

Policy brief two
**Rehabilitating
the workforce: the key to
scaling up MNCH**

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It will not be possible to effectively scale up MNCH care without dealing with the global crisis that currently affects the health workforce. In many countries economic hardship and financial crises have destabilized and undermined the human resources working in the health sector. This affects health systems as a whole, and MNCH care in particular, and requires action at different levels. There is a need to prevent further escalation of the crisis – which has to include measures to prevent the distortions that result from well-intentioned but disruptive global initiatives. There is also a need for planning the expansion of the workforce, and, at the same time, for urgent, immediate corrective measures to rehabilitate productivity and morale. Putting these various elements in place can only be successful if there is a strong national leadership, based on a broad consensus within society.

**THE HUMAN RESOURCE CRISIS:
SHORTAGES AND SHORTCOMINGS**

It is obvious that access to MNCH care depends on the availability of skilled health workers. The low density of health professionals is one of the main factors that explains persistent exclusion from care and high mortality rates – for mothers and newborns as well as for children. Governments have the ultimate responsibility for ensuring that there are enough health workers to practice where mothers and children need them most, in a supportive working environment and legal context, where they are respected and adequately compensated.

Few countries have been able to live up to expectations. Many national health systems are in disarray, with a deteriorating infrastructure and a public sector subject to the restrictions consequent

on structural adjustment and macro-economic ceilings. In a context of lack of managerial autonomy, gender discrimination and violence in the workplace, dwindling salaries discourage the few workers who remain motivated: remuneration in the public sector has often been falling for decades in real terms. More often than not working conditions are inadequate, while salaries and benefits are grossly unfair and insufficient to provide for daily living costs, let alone to live up to the expectations of health professionals. This situation is one of the root causes of the lack of productivity and rural-to-urban, public-to-private and poor-to-rich country brain-drain and migration. Well intended donor interventions often compound the distortions in the health labour market.

Policy brief **Rehabilitating the workforce: the key to scaling up MCNCH**

There are countries where the main problem is an oversupply of staff with a profile that is ill-adapted to the needs. In others – in fact in most of the countries with high levels of maternal and child ill-health – there is a dearth of qualified professionals. These countries face huge shortages and imbalances in the distribution of health workers as a result of insufficient production, downsizing and caps on recruitment under structural adjustment and fiscal stabilization policies, with frozen salaries and with losses to the private sector, migration and HIV/AIDS. The situation may be less critical for child care, but in many places large parts of the workforce do not reach the competency threshold required for effective and safe maternal and newborn care. There is often an absolute lack of qualified staff on the labour market, whilst governments experience major difficulties in recruiting, deploying and retaining them.

Filling the supply gap will remain a major challenge for years to come. The World Health Report 2005 provides benchmarks for the numbers of human resources needed for MNCH services. Scaling up towards these benchmarks in the seventy-five countries that currently face the biggest challenges will require, in the next ten years:

- ▶ the production of at least 334,000 additional midwives (or professionals with midwifery skills);
- ▶ the upgrading of 140,000 existing professionals providing first-level maternal and newborn care;
- ▶ the upgrading of 27,000 doctors and technicians to learn the skills to

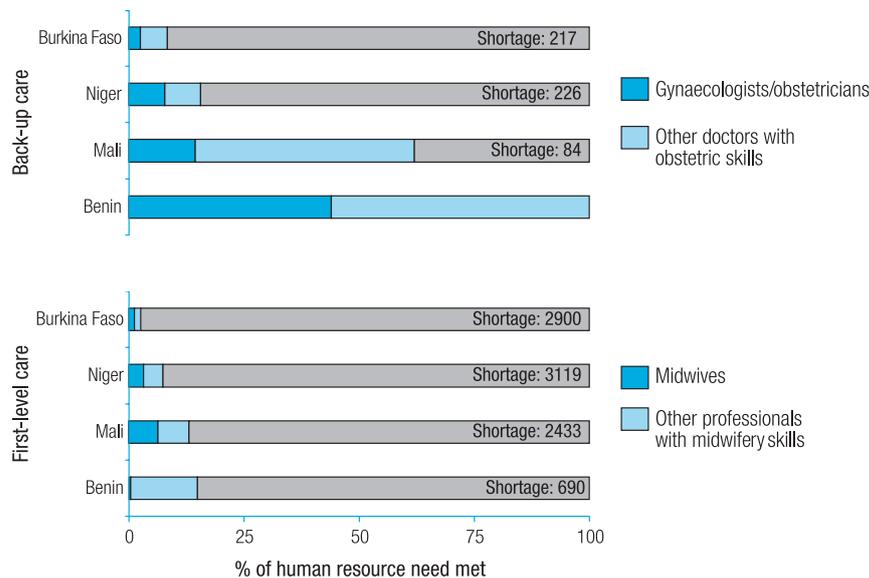
provide back-up maternal and newborn care;

- ▶ the deployment of the equivalent of 100,000 full-time multipurpose professionals backed up by millions of community health workers, in addition to more specialised referral level personnel to scale up child healthcare activities. With less reliance on community health workers the number of multipurpose professionals to be deployed would be much larger.

These are human resources needed to make up for the shortfalls in dealing with the workload for maternal, newborn and child health only. However, corrections for shortages are as necessary in many other compartments of the health system.

The workforce crisis seriously hampers the correct functioning of services even where staff has been deployed. The inadequacy of remuneration has led many professionals to develop individual coping strategies to make ends meet, resorting to dual employment or exploiting their clients. This clearly affects productivity and quality of care. It also jeopardises the essential relation of trust between users and providers of care and contributes to the exclusion of large numbers of mothers and children from the quality care to which they are entitled. This devalues the legitimacy and credibility of the entire health sector, with both health workers and their clients becoming increasingly dissatisfied. Particularly for maternal and child health, which is widely recognised as a core public responsibility, this constitutes a growing political liability.

Figure 2 The human resource gap for maternal and newborn health in Benin, Burkina Faso, Mali and Niger



Source: Adapted from The Unmet Obstetric Need Network (<http://www.itg.be/uonn/>).

COPING WITH CRISIS: POLICY RECOMMENDATIONS

The vicious circle of demotivation, low productivity, and underinvestment affects the whole health sector, not only the workforce that provides care for mothers, newborns and children. For countries to move towards universal access to MNCH care they must establish and implement comprehensive action plans to address the health workforce crisis. These plans have to combine action, within the health sector and beyond, to prevent further harm, expansion of the workforce, and immediate rehabilitative measures, including in terms of remuneration.

Prevent further harm ► Well-intended projects, programmes or reforms in the health sector may be contributing to distortions in the health labour market. Such effects must be anticipated through constant and systematic attention to the implications of such initiatives for the workforce: all major initiatives require a prior assessment of their potential impact, direct and indirect, on the workforce. Anticipating distortions through systematic human resource impact assessments should become a routine part of the preparation of major projects or initiatives in the health sector, and in particular of major disease control projects. This will require improved information systems on human resources so that the policies for which governments opt are based on better intelligence about the evolution of the health system.

Prepare the future - planned expansion of the workforce on the basis of a political consensus ► Producing sufficient numbers of adequately skilled professionals for the health sector in general, and specifically to scale up MNCH services, is a long term endeavour. Choices regarding professional profiles, skills mix and formulas for pre- and in-service training have consequences that play out years down the road: training more without training differently will perpetuate the present problems. Increasing the supply of human resources for health requires careful planning, management and institutional development; there is a long lag-time before the benefits become apparent. This makes it all the more necessary to ensure a long term and structural commitment to developing the workforce. Planning and managing the expansion of the HRH workforce is not something that can be conducted by Ministry of Health technicians alone. It requires the commitment of a broad constituency that stretches well beyond the Ministry of Health and the Ministry of Education. This is crucial in order to protect the continuity of the scale-up efforts from political fickleness and from the pressure to show immediate results. It is also necessary because without a broad political consensus it is difficult to make the necessary improvements to the working environment and the structure of the labour market for recruiting, deploying and retaining the new stream of quality professionals.

Take immediate corrective measures to rehabilitate productivity and morale ► It is true that the workforce crisis is so profound that no piecemeal approach will be able to solve it. Yet, after years of neglect and decay there are distortions that require immediate attention. Governments can in actual fact draw on a battery of short term measures to rehabilitate productivity and morale. None of these measures will by themselves be enough to put right the consequences of years of crisis. They can, however, mitigate the most blatant distortions, or, at the very least, create and expand islands of good practice that can serve as role models for the sector. Together they may thus reinstate confidence and a sense of hope, and pave the way for redressing the situation over a period of years.

There is now more and better documentation on the extent of the workforce crisis. On the other hand, evidence is scanty on what works and what does not to help solve it. But there is a variety of measures that may be of use in particular contexts.

First are the incentive packages, aimed at improving productivity, deployment and retention of staff (for example performance-linked incentives, possibilities for training or career mobility, housing benefits or peer pressure mechanisms), and measures to discourage migration or facilitate return of expatriate staff. A second group of measures is aimed at leveling the playing field: reinstatement of regulatory oversight mechanisms, realistic recruitment policies – directly, through contracting or through other means – and, very important in some countries, putting an end to the payments for ghost workers. Bringing licensing and delegation of authority in line with the reality of the field – for example where regulations prohibit staff from providing care they are capable of giving – is another measure that in some circumstances can yield major dividends, as it removes an obstacle to care and at the same time increases job satisfaction. SWAp mechanisms, bilateral agreements or the introduction of codes of conduct can be used to harmonise the human resource policies of donor and technical agencies as well as other employers of health personnel. None of these measures will by themselves be enough to put right the consequences of years of crisis, but together they may pave the way for bringing productivity and dedication back to the level the population expects and to which most health workers aspire. It is particularly important for countries to carefully monitor the positive – and the perverse – effects of these measures, to gradually build up a body of evidence on how to find a way out of the present crisis.

Confront the remuneration issue ► For all the long term planning and short term rehabilitative efforts, without sufficient remuneration and benefits, and with inadequate working conditions the prospects for recruiting, deploying and retaining the professionals needed for scaling up are bleak in many countries. Though the situation may vary considerably from country to country, many governments have to confront the remuneration issue as a matter of urgency.

First, the volume of funds available for the workforce needs to be increased substantially, over and above current public expenditure on health - modest efforts will be often be insufficient to attract, retain and redeploy quality staff. This has political and macroeconomic implications, and cannot be done for MNCH professionals in isolation. It has to be part of an overall national strategy for human resources for health, which also requires a combined effort from domestic and international funding sources. Second, injecting more funds is only part of the solution. What is now needed is a clear signal that improvements will be structural, sustained and predictable. This requires the human resource funding to be channelled through the core mechanisms and institutions that ensure progress towards universal coverage. Third, there is a need for a strong and effective national leadership, particularly given the distorting influence of the international environment and multiple global initiatives on the labour market in the health sector.

Make the HRH crisis a matter of national importance ► On the eve of a decade that will be focused on human resources for health, the human resource crisis is now well recognised internationally. This is important, but it is not enough. The key is to create the political momentum, within each affected country, that puts the workforce crisis on the agenda as a matter of national, and not merely sectoral importance. This is all the more critical since a real rehabilitation of the workforce requires an atmosphere of stability and hope, to give health professionals the confidence they need to work effectively and with dedication.

For further information concerning The World Health Report
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