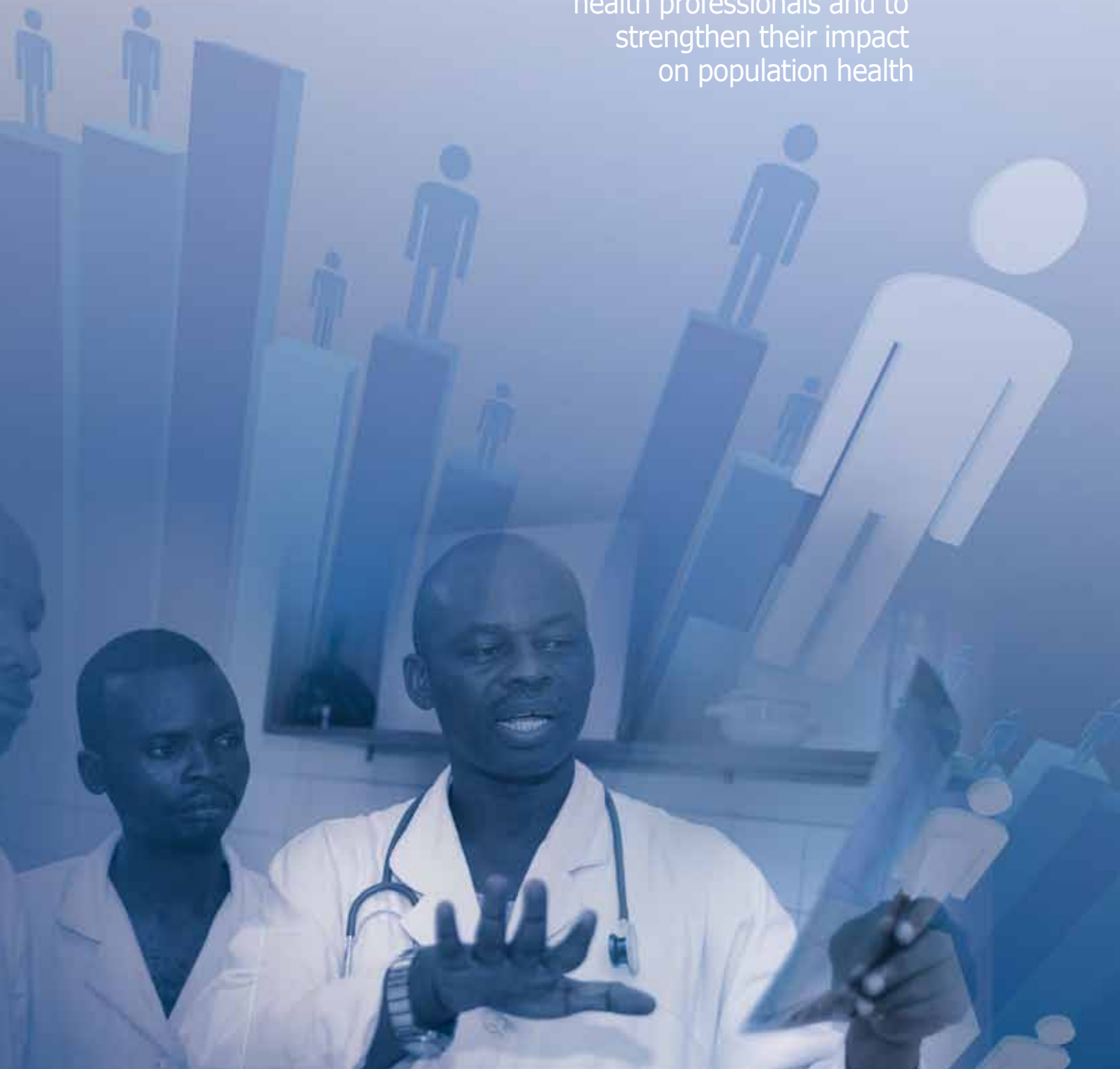
World Health Organization

Transformative scale up of health professional education

An effort to increase the numbers of health professionals and to strengthen their impact on population health



The work of WHO on the development of policy guidelines on transformative scale up of health professional education is being undertaken in collaboration and with the financial support of the US President’s Emergency Plan for AIDS Relief (PEPFAR).

At a glance

- We are currently facing a severe global health workforce crisis with critical shortages, imbalanced skill mix and uneven geographical distribution of health professionals, leaving millions without access to health services.
- More professional health workers are needed — but not simply more of the same. Efforts to scale up health professional education must increase the quantity, quality and relevance of the providers of the future if they are to meet population health needs.
- Reforms in education must be informed by community health needs and evaluated with respect to how well they serve these needs. Stronger collaboration between the education and health sectors, other national authorities, and the private sector will improve the match between health professional education and the realities of health service delivery. Educational institutions need to increase capacity and reform recruitment, teaching methods and curricula in order to improve the quality and the social accountability of graduates. The international community has an important role to play by partnering to support country-led efforts.
- At the request of its member states and partners, WHO is developing policy guidelines to assist countries, development partners and other stakeholders in efforts to expand the health workforce and to improve alignment between education of health professionals and population health needs.
- The WHO work is fuelling a growing movement to tackle the challenges facing the professional health workforce and is addressing the technical dimensions that can bring about a new era for health professional education.

The health workforce in crisis

Today, over a billion people worldwide lack access to quality health services — in large part because of a huge shortage, imbalanced skill mix, and uneven geographical distribution of professionally qualified health workers such as doctors, nurses and midwives.

Currently, WHO estimates that an additional 2.4 million doctors, nurses and midwives are needed worldwide. Yet, nowhere near enough are being educated — especially in Africa where the health needs are greatest. This crisis has disastrous implications for the health and well-being of millions of people. For example, in low- and middle-income countries, an estimated 1,500 women lose their lives in pregnancy and childbirth every day — lives that could often be saved if a qualified health professional were available.

Scaling up educational programmes to produce more doctors, nurses, midwives and other health professionals is clearly urgent and essential. However, increasing the number of graduates will not be enough. The shortage of professional health workers is compounded by the fact that their skills, competencies, clinical experience, and expectations are often poorly suited to the health needs of much of the population they serve. Insufficient collaboration between the health and education sectors, as well as weak links between educational institutions and the health systems which employ graduates, often result in a mismatch between professional education and the realities of health service delivery. These factors limit the capacity of even highly-qualified personnel to improve health outcomes. Fundamental reforms are needed to increase the numbers of health professionals and to strengthen their impact on population health.

"Education, research and health service delivery need to work in synergy."

In October 2009, the World Health Organization (WHO) and the US President's Emergency Plan for AIDS Relief (PEPFAR) embarked on a programme of work to address the technical requirements essential to make the transformative scale up of health professional education a reality. WHO has a global mandate to support member states with health policy and technical guidance. The goal of this work is to develop evidence-based guidelines for scaling up education of health care professionals and to help countries implement the guidelines and evaluate their impact. A related component of the work is PEPFAR's Medical and Nursing Education Partnership Initiatives (MEPI and NEPI). These Partnerships are supporting African medical and nursing education institutions and universities to improve the quality, relevance and retention of their graduates (Box 1). Work is progressing in the context of a number of other important efforts to gather evidence and ideas and to invest in innovation in the field of medical, nursing and midwifery education. Among these, the Sub-Saharan African Medical School Study has examined the challenges, innovations and emerging trends in medical education in the region (Box 2). The 2010 Commission on Education of Health Professionals for the 21st Century has undertaken a major global analysis of the current state of the education of health professionals (Box 3).

WHO and PEPFAR are working with a wide range of stakeholders, including national governments, development partners, professional associations, the private sector, community representatives and academic institutions, to build support for far-reaching reform that must influence both the education and health systems.

Quantity, quality and relevance: three dimensions of the challenge

While the imperative to strengthen health systems and increase access to health services is gaining greater international attention, the gap between what can be done and the reality on the ground continues to widen. The transformative scale-up of health professional education aims to support and advance the performance of country health systems so as to meet the needs of individuals and populations in an equitable and efficient manner. Driven by population health needs, transformative scale-up consists in a process of education and health systems reforms that address the quantity, quality and relevance of health care providers in order to contribute to universal access and improve population health outcomes (Figure 1).

Figure 1. Transformative scale up of health professional education

BOX 1: PEPFAR's Medical and Nursing Education Partnership Initiatives (MEPI and NEPI)

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) has a goal to train at least 140,000 new health care professionals and paraprofessionals. As part of this commitment the Global AIDS Coordinator, Ambassador Eric Goosby, has placed emphasis on strengthening the quality and capacity of health professional education. Through the Nursing Education Partnership Initiative (NEPI) and the Medical Education Partnership Initiative (MEPI), the aim is to strengthen medical, nursing and midwifery education systems in Africa, to expand clinical and research capacity, and support innovative retention strategies for doctors, nurses, midwives and teaching staff in African countries.

NEPI represents a major collaboration involving the PEPFAR partner agencies — the Health Resources and Services Administration (HRSA), the US Agency for International Development (USAID), and the PEPFAR country teams. External partners are WHO, the Clinton Health Access Initiative, the Columbia University International Center for AIDS Care and Treatment Programs, CapacityPlus, and ELMA Philanthropies.

The first phase of the initiative will gather in depth information through country wide assessments of nurse training capacity and needs in three pilot countries (Lesotho, Malawi and Zambia). The information gathered in these assessments will assist the Ministry of Health and other country stakeholders to identify nursing schools to receive support to develop, expand, or enhance innovative models of nursing education. The expectation is that these institutions will serve as a model for transforming nursing education in their countries and other PEPFAR countries. The capacity and needs of nurse training institutions across a wider group of countries will also be surveyed. The information gathered through the assessments and the survey will contribute to the evidence base that is being constructed in collaboration with WHO for the purpose of developing policy guidelines for scaling up medical, nursing and midwifery education. Costing studies to improve understanding of the resource requirements for both medical and nursing education will also be conducted.

The related initiative focused on medical education, MEPI, is also led by a partnership of PEPFAR agencies. These are the National Institutes of Health (NIH), the Health Resources and Services Administration (HRSA), the US Agency for International Development (USAID), the Centers for Disease Control and Prevention (CDC), and the Department of Defense (DoD).

MEPI will invest up to US$130 million over five years in grants to African institutions in a dozen PEPFAR-supported sub-Saharan African countries. Key to this initiative is the formation of a network including about 30 regional partners, country health and education ministries, and more than 20 collaborators from the United States of America.

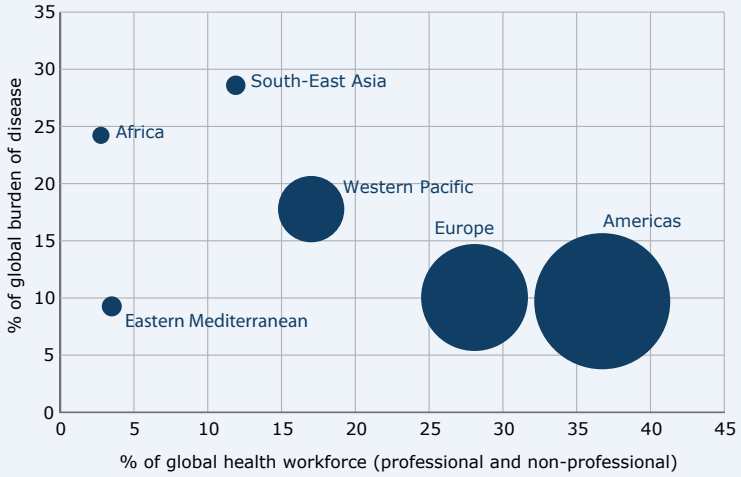
A coordinating centre will link the African sites and their U.S. partners, leverage shared resources and provide technical expertise. A Web-based platform will allow all partners to share data and outcomes. MEPI will enable participating institutions to strengthen their information technology infrastructure, support distance education and data sharing, and encourage the establishment of clinical registries to inform research and health care decision making on national levels. The coordinating center will also form an African leadership network to guide and advocate for the initiative.

For further information on PEPFAR see: http://www.pepfar.gov/about/index.htm
For MEPI see: http://www.fic.nih.gov/programs/training_grants/mepi/index.htm

Quantity

The global shortage of health professionals is most severe in low- and middle-income countries. There are 230 medical doctors per 100,000 people in the USA but only 1.1 in Malawi. Overall, sub-Saharan Africa has a total professional health workforce of approximately 1 per 1000 people — the lowest ratio of any region in the world. Yet the burden of disease in the region is among the highest. (Figure 2)

Figure 2. Distribution of the health workforce relative to the global burden of disease



Source: *World Health Report 2006 - Working together for health.*

At the country level, shortages are made more acute by uneven distribution across the population. In many countries the majority of professional health workers are practising in towns and cities, rather than in rural and underserved areas. In South Africa, 46% of the population lives in rural areas but only 12% of doctors and 19% of nurses are working in non-urban settings. Poor working conditions and low pay also make it hard to retain qualified health professionals in service to hard-to-reach populations and many choose to emigrate to more attractive jobs abroad. In addition, some countries are unable to use all the providers they have educated since new doctors, nurses, midwives and other health professionals cannot be deployed without sufficient budgetary resources to hire and support them.

The rate of production of new professional health workers in the countries of sub-Saharan Africa, as in many other low- and middle-income countries, is too low to improve the ratio between workforce and population. Most recent estimates find that sub-Saharan Africa has around 168 medical schools (compared to 173 medical schools in North America) but these schools only have the capacity to produce between 9,000 and 10,000 graduates per year—half the number produced in North America where the population is much smaller.

Investment in the education of doctors, nurses and midwives is exceedingly modest. Total global expenditure on health professional education (US$1 billion) represents a mere 1.8% of total global expenditure on health, despite the key role played by the health workforce. Budgets of national governments and international development partners rarely specify funding for health professional education.

Quality

No matter how many individuals are educated and deployed, health professionals cannot transform population health unless they have the necessary competencies. Health professionals need to be technically competent and efficient but they also need to be able to work in teams, to adapt to a changing practice environment and to initiate change where needed.

"Driven and informed by population health needs, transformative scale up means delivering educational reforms that address not only the quantity, but also the quality and relevance of health care providers in order to achieve improvements in population health outcomes."

Efforts to deliver high quality education face various challenges. Many educational institutions have insufficient basic infrastructure and equipment. The educational methods are static and fragmented and shortages of teaching staff severe. Post-graduate education is inadequate or non-existent. Regulatory mechanisms designed to ensure the quality of education, such as accreditation, are rarely standardized and are often weak and inconsistently applied, especially in the case of private sector institutions. In addition, variability of secondary education may mean there are not enough qualified secondary school graduates to fill university programmes.

Given these constraints, numbers of graduates often fail to tell the whole story. Data from the Philippines, for example, show that of the 94,462 nursing graduates who took the Nurse Licensure Examination in 2009, only 39.73% passed — meaning that the majority of graduates failed to meet the standard required for certified clinical practice.

Finally, in many settings, a variety of workplace challenges mean that even qualified health professionals do not always perform as well as they might. Poor wages and working conditions contribute to low morale, low productivity and absenteeism. Lack of equipment and other supplies also prevent health professionals doing their jobs properly.

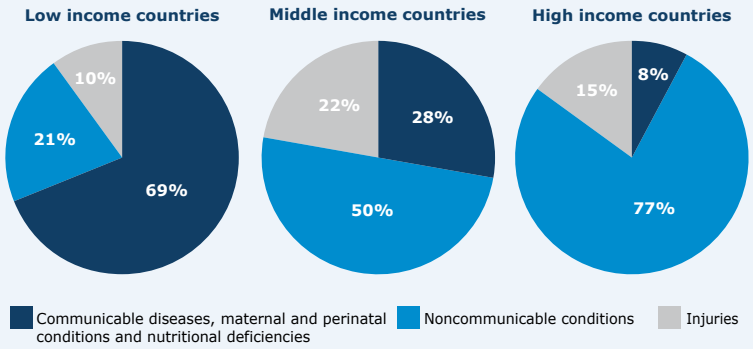
Relevance

Even well-educated health professionals may find themselves ill-prepared to meet the challenges they face when they take up posts within a country health system.

The mix of skills they have acquired during their professional education is often not well oriented to their eventual workplace. The scientific content of their education may be poorly matched to the epidemiology of the communities in which they work.

Countries show wide variations in the burden of different categories of disease. In low-income countries communicable diseases, maternal and perinatal conditions and nutritional deficiencies represent 69% of the disease burden against only 8% in high-income countries. (Figure 3) Excellence of educational institutions is generally not associated with how well students are prepared to address their context-specific population health needs.

Figure 3. Variation in disease burden across national income levels

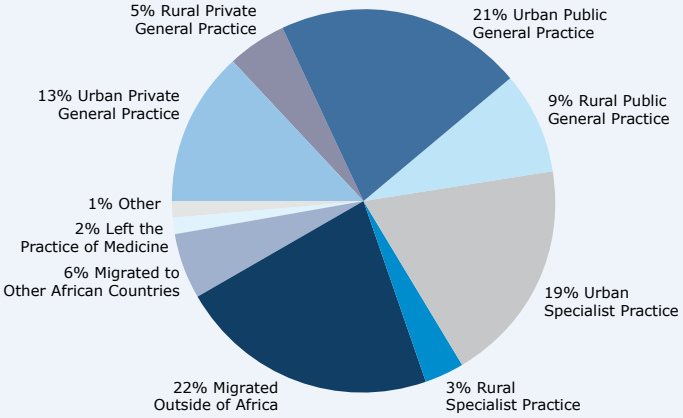


Source: OECD, 2005

Similarly, teaching tends to revolve around service delivery models with limited relevance and there is little training in public health, epidemiology, or health systems management. For example, the majority of people may access health care at the primary level through community and rural health centres. In the case of Pakistan, the proportion of the population receiving services in primary care centres is 85% with only 1% of the population's health care needs being met at the tertiary level. The pattern is similar in many other countries, yet the deployment of the professional health workforce fails to reflect the way service delivery is organized. Less than 9% of graduates from medical schools in sub-Saharan Africa are practicing in rural public general practice (Figure 4).

Other challenges relate to the suitability of the students who are recruited into the health professions. Health professionals who are not representative of the people they serve in terms of language, ethnicity or other social and demographic factors may find it more difficult to understand and respond to the particular needs of communities. Fees for professional education are high and subsidies to ensure affordability are rare, limiting the pool of potential candidates. The concentration of opportunities in urban and specialist settings also influences the types of students that are recruited. Potential candidates from rural or underserved areas face numerous disincentives including travel, accommodation and lack of familiarity with an environment so far from home.

Figure 4. Estimated location of graduates from medical schools in sub-Saharan Africa 5 years after graduation



Source: Sub-Saharan African Medical School Study.

"We need a transformation that increases the quantity of health professionals but also ensures that they are globally competent and locally relevant."

BOX 2: Sub-Saharan African Medical School Study (SAMSS)

The Sub-Saharan African Medical School Study undertook the first ever systematic and comprehensive documentation of the challenges, innovations and emerging trends in medical education in the region. SAMSS was a collaboration between a team of researchers from George Washington University and an Advisory Committee from 13 African nations. It was funded by the Bill & Melinda Gates Foundation. A report of the study was published in the Lancet in November 2011.

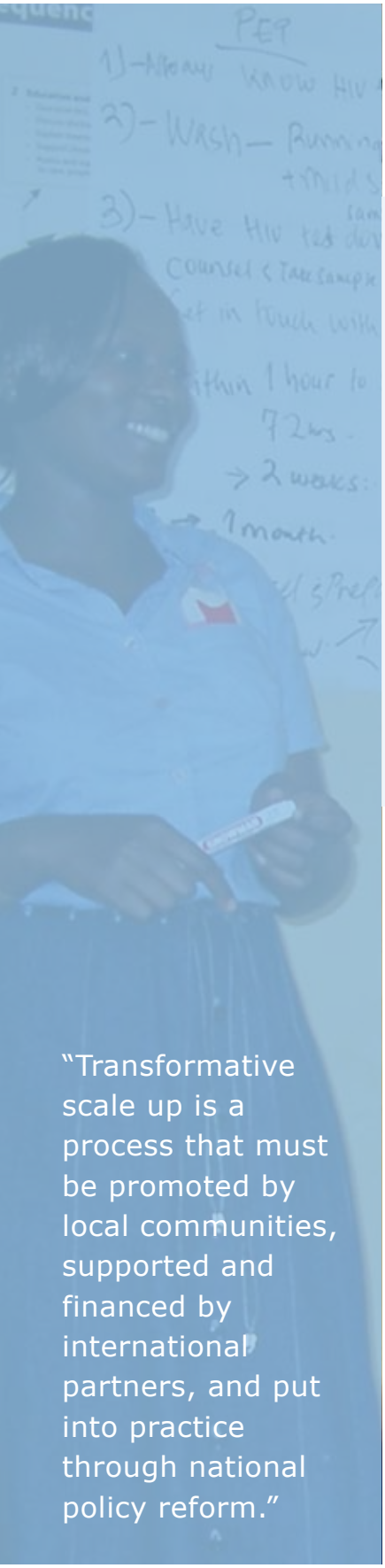
The work began with a comprehensive literature review and a series of key informant interviews to gain an overall picture of medical education in sub-Saharan Africa. Primary data were then gathered using two techniques: site visits to 10 selected schools and a survey of all the schools that had been identified. The study identified 168 medical schools across the countries of the region, of which 105 responded to the survey.

Findings showed that many counties are prioritizing the scale up of medical education as part of overall health sector strengthening. It found that physician "brain drain" is a serious problem and accreditation and quality measurement are important developments for standardizing medical education and physician capabilities. The study also drew attention to widespread faculty shortages in basic and clinical sciences, weak physical infrastructure, and little use of external accreditation. Important findings included the growth of private medical schools, community-based education, and international partnerships, as well as the benefit of research for faculty development. The study made a series of recommendations to strengthen medical education in sub-Saharan Africa.

For the full report see: Medical schools in sub-Saharan Africa, The Lancet, Early Online Publication, 11 November 2010, doi:10.1016/S0140-6736(10)61961-7

Education, the health system, and communities: working together, not in isolation

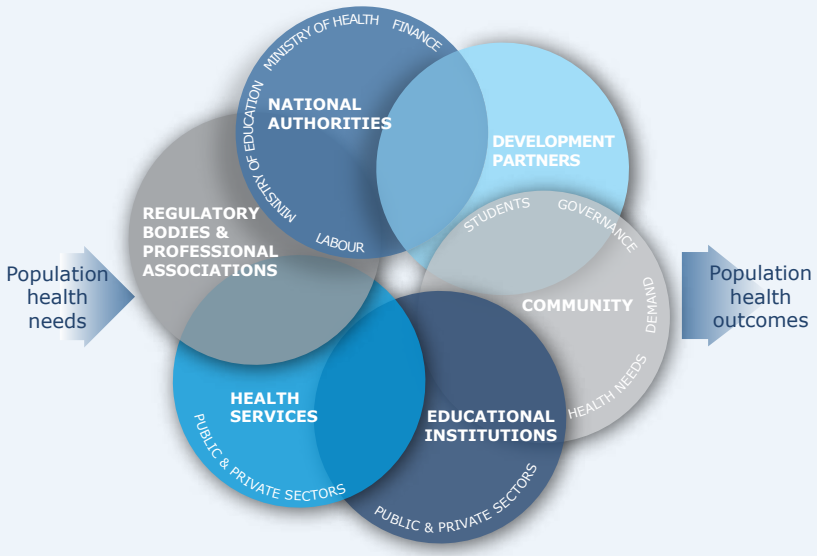
At the root of today's crisis is the gap between the education system and the health system in many countries. Educational planning often takes place in the limited sphere of the educational institutions and the Ministry of Education. Medical, nursing and midwifery and other schools frequently do not operate in synergy with Ministries of Health under whose aegis their graduates will eventually be deployed. With a structural disjuncture so profound, it is little surprise that these institutions often produce cohorts of health professionals who are ill-suited to meet the needs of their country's health system. For example, some medical schools invest in producing highly skilled specialists while mothers continue to die from obstructed labour during childbirth because there is no one on hand who is able to perform a relatively simple caesarean section.



"Transformative scale up is a process that must be promoted by local communities, supported and financed by international partners, and put into practice through national policy reform."

If a new effort to scale up health professional education is to really transform the health of nations, it must be a process of reform that is driven by the people and communities who are the users of health services, implemented by national authorities working with public and private educational institutions, and supported by a broad coalition of stakeholders. (Figure 5)

Figure 5. Actors needed to reform and expand health professional education



Communities must drive reform

The Alma Ata Declaration on Primary Health Care talked of putting "people at the centre of health care". But today, in many countries, meaningful involvement of communities in the governance of local or national health systems, or in decision-making at educational institutions is rare. The experience of Walter Sisulu Medical School in rural South Africa demonstrates what can be achieved when the voice and choice of local communities is allowed to influence the education of the health workforce.

Walter Sisulu Medical School recruits students from surrounding communities, whose health and social needs also guide its education, research and service programmes. Much of the learning takes place within the community and is integrated into the local health care delivery system. In this way, early clinical contact increases the relevance of theoretical teaching, and the programmes encourage a commitment to public service. At graduation, most medical students are deployed to posts that have been agreed well in advance with the local department of health. A total of 835 doctors have graduated, some 70% of whom still practice among the underserved rural communities of the immediate area. These doctors have made a significant impact on the health of the local community and the school makes a point of assessing the excellence of its programmes according to these criteria. Other graduates have found success abroad or as specialists — confounding sceptics who argued that the quality of the education at Walter Sisulu might prove inferior to that of more traditional medical schools.

The experience of Walter Sisulu University demonstrates that a more symbiotic relationship between medical education and health service users — whereby students are drawn from the local community, are educated and trained within the community, are deployed to serve their own community and are evaluated in relation to the health of the community — has the potential to deliver real health improvements for people in the poorest regions of the world.

National authorities — action across sectors to implement policy reform

To achieve greater alignment between educational institutions and health service delivery there must be far greater cooperation and coordination between the education and health sectors at many levels. Closer working relationships must be established between ministries of education and health as well as other relevant ministries such as finance and labour. The process of reform must also encompass the various professional associations that represent doctors, nurses and midwives, and other health professionals and engage those bodies that have a role to play in the regulation and quality control of the professions.

A small number of countries have shown that national commitment to coordination between health and education can produce results in terms of both numbers and relevance. In Brazil, for example, the integration of the health and education sectors has been determined at the highest level. The National Constitution establishes the responsibility of the Ministry of Education for regulating educational institutions but assigns authority over the education of health professionals to the National Health System. This coordinated approach has contributed to producing a workforce well matched to the nation's needs and improved access to primary health care, including among hard-to-reach communities.

The Government of Ethiopia has reserved 20% of capacity in the nation's educational institutions for health sciences programmes as part of a drive to expand the health workforce. This effort has doubled the public sector health workforce since 2003.

"Since the initiation of the joint work on medical, nursing and midwifery education by WHO and PEPFAR in the autumn of 2009, there are signs that a new movement to tackle the current inadequacies of health professional education is gathering pace across a range of different constituencies."

The process of reform must not be limited to the public sector. In many countries, a significant proportion of health service delivery and of health professional education is undertaken in the private sector. In sub-Saharan Africa, nearly half of the 33 medical schools founded during the last 10 years are private non-profit or private for-profit institutions and many health services are delivered by non-governmental and faith-based organizations.

Educational institutions — advancing medicine's social mission

At the heart of educational reform must be the commitment to ensure that health professionals are accountable to the communities they are mandated to serve.

The current association of excellence with specialist skills, and in some cases with education that is oriented to the global market, has meant that family and community-oriented medicine and public health, usually better matched to the overall epidemiological burden and needs of low- and middle-income countries, are often afforded low status and are relatively poorly paid. Similarly, institutional and national funding bodies rarely promote research that is directed to national health needs and systems or that is concentrated on furthering understanding of the most pressing health priorities for local communities.

BOX 3: Education of Health Professionals for the 21st Century: A Global Independent Commission

The Commission on education of health professionals for the 21st century was launched in January 2010. This independent initiative was led by a diverse group of 20 professional and academic leaders from around the world. The commissioners came together to develop a shared vision and a common strategy for postsecondary education in medicine, nursing and public health that reaches beyond the confines of national borders and the silos of individual professions.

The commission pursued research, undertook deliberations and promoted consultations during one year.
The work of the commission culminated in the publication of a report in December 2010 in the Lancet. The commission report states that the redesign of health professional education is necessary and timely. It proposes a series of instructional reforms to achieve transformative learning as well as institutional reforms to promote interdependence in education.

For the full report see: The Lancet, Volume 376, Issue 9756, Pages 1923 - 1958, 4 December 2010

Institutions, graduates, and workforce by region (2008)

	Population (millions)	Estimated number of schools		Estimated graduates per year (thousands)		Workforce (thousands)	
		Medical	Public Health	Doctors	Nurses/ Midwives	Doctors	Nurses/ Midwives
Asia							
China	1371	188	72	175	29	1861	1259
India	1230	300	4	30	36	646	1372
Other	1075	241	33	18	55	494	1300
Central	82	51	2	6	15	235	603
High-income Asia-Pacific	227	168	26	10	56	409	1543
Europe							
Central	122	64	19	8	28	281	670
Eastern	212	100	15	22	48	840	1798
Western	435	282	52	42	119	1350	3379
Americas							
North America	361	173	65	19	74	793	2997
Latin America/Caribbean	602	513	82	35	33	827	1099
Africa							
North Africa/Middle East	450	206	46	17	22	540	925
Sub-Saharan Africa*	868	134	51	6	26	125	739
World	7036	2420	467	389	541	8401	17684

* The Sub-Saharan African Medical School Study finds 168 medical schools in the region in 2010.

Source: *The Lancet*, Volume 376, Issue 9756, Pages 1923 – 1958, 4 December 2010

There is increasing evidence that multidisciplinary teams with reorganization of tasks among providers ("task shifting") may be the most effective means of care delivery, particularly for primary care services, in a variety of settings. The form and content of medical, nursing and midwifery, and other curricula must evolve to adequately prepare health professionals to practice within this model, and will likely require the incorporation of progressive educational strategies, such as interdisciplinary and inter-professional training.

Evidence that students recruited from rural and marginalized communities are more likely to provide responsive care, and to serve those communities for an extended period once they are qualified, points to the need for institutions to explore new recruitment strategies and selection criteria.

The Christian Medical College in Tamil Nadu has achieved success through a highly community-oriented approach. Information systems evaluate health and disease trends in the community which, in turn, inform the curriculum. Graduates are committed to work in an area of high need for a minimum of two years upon qualification. Particular attention is also paid to faculty development: most teachers have been trained at the College and then undertake compulsory rotations in centres of excellence abroad. The College is consistently ranked as one of the top three teaching hospitals in India. It has a catchment area of 80 villages and serves 100,000 people — but its greatest claim to success is that 66% of its graduates are still working in the country and an impressive 80% of these graduates work in non-urban settings.

The University of Gezira has changed attitudes to medical education in Sudan by pioneering a community-oriented and community-based approach that aims to improve population health outcomes. Each student is attached to a particular family for the period of their training. Student teams consult community members to identify priorities around which they develop projects and then seek funding for implementation and evaluation. Changes to the teaching programme were initially resisted by students. They even went on strike to protest that the new approach would lower the quality of their education and qualifications, turning them into medical assistants rather than doctors. However, as evaluations began to show a 70% reduction in maternal and child mortality in Gezira state, the model gained credibility and has now been adopted by some 30 other medical schools in the country.

A reorientation of medical, nursing and midwifery education should not be associated with compromise on quality but must strive instead to achieve an appropriate balance of global excellence and local relevance.

"Educational institutions must implement reforms that allow them to recruit from the communities they serve, teach to the local disease burden, and educate students to practice within the care delivery models that are likely to best serve the local population health needs."

International community — partners for progress

International partners have a key role to play in supporting country-led strategies for reform and helping to facilitate the engagement of many stakeholders. Global political leadership and the commitment of international policy-makers responsible for priority health programmes and education programmes will be crucial to success. Those who exert influence, such as deans of schools and the various organizations that represent the medical, nursing and midwifery professions, will be essential in helping overcome possible resistance to change.

The capacity of the international community to support countries by generating new financial resources will also be important in this effort. Better collaborative planning, improved facilities, and increased numbers of both faculty and students, as well as the introduction of innovative curricula and teaching practices, will all require long-term financial investment.

Population health is a crucial determinant of the social and economic well-being of nations. If scale up of medical, nursing and midwifery education can be achieved in a manner that has a transformative impact on population health, it will prove a worthwhile investment.

Taking action

Reforming and expanding health professional education

The WHO guidelines will aim to strengthen health service delivery by increasing the quantity and improving the quality and relevance of the professional health workforce through reforms that reorient health professional education. The effort is building on other policy development work in this area and is intended to complement previous and ongoing efforts. (Box 4)

Based on the work to date, it is clear that reforms will need to address, first and foremost, the issue of coordination between different sectors, both public and private, to align health systems and workforce planning with educational production and population health needs, and to create stronger links between education, communities and health service delivery. Increased investment at national and international level and support to country-led strategies are also of paramount importance.

Reforms will also need to address increased retention and better distribution of the workforce across underserved areas through innovative student selection, recruitment and preparation for health professional education.

At the institutional level, reforms will need to address: the production capacity of educational institutions, including the need for teaching staff; adequate equipment and teaching methodologies; enabling learning environments; curricula that address the realities of local epidemiology and service delivery; and the need to promote a culture of social accountability among health professionals. Appropriate regulation, including certification and licensing of graduates and accreditation systems to ensure the quality of educational programmes, will need to match and support such changes.

The plan and the process for developing WHO guidelines

The development and publication of formal WHO policy guidelines involves a stringent process of consultation, evidence gathering and consensus building. The work is proceeding in collaboration with many partners and is informed by the related work that is being undertaken by NEPI and MEPI as well as other initiatives.

As the convening agency for the development of the guidelines, WHO aims to generate dialogue among all those who have a role to play in the transformative scale up of health professional education. An essential part of this process is to gather and assess all the available evidence, and to address knowledge gaps through additional data collection, in order to construct a robust evidence base to inform new policies. This evidence must then be subject to review and analysis by experts, including doctors, nurses, midwives, service users, policy makers, implementers and development partners.

The outcome of this process will be the development of broad consensus on the best way forward. Equally important, the process will help to generate interest, engagement and support for implementation of the guidelines.

Once agreement is reached on policy guidelines, WHO will assist countries who chose to implement the guidelines and will participate in the process of monitoring and evaluation.

BOX 4: Global policy developments around human resources for health (2006 – 2011)

The health workforce crisis is not new. The WHO policy guidelines on transformative scale up of health professional education represent the most recent component of a progressive and interconnected set of global policy developments in the area of human resources for health.

The 2006 World Health Report shone the spotlight on the challenges facing the health workforce and the need for new investment, innovation and progressive policies (1).The World Health Assembly that year passed a resolution on scaling up health workforce production (2) and one on strengthening nursing and midwifery (3). The year 2006 also saw the launch of the Global Health Workforce Alliance, a partnership created as a common platform for action and dedicated to identifying and implementing solutions to the health workforce crisis (4).

In the following years, human resources for health continued to be high on the international agenda. In 2008 WHO published the Global Recommendations and Guidelines on Task Shifting which are already being implemented in many countries (5). Among other relevant developments, the report of the Task Force for Scaling up Education and Training for Health Workers was also published in 2008 (6).

Then in May 2010 the World Health Assembly adopted the WHO Global Code of Practice on the International Recruitment of Health Personnel (7). The code, only the second in WHO's history, addresses the growing problem of migration of health workers from lower income countries with fragile health systems. It serves as an ethical framework to guide member states in the recruitment of health workers.

Further work by WHO on health workforce retention led to the publication, in 2010, of Global Policy Recommendations on increasing access to health workers in remote and rural areas through improved retention (8).

These global developments, among others, represent significant progress in terms of policy development and political commitment in the area of health workforce strengthening. The forthcoming WHO guidelines on health professional education address a dimension that has so far been missing and this effort is positioned firmly within the context of the preceding work.

1. The world health report 2006 – Working together for health. Geneva, World Health Organization, 2006
2. World Health Assembly 2006 WHA57.19
3. World Health Assembly 2006 WHA59.27
4. www.who.int/workforcealliance
5. WHO Global Recommendations and Guidelines on Task Shifting available at: www.who.int/healthsystems/TTR-Taskshifting.pdf
6. Scaling Up, Saving Lives, Task Force for Scaling up Education and Training for Health Workers available at: www.who.int/workforcealliance/about/taskforces/education_training/en/
7. WHO Global Code of Practice on the International Recruitment of Health Personnel (WHA63.16) at: www.who.int/hrh/migration/code/practice/en/index.html
8. Increasing access to health workers in remote and rural areas through improved retention, WHO Global Policy Recommendations, 2010, available at: http://whqlibdoc.who.int/publications/2010/9789241564014_eng.pdf

A movement around health professional education

The urgent need for better functioning health systems capable of delivering health services that are well-matched to people's needs, and the crucial role that professional health workers have to play, are now widely recognised. There is also increasing consensus globally that the education of health professionals is failing to keep pace with the scientific, social and economic changes transforming the healthcare environment. Since the initiation of the joint work on health professional education by WHO and PEPFAR in the autumn of 2009, there are signs that a new movement to tackle the current inadequacies of health professional education is gathering pace across a range of different constituencies.

What is needed is a radical transformation that puts population health needs at the centre of health professional education and positions health outcomes as a crucial component by which the educational process is assessed.

To achieve this transformation, isolated improvements in educational institutions or narrowly defined health sector reforms will not be enough. While the expansion of health professional schools may serve to increase the quantity of professional health workers, expansion alone will not meet the equally important objectives of improving the quality and relevance of the health workforce. By the same token, the efforts of education and health ministries will bear little fruit without the simultaneous engagement of educational institutions, private sector providers, professional associations, and communities.

The WHO policy guidelines on transformative scale up of health professional education will serve to facilitate real progress in a number of ways. First, by providing a robust scientific basis to guide decision making at the global and country level and a technical instrument for the implementation of reforms; second, by engaging many different stakeholders in a process of consensus building to support reform; third, by helping to establish partnerships across sectors and national boundaries.

Without the active engagement of real people, with passion and commitment, it often proves impossible to change established norms. Yet social movements rarely succeed without appropriate technical instruments that can help convert aspirations into practical action on the ground. The engagement of a diverse and expanding group of stakeholders in the process for development of WHO policy guidelines on transformative scale up of health professional education signifies a powerful relationship between social movement and technical support. Such a combination of forces is just what is needed to bring about a new era for the education of health professionals.

Additional information

Enquiries can be addressed to: hrhinfo@who.int

A range of documents and information on health workforce education and training are available at: www.who.int/hrh/documents/education/en

Report on the WHO/PEPFAR planning meeting on scaling up nursing and medical education, Geneva, 13-14 October 2009, available at: http://www.who.int/hrh/resources/scaling-up_planning_report.pdf

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Task Shifting, Global Recommendations and Guidelines, WHO, 2008, available at: http://www.who.int/healthsystems/TTR-TaskShifting.pdf

Global Consensus for Social Accountability of Medical Schools
http://www.healthsocialaccountability.org

WHO Global Code of Practice on the International Recruitment of Health Personnel WHA63.16 available at: http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R16-en.pdf

Medical Education Partnership Initiative
http://www.fic.nih.gov/programs/training_grants/mepi/index.htm

The United States President's Emergency Plan for AIDS Relief
http://www.pepfar.gov/about/index.htm

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"Only broad and inclusive multi-sectoral planning at the national level will allow the coordination necessary to effectively scale up numbers and align health professional education with country health needs."

Health Systems and Services (HSS/HRH)
World Health Organization
20, Avenue Appia
1211 Geneva 27
Switzerland

www.who.int/hrh

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