potentiated and constrained


13 The identified set of health workforce innovators is not exhaustive, but it is robust enough to demonstrate that health workforce innovation is occurring globally in resource-poor settings where the health worker shortage is most acute.

14 Appendix B contains detailed information on the innovators reviewed by the PSTF.
their reach and scope. It was clear from this limited sample that the
direction of causality was bi-directional: health workforce innovators
are influencing the enabling environment as it is influencing them. The
report suggests that innovations wither or flourish, not solely on the
merits of the product or service itself, but inter-dependently with the
surrounding complementary organizations and environment, both
political and social, that influence the innovators’ outcomes.

The PSTF identified the characteristics of the enabling environment
for the 31 workforce innovators while working collaboratively with
three projects: AMREF’s Nurses’ eLearning Upgrade Programme in
Kenya, the Zambia Access to ACT Initiative (ZAAI), and the Santé
Sud-Mali Rural Physicians Initiative. Nine enabling environment
factors were salient for this sample of health workforce innovators.
These components of the enabling environment both constrain and
potentiate continued health workforce innovation.15

**Government engagement:** Governments operate in four roles:
- **Enactor:** intervening to create reforms that influence or create
  the opportunity for innovation;
- **regulator:** ensuring checks and balances for a level playing field
  among competing private sector firms to ensure quality of services
  and competition;
- **active partner:** contributing through public-private partnerships
  (PPPs); and
- **provider:** funding and provisioning the healthcare infrastructure
  in which innovators operate their projects.

**Political will:** Workforce innovations require political will
exercised by influential leaders, both elected and in civil society.
Sustaining political will and support is important to workforce
innovation, particularly with regards to expanding and reaching
full scale and replication.

**Health worker advocacy organizations:** Health workers are
organized into professional associations and advocacy groups.
In many countries, these groups have formal regulatory standing
or work closely with governments to assure competency and
training standards. Additionally, they frequently advocate for
policies regarding quality and safety, health worker training,
preparation and certification, and pay. Many workforce innovators

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15 An important threshold requirement for the private sector is the business institutional environment. This
component of the private sector environment includes financial systems, contract enforcement legal
systems, and failure recovery mechanisms. These factors are included in the “business and capital”
dimension of the enabling environment for health workforce innovators. The analysis in this report does
not attempt to quantify the minimal requirements for the business institutional threshold to be established.
It assumes that where health workforce innovation is found, the threshold has been met, while reporting
that its continued development is necessary for health workforce innovators to expand and replicate
beyond their current levels. For more information, see: McCraw, T. 1986. Cambridge, MA: Belknap Press.
work or lobby directly with these advocacy organizations for changes in standards. Box A provides an example of how the Medical Council of India introduced a new degree for rural physicians.

**Local ownership:** Many workforce innovations include local ownership as a means to secure local buy-in and increase local capacity. Where the innovation has become partially or fully self-sustaining, local ownership (through franchise or other local ownership mechanisms) has been observed. Box B shows one example of a franchising model.

**Civil society:** Health workforce innovators must fit their approaches into the social and cultural environment of the country in which they operate. Box C describes how public-private dialogue (PPD) can be used to engage civil society.

**Business and capital:** Research has identified three market factors necessary for institutional development of business: financial systems, legal systems for enforcing contracts, and constructs to allow failure. Access to capital (e.g., from local or international investment or loans, government or foundation aid, or private donations) is a critical enabling factor for the initiation, scaling, and replication of health workforce innovation.

**Technology:** Many workforce innovators use information and communications technology to expand their reach, lower costs, or create new models of healthcare delivery. Technology innovation assumes a local infrastructure that is reliable, stable market prices, and trained individuals with technology-specific capabilities. Educational institutions and private sector training of technical staff are therefore included in this component of the enabling environment.

**Education and training:** Health workers are trained and educated by public institutions, private educational organizations, non-governmental organizations (NGOs), and private firms. Innovators are seeking faster and more cost effective methods to meet their workforce needs by introducing new care delivery models and paraprofessional roles. These new models of care and new roles create tensions among government as the regulator, health advocacy professional organizations as educators and trainers, and the workforce innovator.

**Health workforce innovators:** Workforce innovators are a part of the enabling environment in which they operate, but vary in
their ability to operate as effective businesses. For instance, only some have plans for self-sustaining their organizations and capabilities to measure performance and link with other initiatives. Health workforce incubators are one strategy advocated by PSTF and the International Partnership for Innovative Health Care Delivery (IPIHD). IPIHD will include workforce innovators such as those identified by PSTF in its innovative health delivery incubator to accelerate the development of individual innovators and the enabling environments that support them.

## D. Health workforce incubators

Business incubators increase the number of businesses, which in turn increases the capacity of the business institutional market (i.e., the enabling environment).¹⁶ Spawning, scaling, and replicating through incubation can be applied directly to the HRH crisis through what the PSTF calls health workforce innovators. In parallel and in collaboration with the PSTF, the IPIHD has identified a number of gaps that restrain health provider innovators who survive start up and expand to the intermediate stage of development.¹⁷,¹⁸ The PSTF and IPIHD recommend the development of a health innovation incubator to promote the growth and replication of selected private healthcare providers in resource-poor settings. The PSTF recommends that its call for the expansion of health workforce innovation through incubation be conjoined with the IPIHD effort. The PSTF and IPIHD recommend three critical components for a health innovator incubator.

- Identification of local unmet healthcare needs, local health workforce innovators, and an assessment of the enabling environment factors
- Leadership, management (and enabling environment) training; business plan preparation
- Matching of funders to plans

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¹⁶ There are 134 business incubators operating in 68 emerging markets. For more information, see: World Bank survey. 2006.

¹⁷ See www.IPIHD.org

Box A

Professional Health Worker Advocacy Groups: Introducing a new physician training program in India

Physician shortages in rural areas impede the achievement of universal health care in India.¹ As indicated in Figure B, physician density is four times greater in urban areas than rural areas. The country’s medical degree policies partially explain this trend.² Proponents of medical education reform, including the Medical Council of India (MCI), determined that the five-year Bachelor of Medicine and Bachelor of Surgery (MBBS) program was creating graduates with professional and personal expectations that were incompatible with serving in rural areas.¹ However, regulatory authorities were unwilling to consider alternate training schemes as such schemes were frowned upon by some prominent physicians and were believed to provide subpar care to rural patients. Although the medical fraternity voiced opposition to the rural degree, MCI used its position as the country’s statutorily mandated professional association to advocate for this innovation in medical education.³,⁴

Unable to gain regulatory approval of a shorter MBBS degree program, MCI defied regulatory authorities and began offering a shorter, four-year training program. Only after MCI was already placing graduates of this program in rural areas did the regulatory authorities concede and recognize the new degree.

The rural MBBS program is one year shorter in duration because it excludes content (e.g., advanced surgical techniques) irrelevant for rural primary care practitioners. The focus on a particular care setting ensures that clinicians will be fully competent in the skills necessary for rural practice. Detractors argue that physicians trained for only four years will be of lower quality than traditionally trained physicians, but little evidence indicates how long it takes to produce a competent doctor.³ The MCI’s rural MBBS program has been lauded for its innovation, particularly in light of the enabling environment constraints it initially faced.

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Family planning services are out of reach for millions of Pakistanis. Family planning options are limited by poor quality programs, a lack of serious government efforts to promote family planning, and insufficient local buy-in. To overcome these hurdles, Greenstar Social Marketing Pakistan uses a franchising model to distribute family planning products and services. The organization operates a network of over 7,500 private healthcare providers, including male and female doctors, female paramedics, and pharmacists. Greenstar signs franchising agreements with providers for distribution of 19 products or services and maintains ongoing contact to ensure quality.

In addition to providing supplies and technical support, Greenstar employs doctors who train franchisees in family planning counseling, hormonal contraceptive dispensing, and IUD insertion. Greenstar has developed a strong brand associated with high quality care. It is now the country’s second-largest provider of family planning services.

Greenstar’s local ownership model helps create demand for health services and products. In addition to mass media campaigns, local clinics use street theater and mohalla (neighborhood) meetings to foster greater awareness of family planning. For women, mohalla meetings encourage open discussion of sensitive issues in a safe and conducive environment. Trained Greenstar providers, who are highly regarded within their community, lead the meetings and provide accurate medical information. A 2002 external evaluation showed that as many as 25% of attendees subsequently seek a family planning consultation with a Greenstar provider.

Civil Society: The role of public-private dialogue in advancing the business environment in Malawi

The liberalization of Malawi’s economy in the early 1990s aimed to increase private sector diversity and competition. However, Malawi’s economy remained characterized by high levels of government ownership and control. Attempts in the late 1990s to engage the private sector and civil society were generally weak and inappropriate. Some dialogues degenerated into a running argument in private and public, resulting in further entrenchment of positions and abandonment of dialogues. Consequently, the private sector often ignored governmental processes or was unhelpfully critical of government.

Engaging civil society, including civic groups, trade associations, labor unions, religious entities, and professional associations, is crucial to the ability of health work workforce innovators to carry out their mission. Such engagement stimulates local initiative and draws inward investment. In Malawi in the 1990s, a lack of trust between these entities and government hindered progress. Public-private dialogue (PPD) can play a role in engaging civil society and promoting enabling environment reform. Governments that listen to the private sector are more likely to promote workable reforms, while entrepreneurs who understand government objectives are more likely to support these reforms.

In Malawi, processes emerged to create opportunities for effective PPD. These were often initiated by forward-looking business people, civil servants, and government ministers who saw the need for and benefits of engaging with each other. As indicated in Figure D, PPD was just one way in which the private and public sectors interacted. In 2001, following a national event about developing the private sector, a small group of senior public and private sector leaders met to prioritize sub-sectors for national focus. Titled the National Action Group (NAG), it recognized the need for continuing dialogue and continued to meet with the help of local facilitators. Since 2001, NAG has progressively expanded its discussions by inviting in other people and organizations that can help resolve barriers to business development. Its objective is to improve the enabling environment through dialogue and action.

In 2002, DFID funded a Secretariat to support the NAG process by convening the group, undertaking supporting analysis, establishing and developing industry working groups, and following-up on agreed actions. In 2003, NAG determined that it should not just address issues as they arose, but should develop a “business plan for Malawi.” This resulted in a joint public-private strategy for private sector development, the Malawi Economic Growth Strategy (MEGS). Among other components, the MEGS states: “The economic returns for public and private investment in people are often extremely high. Markets in developing countries cannot generally be relied upon to provide people, especially the poor, with adequate education (especially primary education, health care and nutrition). In addition to increasing the quality of human investment, Governments must improve its quality.” The NAG promoted PPD by engaging civic groups, business, and the government.

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E. The way forward

The private health sector can play a role in solving the HRH crisis. Health workforce innovation can contribute to those private sector efforts with observation, research, expansion, and replication. A number of organizations serve as repositories of research and provide support for the development of health workforce innovators. For example, the Center for Health Market Innovations (CHMI) is a web-based model that observes continuing workforce innovation. A clearinghouse or data repository such as CHMI can include workforce analysis or a specific thematic interest in workforce innovations. The Health Systems Initiative (University of California at San Francisco), ACCESS Health International, the IFC, the Corporate Council on Africa, the Rockefeller Foundation, the Bill and Melinda Gates Foundation, and the Institute for Healthcare Improvement are also repositories of research and support, case studies, and critical success factors regarding private sector innovation and expansion in resource-poor settings.\(^{19}\) The PSTF recommends the following next steps to foster health workforce innovation and respond to the HRH crisis:

Observation

- **Create a clearinghouse or data repository with updated information on health workforce innovators across the globe:** Private sector actors need resources to make them aware of alternative models to meet health workforce needs. As has been described, the CHMI is a web-based model that identifies private sector innovations and includes a feature that matches innovators to funding. It would be desirable if the CHMI included analysis or a specific thematic interest in health workforce innovations. A clearinghouse or data repository such as CHMI that tracks innovators will assist in the dissemination of this knowledge.

- **Standardize measurement and evidence regarding activities and outcomes:** Many universities, foundations, and private organizations have their own approaches and requirements for funding. These requirements often prescribe measurement and evidence gathering. Those institutions can collaborate to develop standards.

\(^{19}\) The aforementioned organizations and firms are representative and are not a complete listing.
Research

- **Acquire funding to study several of the most promising workforce innovator approaches:** Most health workforce innovators report self-developed information. Rarely does that information include health outcomes or results validated by third parties with statistically rigorous methods. Actors interested in replicating or modifying these approaches would benefit from research. One partition in such a research design would be to compare innovators that are attempting self-sustaining business models versus those that are not (partial or full self-sustenance may not be possible given the nature of the service population or business model).

- **Develop a medium- to long-term research agenda focused specifically on private sector workforce innovation:** Workforce innovation and the scope and immediacy of the workforce shortage demand an action-research model: supporting innovation while observing. Private sector contributions to filling the workforce gap can be better understood and accelerated through research. Many of the institutional actors identified for involvement in the development of common evidence standards are also engaged in research and could develop this type of a research agenda.

- **Apply the new science of implementation research to health workforce innovation:** Typically, implementation science is defined as the translation of medical evidence to real world application. As applied to scaling and/or replication across national borders, it could provide useful concepts and approaches to research. Many of the university and research-oriented institutions cited in this report are organizing various disciplines to build implementation science capabilities. The PSTF recommends that health workforce innovation serve as a subject area to test these emergent insights and skills.

Expansion

- **Provide training to workforce innovators in business planning, self-sustenance, measurement and linkages, and assessing the enabling environment:** Health workforce innovators frequently do not reach scale due to constraints in the enabling environment, including the innovators themselves.
National governments and NGOs with a focus on HRH and/or economic development in the health sector may target workforce innovators for such training.

• **Increase dialogue between key actors in the workforce enabling environment:** Dialogue has the potential to reduce barriers that result from long-standing misunderstandings between the public and private sectors. The HRH crisis has created an imperative for action that can be supported by dialogue. Abt Associates and Bannock Consulting\(^{20}\) have demonstrated successful techniques and the benefits of such dialogue. In addition, IFC’s Healthy Partnerships report describe case examples and effective approaches to promoting such dialogue. The KD-AGA country co-ordination and facilitation (CCF) process also brings all HRH stakeholders in a country together to jointly plan, implement, monitor, and evaluate comprehensive HRH policies, strategies, and plans. Health worker advocacy organizations must be directly engaged not only to lobby for the conditions to help their members succeed but also to support private health workforce innovation. At times, these may be conflicting and competing demands.

• **Direct government and NGO economic development efforts to the private health sector with particular attention to including health workforce innovators:** USAID’s Banking on Health initiative has demonstrated that direct efforts with local banking institutions and private sector for-profit firms can improve access to capital. Assisting a select group of workforce innovators to reach scale in a local, regional, or national context can serve as a model for addressing health workforce needs while introducing new approaches to financing, health delivery, and/or quality.

**Replication**

• **Recruit health workforce innovators to participate in existing health sector incubators:** Lack of replication by health workforce innovators is in part the summary effect of lack of observation, research, and expansion. Expansion and replication may also be limited by the surrounding complementary organizations and environment, both political and social, which constrain the innovators’ outcomes. The

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PSTF suggests identifying and recruiting health workforce innovators to participate in existing initiatives such as the IPIHHD, which is organizing private corporate partners to initiate an incubator for health provider innovators.

- **Provide funds and a competitive bidding process (including a cycle of needs identification, requests for proposal, proposal responses, awards, and funding) to foster replication of innovators**: Incubators are not the only method to promote replication. Governments, local universities, or NGOs could sponsor such activities. Local and regional actors can review their health needs and seek out private sector partners to find models worthy of replication. While governments and NGOs may require technical support, global foundations and bi-lateral aid programs can initiate such a cycle by focusing on the replication of successful health workforce innovations.
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Descriptions of Health Workforce Innovators\(^{21}\)

Health Workforce Innovation to Increase Health Worker Supply

Nine private sector initiatives were selected based on their innovative approaches to increase the supply of health workers.

**Rural Technology Business Incubator – First Care Health Enterprise:** First Care is directed toward training, credentialing, equipping, and supporting “rural medical practitioners” to deliver simple primary health interventions. The program works to improve providers’ knowledge and skills; develop documentation systems for patient follow up; promote a holistic approach to patient care; develop strategies for standardization of health services; supply providers with low cost commodities, public health products, equipment, and audio-visual health education material; and develop simple diagnostic services. All this is enabled through the use of information and communications technology (ICT). Additional information is available at http://www.rtbi.in/.

**Medical Knowledge Institute (MKI):** MKI is a Dutch non-profit organization that helps bring medical education and knowledge to local communities in 14 sub-Saharan African countries. The organization’s emphasis is on empowerment of local community members (vs. professional healthcare workers) through Health Information Centers that serve as educational resources and community centers. In 2008, MKI opened several Health Information Centres in Khayelitsha, Cape Town, Stellenbosch, Pietermaritzburg, and Soweto. The Health Information Centres created for the local communities offer a selection of training courses teaching different life skills and provide contacts with relevant support/information. Like many of the projects

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\(^{21}\) Information on these health workforce innovators was gathered in 2008 and updated in 2010.
Interviewed for this report, MKI is just starting to measure results. However, it can be said that more basic health services are being provided by a greater number of unqualified, but now trained, basic health workers through MKI efforts. Additional information is available at http://www.infomki.org/.

AMREF – Maridi: AMREF opened Sudan’s Maridi National Health Training Institute in 1998; the first group of students graduated in 2001. By 2008, AMREF had trained 130 clinical officers, who accounted for more than half the total number of clinical officers in the whole region. In addition to its three-year course in public healthcare, nursing care, and surgical procedures, AMREF trains community or auxiliary health workers such as community health workers (CHWs). AMREF – Maridi is scaling-up a nine-month training program for CHWs. Upon completion, they can go on to become nursing assistants (which requires one year of study), and clinical officers. The program is also training community midwives and helping the government train medical technologists and nurses of all levels. The project plans to train public health technicians, officers, and laboratory technologists in the near future. Additional information is available at http://www.amref.org/where-we-work/our-work-in-southern-sudan/.

Touch Foundation: The mission of the Touch Foundation is to provide funding and management resources to developing countries for local programs that create HRH; build awareness around problems in healthcare delivery in developing countries; create, collect, store, and provide access to the leading information about global health; and share the knowledge gained from programs the foundation supports. The Touch Foundation works at Bugando Hospital, a public hospital that is the second largest hospital in the country and is funded partly by the Tanzanian government. Touch funds the hospital’s medical school (almost all students come from Tanzanian public schools), and, through the government, funds several students. In 2008, just four years after the initiation of the Touch Foundation, the number of medical students had increased from ten to 277, while total student enrollment across the university’s medical, specialist, and six paramedical programs had grown to around 800. Additional information is available at http://www.touchfoundation.org/.
Healthstore Foundation/CFW Shops: The HealthStore Foundation, a global leader in the use of franchising to distribute basic healthcare in the developing world, operates child and family wellness clinics (CFWclinics) in Kenya and Rwanda. HealthStore/CFWclinics target nurses and CHWs as franchise owners to address a short list of diseases. Franchisees offer therapies and interventions, including medicines supplied through the CFW shops, for which they are specifically trained. As of 2008, HealthStore had served over 2,000,000 patients and customers through its network in central Kenya. This network treats an average of 40,000 customers and patients per month. Additional information is available at http://www.cfwshops.org/.

Accredited Drug Dispensing Outlets (ADDOs): The aim of the ADDO program is to ensure that more than 80% of rural and peri-urban areas in Tanzania Mainland have an opportunity to purchase quality-assured basic medicines from well-regulated and properly operated private medicine outlets manned by trained personnel. MSH’s ADDO project supplements the public drug supply system. The ADDO shops are organized as private ownership opportunities using a PPP model, which is a new approach for many governments and civil servants. The ADDO network has also created a system for application and repayment of loans by ADDO owners through micro-financing institutions and provides access to medicines through health financing schemes such as the National Health Insurance Fund and the Community Health Fund. Like HealthStore/CFW, it holds the promise of being self-sustaining as the new health workers operating through these vehicles act as owner-operators. Additional information is available at http://www.msh.org/projects/rpmplus/WhereWeWork/Africa/ADDOs.cfm.

Health Careers of America: Health Careers of America (HCOA) addresses the shortage of nurses and healthcare workers by supporting universities in developing countries with the funding, curriculum, technology, and trainers needed to develop healthcare workers. HCOA source countries include Ghana, Liberia, Uganda, Burundi, Rwanda, and Kenya. HCOA contracts with health facilities in developed host countries that are experiencing a shortage of nurses and are willing to pay to attract highly trained and qualified nurses from the developing world to work at their institutions. Host countries include the United States, Australia, and Canada. In April 2009, HCOA
launched the Millennium Managed Migration Investment Plan (M(3) Investment Plan) to train and place 500 health workers. HCOA employs an innovative financing mechanism: the HCOA Alliance Fund. The Fund was jumpstarted by five hospitals in the United States and Canada and some private investors. The Fund is sustained by private enterprise, makes a return on its investment, and is financially sustainable. Additional information is available at http://www.healthcoa.net/.

**Aga Khan School of Nursing (AKU-SON):** Since its inception in 1980, AKU-SON has played a leading role in establishing an internationally acceptable model for nursing education and practice in Pakistan and has trained 2,232 nurses. AKU-SON’s first academic initiative outside Pakistan, the Advanced Nursing Studies (ANS) Programme, began in Africa in 2001. It is designed to improve the quality of patient care by encouraging practicing nurses to enhance their expertise through the pursuit of higher education. An interviewee reported that, as of 2008, only three of 800 AKU-SON graduates have left Uganda in the last six years, which they believe is due to AKU’s highly active career management activities, which helps graduates find opportunities within the country. AKU demonstrates both flexibility in the delivery of its training as well as on-going support to increase the supply of qualified healthcare workers. Additional information is available at  http://www.akdn.org/aku_nursing.asp.

**AMREF’s Nurses’ eLearning Upgrade Programme in Kenya:** To pioneer a country-wide eLearning program for upgrading nurses in Kenya, AMREF formed a PPP with the Nursing Council of Kenya (NCK), the African Medical and Research Foundation (AMREF), Accenture, the Kenya Medical Training Colleges, several private and faith-based nursing schools, and the Ministry of Health (MoH) Kenya. AMREF chose to use distance learning. In 2008, they developed 100 eLearning centers with 25 participating nursing schools. They had more than 4,500 nurses enrolled in 29 nursing schools across the country that year, using both print and eLearning modules. The 100 computer-equipped training centers were set up in eight provinces, including remote and marginalized districts. Currently, AMREF eLearning offers 17 short, distance-learning courses in areas of need. This innovative approach is increasing the supply of qualified nurses. Additional information is available at  http://www.amref.org/info-centre/amref-courses--training-programmes/elearning-programme-/.
Health Workforce Innovation to Improve the Effectiveness and Efficiency of Existing Health Workers

Thirteen private sector initiatives were analyzed and selected for discussion regarding their innovative approaches to improving the effectiveness and efficiency of healthcare workers.

Tulane University Technical Assistance Program – Ethiopia (TUTAPE): The Tulane School of Public Health and Tropical Medicine piloted the TUTAPE program in 2006. The partnership between Tulane University and Jimma University in Ethiopia created a monitoring and evaluation curriculum for the Ethiopian Ministry of Health and provides the African country with a core of health workers trained to assess the effectiveness of health programs. TUTAPE itself is being rigorously monitored and evaluated, but large-scale results are not yet available. Interim results have been assessed and implemented regarding ancillary initiatives (health information systems) that have changed and standardized the structure of data collection in the country. This novel approach recognizes that on-going monitoring and evaluation will require specialized skills and a new cadre of professionals to carry out those duties.

HIV/AIDS Coordination, Human Resources, and Health Systems – Zambia: In 2004, Abt Associates began a six-year health services and systems program (HSSP) with the Ministry of Health to review and provide feedback on 72 district health action plans and ensure that 28% of districts had one facility offering a minimum package of HIV/AIDS services. This work includes analyzing human resource and training needs, introducing a health workers retention scheme, implementing an antiretroviral therapy information system (ARTIS) in 76% of the facilities nationwide, and developing a mechanism to accredit antiretroviral therapy (ART) providers in the private sector. Currently, clinical care specialists (seconded to all Provincial Health Offices) offer technical support supervision to health workers to improve quality, with special emphasis on HIV/AIDS services. Additional information is available at http://www.abtassociates.com/collateral/ZambiaHSSP.pdf.
The Council for Health Service Accreditation of Southern Africa (COHSASA): The COHSASA assists a range of healthcare facilities (public and private) to meet and maintain quality standards. It does so by enabling healthcare professionals to measure themselves against standards and monitor improvements using quality improvement methods, internationally accredited standards, and a web-based information system. COHSASA provides data on the quality of health service provision to governing authorities so that the data can be used for strategic decisions. As of 2009, over 435 facilities have entered the COHSASA program. Additional information is available at http://www.cohsasa.co.za/.

Bidan Delima Quality Recognition of Private-Sector Midwives: IBI, the Indonesian Midwives Association, collaborated with STaRH to form and launch the Bidan Delima network of high-quality midwives. Members of Bidan Delima have passed rigorous evaluations of their professional midwifery practices, including clinical and counseling practices for safe delivery, family planning, and pre- and post-natal care. The Bidan Delima project is an attempt to reach private practice midwives and provide an opportunity to bring their skills to the established standards and the rank of “Bidan Delima.” As of 2008, 1,668 midwives received the Delima certification. In West Java, there were 8,537 midwives, of which 6,000 were private midwives. There is still opportunity for growth of the Bidan Delima program. Additional information is available at http://healthmarketinnovations.org/sites/healthmarketinnovations.org/files/FINAL_BidanDelima72011.pdf.

RAISE Service Delivery Training Centers: RAISE is a five year joint program between Columbia University and Marie Stopes International to improve the reproductive healthcare response in crisis settings. The program has three major goals: 1) strengthen the institutional commitment of healthcare facilities; 2) expand the quality of reproductive health services provided; and 3) enable policy and funding environment. RAISE has centers in Nairobi and Burkina Faso that train existing healthcare workers in reproductive health. RAISE is developing a train-the-trainers course and a clinical supervision course. When the health workers return home from the training course, RAISE provides monitoring and support in the health worker’s country of origin through partner organizations. Additional information is available at www.raiseinitiative.org.
**MSH Technical Assistance to COMBASE:** COMBASE is a nonprofit Christian evangelical organization founded in 1964 to provide health services to the people of Cochabamba, Bolivia, and surrounding areas. Through its small general hospital and five clinics, COMBASE serves low-income groups, primarily women and children. In 2001, assessments showed that poor leadership, deficiencies in management systems, cash shortages, and debts were affecting the performance, financial stability, and sustainability of the organization. To remain competitive as a health service provider, COMBASE worked with MSH to update the program and financial information systems; design new human resource, administrative, and financial management systems; and improve overall organizational financial performance, which included a change from a salary system to a fee-driven system that ties payments to performance. This shift in remuneration policies, the improved effectiveness and efficiency of the organization, and the staff’s religious devotion to the organization’s mission has helped to retain healthcare workers. Additional information is available at http://www.msh.org/projects/mandl/4.8.1.html

**Karuna Trust:** The project is a collaboration between the Ministry of Health and Family Welfare, the government of India, the Department of Health and Family Welfare, the government of Karnataka, the UNDP, and the National Insurance Company to deliver community health insurance that is not exclusive of any disease at an affordable cost. The objectives are to develop and test a model for community health financing; increase access to public healthcare for the rural poor; and ensure equitable distribution of health through social insurance. As of 2008, Karuna Trust was running 30 primary health centers in all the districts of the state of Karnataka and nine primary health centers in Arunachal Pradesh.

**FriendlyCare Foundation, Inc.:** FriendlyCare was founded in the Philippines in 1999 with the vision of becoming a vehicle for greater private sector participation in the delivery of basic family health services such as family planning and reproductive health. The clinic offers family planning (donor subsidized) and other health services (fee-based). Today, its network of six clinics provides comprehensive, quality, out-patient services at affordable prices and is able to pay its nurses at a higher rate than in other clinics and provide a fee-for-service scheme for doctors within the network. FriendlyCare supports its
partner universities by providing on-the-job training for nursing students, and training of graduated midwives in business and other clinical skills. Additional information is available at http://healthmarketinnovations.org/program/friendly-care-foundation-fcfi

**Rwanda: Community Health Insurance Plan (CBHI):**
Community Health Insurance Plan (CBHI) schemes in Rwanda are health insurance organizations based on a contract between the community and healthcare providers (e.g., health centers, hospitals). They were started in Rwanda in 1999 and slowly, but progressively, expanded to cover 85% of the population by 2008. The CBHI schemes create legal mechanisms and elect representatives to regulate contractual relations between the organization and its members. Members of the insurance schemes use services four times more than non-members; thus, the government made participation in the private, community-based schemes mandatory. Members pay $2/person/year and Global Fund financing is used to cover 15% of the costs for the poorest sector of the population. In total, 73% of the population is currently covered.

**Hygeia:** Hygeia Nigeria Limited was incorporated in 1986 as a limited liability company. In 2003, the company reorganized itself and became the Hygeia Healthcare Services Group, comprised of four structures. The goal of Hygeia is to scale HIV/AIDS treatment via private sector providers by implementing capacity building for healthcare professionals in HIV/AIDS, TB, and malaria. The Hygeia Community Health Plan is a partnership between Hygeia, PharmAccess, and the Dutch Health Insurance Fund that resulted in the development of a community health insurance scheme offering insurance premiums for low-income communities. As of 2008, over 50,000 people have enrolled in the scheme from the communities of Shonga, Bacita, and Lafiagi. Since then, there has been a plan to enroll and provide access to medical care for an additional 50,000 individuals over a five year period.

**Janani:** Janani is a non-profit that implements a large service delivery program of quality health and reproductive health services and products in three of the poorest states of India. Identifying rural practitioners and private doctors as the avenues of opportunity, Janani has trained over 40,000 rural health providers, established 620 franchised medical clinics,
and delivers its products through 31,000 shops. Janani has established a partnership with the government and uses a business-franchising model and social marketing to network private providers. Additional information is available at http://www.janani.org/

**The AIDS Support Organization (TASO) – Uganda:** TASO is the largest indigenous NGO providing HIV/AIDS services in Uganda. The organization provides care and treatment to people living with HIV/AIDS, trains clinic healthcare workers, and educates the broader community. The Ugandan Ministry of Health (MOH) outsources to TASO clinics in 11 of its hospitals. TASO follows the guidelines put in place by the MOH for HIV/AIDS health services. Funding comes from a variety of sources including PEPFAR, SIDA, Irish Aid, and the Danish International Development Agency. As of 2008, 21 years after its inception, 200,000 people have received care from TASO. Additional information is available at http://www.tasouganda.org/

**Health Workforce Innovation to increase Retention of Health Workers**

Nine private sector initiatives were analyzed and selected for their novel approaches to improving the retention and/or overcoming misdistribution of healthcare workers.

**Santé Sud-Mali:** In 1989, Santé Sud (a French-Malian NGO) and the University of Bamako Faculty of Medicine, Pharmacy, and Dental Medicine (FMPOS) professors created the Rural Doctors Association and launched the Rural Physicians Initiative (Medecins de Campagne) to place young, well-trained physicians in remote rural areas in Mali. The European Union and French Cooperation funded the program, which recruits, trains, places, and supports young Malian doctors. From 1989 to 2009, more than 200 doctors worked with rural communities in the eight regions of Mali for an average of three years, serving a total of two million inhabitants. The program recruits young doctors wishing to relocate to rural areas, ensures they receive additional medical training in community health (theoretical and practical) to reduce the gap between their basic training and community demand, and incorporates them into a continuing education network. The process includes supervision and mentoring services for the doctors. The doctor has a contract that permits him to generate additional financial resources by earning a
percentage of the services that he provides in his facility. This process ensures the financial viability of the health center, while improving local health indicators. The experience of Medecins de Campagne has shown that the introduction of incentives and a proper monitoring mechanism attract and stabilize medical staff in rural areas who, due to a lack of funding, would otherwise have an uncertain future.

**Uganda Private Midwives Association (UPMA):** The UPMA’s mission is to provide high quality, accessible, and affordable reproductive health services, including primary care, to the community. The UPMA supports and trains over 700 private sector midwives in the areas of family planning, reproductive health, PMTCT, HIV prevention, testing, counseling, and basic women’s health. UPMA members must work in the public sector for at least five years and must be registered before qualifying to own a private clinic. Therefore, most of the members are retired. The UPMA provides support and training to retired government midwives so that they can continue to practice in the private sector, thus reducing the attrition out of active service and extending midwifery careers into retirement. Additional information is available at [http://www.wougnet.org/Profiles/upma.html](http://www.wougnet.org/Profiles/upma.html).

**JHPIEGO:** JHPIEGO is an international non-profit health organization affiliated with Johns Hopkins University. For nearly 40 years, JHPIEGO has empowered front-line health workers by designing and implementing effective, low-cost, hands-on solutions to strengthen the delivery of healthcare services for women and their families. Current projects include work in Mozambique, Afghanistan, Angola, Nigeria, Philippines, Ethiopia, and Tanzania. JHPIEGO uses a monitoring and revision unit for all projects, which is usually established by the donors (e.g., private organizations, USAID, CDC) and in which indicators are tracked to measure program achievements. Some of the performance mechanisms include healthcare worker retention and strategies for combating attrition. Additional information is available at [http://www.upmouganda.org/](http://www.upmouganda.org/)

**JTA International:** JTA International is an international health services provision, consulting, and project management firm that specializes in the provision and implementation of health services to governments, industry, and global partnerships in remote and challenging environments. JTA International is
currently operating in a number of locations throughout Australia, South East Asia, Papua New Guinea, and the Pacific. Additional information is available at http://www.jtai.com.au/

**JHPIEGO Ethiopia:** JHPIEGO implements training in PMTCT, infection prevention, counseling and testing for HIV, and provider-initiated counseling and testing for 89 sites in Ethiopia. JHPIEGO supports the Ministry of Health in pilot-testing the use of non-health professionals as counselors. In addition, the organization is facilitating the use of a standards-based management and recognition (SBM-R) approach to improving performance and quality of health services for PMTCT, with plans to expand SBM-R to other areas, including antiretroviral therapy. JHPIEGO is also working to integrate HIV/AIDS content with pre-service medical and nursing/midwifery education at three Ethiopian universities. As of 2008, 128 Ethiopian trainers had completed JHPIEGO’s clinical training skills course and 23 trainers had completed the advanced training skills course. Additional information is available at http://www.jhpiego.org/en/content/ethiopia

**BD Global Health Department:** BD (Becton, Dickinson and Company) is a global medical technology company. The company’s Global Health Department makes investments in global health projects in developing countries to strengthen health systems. BD works to strengthen lab systems, educate health workers on medical devices, and provide training on CD4 monitoring equipment. BD initiated global measurements regarding HIV needle stick transmissions in collaboration with the University of Virginia. This process also has feedback mechanisms to measure working conditions, health conditions, and services that impact employee morale and migration out of country and out of profession. This program was first implemented in five countries and now is being evaluated to scale up to 14 countries across sub-Saharan Africa. Additional information is available at http://www.bd.com/globalhealth.

**Rwanda: Performance Based Financing:** To address the misdistribution of healthcare workers in Rwanda, the government introduced a performance based financing scheme to provide incentives to healthcare facilities and their employees to improve quality of care in rural areas. Predetermined targets were set (for example, 90% of women should deliver in a health facility)
contracts between the government (with funding support from bilateral agencies such as PEPFAR, the Global Fund, and the World Bank) and health facilities were created. Between 2002 and 2009, Rwanda scaled-up access to community-based health insurance from 7% to 85% of the population, which has led to increased use of health services by poor children. Currently, every health facility and hospital has its own contract with the government.

**Santé pour le Développement et la Stabilité d’Haiti – Pwojè Djanm (SDSH) (MSH):** Pwojè Djanm is an MSH-led collaboration of Johns Hopkins Bloomberg School of Public Health/Center for Communications Programs (CCP), AIDS Healthcare Foundation (AHF), JHPIEGO, and Fondation pour la Santé Reproductrice et l’Education Familiale (FOSREF) with USAID, the Government of Haiti, local NGOs, community leaders, and the commercial private sector. Pwojè Djanm’s focus is on supporting decentralization, strengthening public-sector capacity in service delivery, and supporting local NGO service delivery by leveraging funding from the commercial sector and other donors. As of 2008, the project was working in 152 health sites in 10 regions across Haiti, offering services to approximately half of the 8.2 million people in the country. Additional information is available at [http://www.msh.org/global-presence/haiti-sdsh.cfm](http://www.msh.org/global-presence/haiti-sdsh.cfm)

**Inter-Religious Council of Uganda (IRCU):** Established in 2001, the IRCU serves as a representative body for the five major faith-based organizations (FBOs) in Uganda (Roman Catholic, Muslim, Anglican, Orthodox, and Seventh Day Adventist), for coordinating the country’s response to various national issues, including HIV/AIDS. It serves as the governing body through which FBOs, which currently make up 40% of the country’s healthcare services, can apply for sub-grants to carry out their various projects. It also serves to provide guidance and support in project planning, monitor project progress, and provide accountability to donor agencies. Additional information is available at [http://www.ircu.or.ug/](http://www.ircu.or.ug/)

**The Abt Associates-led Private Sector Partnerships (PSP) project in Ethiopia:** The PSP/Ethiopia works with Ethiopian private-sector organizations to increase access to HIV/AIDS and tuberculosis prevention, care, and support services. Funded
by the U.S. Agency for International Development (USAID), the project seeks to improve access, quality, and consistency of HIV/AIDS and tuberculosis prevention, care, and treatment by working with commercial industry, large employers, medium and small companies, and business coalitions. The program provides clinical training and clinical mentoring (i.e., ART services) as well as supportive supervision that will improve the effectiveness of healthcare workers. As of 2008, PSP-Ethiopia had supported workplace programs in 65 of the largest organizations in Ethiopia and provided training to improve the clinical skills of 220 clinicians in the area of TB and HIV prevention and clinical management. Additional information is available at http://www.abtassociates.com/Page.cfm?PageID=40454.
PSTF Reports and Supporting Documents

Four reports are available upon request that were supported by the PSTF and/or co-authored by members of the Secretariat. Please contact Caroline Hope Griffith (cah38@duke.edu), +1 919 613-6124 to request a copy.

1) AMREF’s Kenya Nurses’ eLearning Upgrade Programme case study

2) Zambia Access to Artemisinin-based Combination Therapy Initiative (ZAAI) case study (written by John and Vivian Mthetwa, Master Trainers, Consultants, Zambia)

3) Santé Sud Rural Physician’s Initiative - Mali epidemiological study overview

4) 31 Health Workforce Innovators – Long Descriptions
Documents Referenced


De Costa, A, Diwan, V. 2007. Where is the public health sector?’ Public and private sector healthcare provision in Madhya Pradesh, India. Health Policy 84. 269–276


PSP One. 2009. The Vital Role of the Private Sector in Reproductive Health, Policy Brief. USAID.


Launched in 2006, the Global Health Workforce Alliance is a partnership dedicated to identifying and coordinating 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 Alliance is hosted by the World Health Organization.

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