POLICY LEVERS TO ENHANCE HEALTH WORKFORCE PERFORMANCE FOR COMPASSIONATE AND RESPECTFUL CARE

Human Resources for Health Observer Series No. 26
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Abbreviations

| CCC  | Compassionate City Charter |
| CRC  | compassionate and respectful care |
| HEE  | Health Education England |
| IPCHS | Integrated, People-Centred Health Services |
| NHS  | National Health Service |
| RMC  | respectful maternity care |
| SDGs | Sustainable Development Goals |
| UHC  | universal health coverage |
| WHO  | World Health Organization |
**Executive summary**

The progressive realization of universal health coverage (UHC) requires not only that health services be available and accessible but also that they be rendered to the population in a compassionate and respectful manner, according to quality standards, and that they be acceptable to people. Health workers’ knowledge, skills and attitudes play a central role in the provision of compassionate and respectful care (CRC). But health workers’ behaviour in turn is influenced by the work environment, the health labour market and the employment conditions in which they operate, as well as other determinants of health workforce availability, motivation and performance. Identifying relevant policy levers to enhance CRC must therefore include actions that enable health workers both to enjoy their rights and to fulfil their roles and responsibilities.

Relevant policies may apply at the individual, organizational or system-wide level. Some interventions to promote the delivery of CRC are highly specific to this objective and may include, among others, relevant competencies in pre-service education and in-service training, and implementation of supportive supervision and accountability mechanisms. Other relevant actions may target health workforce availability, distribution, terms and conditions of employment, the practice environment or even broader health facility or system-wide factors, such as regulatory and financial aspects.

Selection of the appropriate combination of system-wide and CRC-specific interventions should be tailored to the national and operational context with reference to specific policy objectives and feasibility and affordability considerations. Identifying verifiable performance metrics and collating and analysing required data are essential for monitoring the effectiveness of the interventions adopted.
1. Introduction: framing the problem of disrespectful care

Effective coverage of services requires that these not only be available and accessible but also that they be provided to the population according to quality standards and that they be acceptable (1). Despite long-standing recognition of the importance of delivering care that is respectful and compassionate (2), in many contexts actual practice deviates substantially from ideal standards. Challenges in providing respectful care have been documented in several clinical areas, ranging from treatment and care for HIV (3), to mental health (4), sexual and reproductive health, and obesity (5), among others. Similar challenges also arise in relation to specific population groups, such as ethnic minorities, as well as stigma and discrimination on the basis of sexual orientation.

Shortcomings in the provision of CRC can be categorized according to different types of abuse and inappropriate behaviour that patients may be exposed to. A landscape analysis outlined the issue of disrespectful and abusive care that women experienced during childbirth in health facilities (6). WHO’s vision that “every pregnant woman and newborn [should receive] quality care throughout pregnancy and childbirth” (7) requires, but is not limited to, eliminating mistreatment of women and promotion of respectful care during childbirth (8, 9).

Based on a systematic review published in 2015, the typology of mistreatment during childbirth has been categorized according to the perspectives of women, community members, health workers and administrators (Table 1) (10). Mistreatment may occur at the level of interaction between the service user and the provider as well as through systemic failure at the health facility and health system level. A WHO-led multicountry (Ghana, Guinea, Myanmar, Nigeria) study has also developed and validated two tools for measuring mistreatment of women (community survey and labour observation) that can be used in various settings (11).

Table 1. Typology of mistreatment during facility-based childbirth measured using the community survey and labour observation tools

<table>
<thead>
<tr>
<th>Any physical abuse</th>
<th>Any verbal abuse</th>
<th>Any stigma or discrimination</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Pinched, kicked, slapped, punched, hit with an instrument, gagged, physically tied down, forceful downward pressure</td>
<td>* Shouted at, insulted, scolded</td>
<td>* Economic circumstance, race, educational level, marital status, religion, HIV status</td>
</tr>
<tr>
<td>* Mocked woman’s physical appearance, baby’s appearance, woman’s sexual activity</td>
<td>* Mocked woman’s physical appearance, baby’s appearance, woman’s sexual activity</td>
<td></td>
</tr>
<tr>
<td>* Threatened with medical procedure, physical violence, poor outcome, withholding care</td>
<td>* Threatened with medical procedure, physical violence, poor outcome, withholding care</td>
<td></td>
</tr>
<tr>
<td>* Blamed</td>
<td>* Blamed</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Poor rapport between women and providers</th>
<th>Failure to meet professional standards</th>
<th>Health system conditions and constraints</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Autonomy (mobilization during labour, preference of birthing position)</td>
<td>* Informed consent and confidentiality</td>
<td>* Lack of resources</td>
</tr>
<tr>
<td>* Supportive care (birth companion)</td>
<td>* Pain relief</td>
<td>* Facility culture</td>
</tr>
<tr>
<td>* Communication</td>
<td>* Neglect, abandonment and long delays</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Respectful maternity care (RMC) encompasses a broader concept than simply preventing mistreatment of women during childbirth. It emphasizes the fundamental rights of women, newborns and families to equitable access to evidence-based care while recognizing the unique needs and preferences of both women and newborns. A qualitative evidence synthesis outlined 12 domains of RMC from the perspectives of users (women and their families), providers, administrators and policymakers (Table 2) (12). These principles were emphasized and reiterated by the 2018 WHO recommendations on intrapartum care for a positive childbirth experience, which go beyond the prevention of mortality and morbidity to encompass a woman-centred, rights-based approach (8).

Table 2. Domains of RMC

| 1. Being free from harm and mistreatment |
| 2. Maintaining privacy and confidentiality |
| 3. Preserving women’s dignity |
| 4. Prospective provision of information and seeking informed consent |
| 5. Ensuring continuous access to family and community support |
| 6. Enhancing quality of physical environment and resources |
| 7. Providing equitable maternity care |
| 8. Engaging with effective communication |
| 9. Respecting women’s choices that strengthen their capabilities to give birth |
| 10. Availability of competent and motivated human resources |
| 11. Provision of efficient and effective care |
| 12. Continuity of care |

While developed specifically in the context of maternal and childbirth services, the domains listed in Table 2 provide a useful lens to understand the broader issues and concepts relating to the provision of respectful and appropriate care in other clinical areas. In exploring the evidence base and policy options for the health workforce role in CRC, it is important to couple this analytical lens with existing health workforce conceptual frameworks to identify a coherent and overarching theory of change.
2. The evidence base on CRC initiatives

To date, few studies have examined the impact of specific policies for enhancing CRC, either as a single component or as a package of measures. A systematic review published in 2018 based on data from five studies showed that CRC in the context of maternal care reduces experiences of disrespectful or abusive behaviour and of physical abuse by health workers (13). However, the evidence on reductions in non-dignified care, lack of privacy, verbal abuse, neglect and abandonment, and reduction in episiotomy rates was less certain. The review suggests that a multicomponent CRC policy could increase women’s experiences of good-quality maternity care.

To develop this paper, we conducted a selective review of the literature to identify illustrative case studies of the issues faced and approaches that countries at different levels of socioeconomic development have attempted. The text boxes detailing case studies 1–9 provide examples of specific initiatives that have focused explicitly on CRC. The evidence of effectiveness of different strategies is, however, of variable depth, maturity and certainty. In particular, most of the available literature is descriptive in nature, and firm indications of demonstrable and attributable results arising from these initiatives are largely lacking.

Case study 1

Impact of training on RMC in Ghana

The concept of RMC is still growing in many African settings, including the Republic of Ghana. Afulani and colleagues (14) sought to understand the impact that emergency obstetric simulation training could have on health outcomes and RMC. An integrated, low-tech, high-fidelity obstetric emergency simulation training was introduced for health workers providing care to pregnant women and patients, using a person-centred maternity care scale.

The average person-centred maternity care score increased relatively by 43%. Scores on the subscales also increased between baseline and endline: a 15% increase for dignity and respect, an 87% increase for communication and autonomy, and a 55% increase for supportive care.

The results revealed a significant improvement in RMC and suggest that providing health workers with training opportunities that allow them to learn, practise and reflect on how to provide RMC could be helpful in improving the situation.

Case study 2

“All with You” (Todos Contigo): a new method of developing compassionate communities – experiences in Spain and Latin America

Global attention is increasing with regard to scaling up the provision of compassionate care for people at the end of their lives. Developing compassionate communities has been found to be an effective public health approach to making this type of compassionate care a reality.

“All with You” (Todos Contigo) is an approach to developing compassionate communities that is built on the Compassionate City Charter (CCC) using social awareness and training and implementing networks of care (15). These networks of care are typically led by “community promoters” who deploy an “intervention protocol” in their management.

This method of developing compassionate communities is growing in popularity and has been adapted across four cities each in Spain and Colombia, and one city in Argentina.
Case study 4

Delivering high-quality, compassionate care in the United Kingdom of Great Britain and Northern Ireland

In 2013, following the report on a public inquiry into events at the Mid-Staffordshire National Health Service (NHS) Foundation Trust, the government of the United Kingdom issued a renewed mandate to Health Education England (HEE) to raise the quality of compassionate care provided by the NHS network of service providers and caregivers to citizens (17). This mandate obligated HEE to undertake reforms across key policy areas such as strengthening integrated care; ensuring competency of staff (including behaviour and values); increasing workforce flexibility and receptivity to changing environments and to research and innovation; ensuring the inclusion of patients’ voices and local participation; and ensuring value for money, transparency and fairness.

Prior to the HEE mandate, nurses and midwives under the NHS Commissioning Board had developed a vision and strategy titled Compassion in practice (18). The strategy is founded on six action areas and the 6Cs of compassionate care values: care, compassion, competence, communication, courage and commitment. As of 2014, around 3200 nurses had attended leadership training courses as an outcome of a key action area (19).

This mixed approach by the UK Government involves compassionate care reforms across actors in health worker education and training and those already in practice settings and is akin to a health labour market approach. This approach will ensure better links between the components of the system, enabling more efficient pre-service and in-service training for students and NHS staff, respectively.

Case study 3

Developing compassionate communities in Canada

Canada’s population is rapidly ageing, and the country recently introduced legislation on medical assistance in dying. These two factors (among others) have contributed to a renewed focus on palliative and end-of-life care.

Canada is now taking active steps to develop compassionate communities through the CCC. The CCC is a multisectoral collaborative initiative that connects all stakeholders to a common purpose of providing compassionate care by utilizing tools such as adaptation of educational platforms and curricula, developing compassionate workplace initiatives and partnering with faith communities (16).

The compassionate communities model is an example of a contemporary public health approach to providing palliative and end-of-life care that is underpinned by the principle of whole-of-society engagement for the benefit of the community.

Case study 5

Improving palliative care opportunities at the community level in Brazil: “Estar ao seu lado” (“We are by your side”) project

An estimated 180,000 people in Brazil are without access to palliative care. The lack of a public health approach to addressing the challenge means that capacities remain at the secondary and tertiary level of care. One way of solving the problem includes integrating palliative care in primary care packages.

The “Estar ao seu lado” project offers high-quality palliative care at the primary care level to patients and families by providing holistic care, including physical, social, psychological and spiritual support.

Factors necessary to ensure success include the presence of primary care team networks on the ground, enhancing training and awareness, and improving policy and service delivery pertaining to palliative care (20).
Case study 6

**CRC as a pillar of Ethiopia’s national health strategy**

The national movement towards creating a compassionate, respectful and caring health workforce was among the four agendas of the health sector transformation plan for 2015–2020 (21). A study of Jimma University medical students published in 2012 found that students scored lower than the global average on emotional and cognitive empathy tests (22). The main elements of the initiative (23, 24) included developing and introducing a national CRC implementation guideline; establishing regional CRC councils and health professional association consortia; mainstreaming CRC in pre-service and in-service training curricula (over 30,000 health workers trained to date) and integrating supportive supervision; establishing community feedback mechanisms; promoting, identifying, providing support for and retaining model professionals; conducting an annual health professional recognition event; strengthening ministry of health initiatives in the area of human resources, including motivation and retention mechanisms, to more effectively manage health professionals already in practice; enhancing ownership and commitment of leadership; conducting national and regional advocacy campaigns; and putting in place a favourable regulation to reinforce CRC, including patients’ rights and responsibilities. A challenge and an important element of future strengthening of the initiative will be to develop and implement a monitoring and evaluation framework to better track results and impact.

Case study 7

**Compassionate care for people living with HIV in India**

As of 2019 an estimated 2.35 million people in India were living with HIV (25). Many of them face stigma and social exclusion. A study published in 2020 (26) examining strategies to foster compassionate care found that investing in health workers to improve clinician availability as well as their relationships with patients represents an important component in improving quality of care, while ensuring that people living with HIV (and other vulnerable populations) feel safer and are treated with dignity and respect while receiving care.

Case study 8

**Survivor-centred care in managing gender-based violence in Afghanistan**

In 2014 a treatment protocol for survivors and sufferers of gender-based violence in Afghanistan was adopted by the Ministry of Public Health (27). The approach outlines the signs and symptoms, minimum requirements and scope of treatment for managing cases. It also highlights the role of quality survivor-centred care, emphasizing that it should embody an empathetic attitude, allow active listening to the survivor and create room for his or her empowerment. The roll-out and implementation of the protocol have since enabled the government of Afghanistan to improve the competencies of an estimated 6500 health workers to provide CRC while also strengthening the public health system (28).

Case study 9

**Strengthening the policy environment for developing compassionate care in Australian communities**

In 2017 the Tasmanian (Australian) government authorities developed a policy framework titled *Compassionate communities: a Tasmanian palliative care policy framework 2017–2021* (29). The approach outlines a comprehensive set of actions that include strengthening community and public health approaches to ensure that people receive the best end-of-life care. The policy framework emphasizes the need to transition from hospital-focused care to increasing support at the community and family level. The framework recognizes the pivotal role of a knowledgeable, skilled and capable workforce, and the need for targeted and inclusive capacity-building approaches that emphasize elements of compassionate care.

These examples illustrate the variety of strategies that have been adopted to enhance CRC, ranging from training and community engagement to integrated approaches encompassing several aspects of service delivery reform and health workforce management.
3. A theory of change for enhancing health worker behaviour

**Health labour market framework**

The quality and performance of the health workforce depend on different but interrelated factors having to do with health worker supply, distribution, competencies acquired through pre-service education and reinforced through continuous medical education, an enabling work environment, supportive supervision, quality assurance and appropriate management systems. A health labour market framework can assist in systematizing the main determinants of health workforce availability and performance, recognizing the risk of the most common labour market failures and determining policy responses (Fig. 1).

Various health labour market factors can impact the motivation and job satisfaction of health workers. For example, it may be necessary to address the root cause of burnout among health professionals by ensuring a reasonable workload in a conducive and supportive work environment; reducing occupational diseases and injuries by adequately investing in occupational safety measures in the workplace; dealing adequately with secondary traumatic stress conditions by putting in place support and counselling services; and reducing abuse of health-care workers by ensuring a safe and protected work environment, coupled with sensitization of communities. Conversely, evidence from a 2018 systematic review shows that strategies for improving the performance of health workers that focus exclusively on training alone or on providing training and advocacy materials have very limited impact (30).
Labour market failures

Health worker production does not meet needs: inadequate skills mix, quality and capabilities to provide CRC

Informal work, lack of decent work, inequitable remuneration, demotivation and strikes

Abroad

Out of the labour force

Health workforce capable and equipped to deliver quality health services

Weak performance management, regulation and accountability may translate into poor attitude towards patients

Universal health coverage with safe, effective person-centred health services

Labour market dynamics

Education sector

Secondary education

Pre-service health worker education

Education in other fields

Pool of qualified health workforce

Workforce pool does not meet needs: inadequate skills mix, quality and capabilities to provide CRC

Employed in public sector

Incentivized in public sector

Health workforce capable and equipped to deliver quality health services

Universal health coverage with safe, effective person-centred health services

Weak performance management, regulation and accountability may translate into poor attitude towards patients

Out of the labour force

Unemployed

Other sectors

Abroad

Education sector

Pre-service health worker education

Secondary education

Education in other fields

Policies on production:
• Infrastructure, materials, faculty
• Transformative education models (TVET, accelerated programmes, rural pipeline, social accountability)
• Student selection and enrolment

Policies to address inflows and outflows:
• Investing in decent employment
• Migration
• Attract unemployed health workers
• Attract health workers back into the sector

Policies to regulate the public and private sector:
• Uphold standards of practice (dual practice, ethics, quality)
• Improve quality of training
• Enhance service delivery

Policies to address maldistribution and inefficiencies:
• Improve productivity and performance
• Improve skills mix composition
• Retain health workers in underserved areas
• Gender-sensitive policies for equity

Labour market failures

Labour market failures

Attrition and migration deplete scarce workforce pool

Unemployed

Employed in public sector

Incentivized in public sector

Health workforce capable and equipped to deliver quality health services

Universal health coverage with safe, effective person-centred health services

Weak performance management, regulation and accountability may translate into poor attitude towards patients

Out of the labour force

Unemployed

Other sectors

Abroad

Education sector

Pre-service health worker education

Secondary education

Education in other fields

Policies on production:
• Infrastructure, materials, faculty
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• Improve skills mix composition
• Retain health workers in underserved areas
• Gender-sensitive policies for equity

Fig. 1. Understanding health labour markets and addressing common market failures. HRH: human resources for health. TVET: technical and vocational education and training. Source: WHO
Rights, roles and responsibilities of the health workforce

Health systems are much more than mechanisms for delivering health interventions; rather, they are core social institutions which, when operating suboptimally (for instance through neglect, exclusion or abuse), can worsen social exclusion and exacerbate the experience of poverty (31). Conversely, engagement with a “just” health system can serve to advance individual agency, human rights and inclusion in society alongside improvements in health.

The values and organization of a health system underpin the treatment that both citizens seeking care and health service providers experience. Far too often “those who struggle in the most challenging conditions to provide ethical, compassionate, high-quality care find themselves unrewarded – or even punished – for taking initiative” (31). At the same time, those who choose to exploit a poorly functioning system often do so with impunity.

As with the systems in which they reside, health workers can take on more roles – both positive and negative – than simply that of care provision. Additional positive roles include acting as advocate, counsellor, educator, innovator, mentor and human rights champion. At the opposite end of the spectrum are negative behaviours relating to taking advantage of health workers’ position of power, resisting change and innovation, and reinforcing hierarchies within the workplace and the broader society.

Ensuring fulfilment of the rights and responsibilities of health workers (32, 33) helps to amplify the positive roles that health workers play and to mitigate the negative roles. The NHS constitution for England (34) and the WHO guideline on health policy and system support to optimize community health worker programmes (35) are just two examples (at the national and global level, respectively) of policy frameworks that emphasize the fundamental importance of attention to health worker rights. These guidelines do so by addressing the contractual framework for health workers’ employment, fair pay, equal treatment, safe and conducive working environment, professional representation and complaint mechanisms, as well as the delivery of CRC.

While the rights and responsibilities of health workers are increasingly well articulated and recognized at the global and national level – including in international human rights law, international labour standards, national legislation, professional standards and professional regulatory frameworks – they often neither reach nor are implemented at the operational level.

In this context, and recognizing the interplay among the factors that both enable health workers to fulfil their responsibilities and to have their rights upheld (Fig. 2), it has become necessary to identify policy levers related to optimizing the health workforce in general as well as highly specific interventions aimed at enhancing the delivery of CRC.

Fig. 2. The two-way relationship between respecting workers’ and patients’ rights. Source: WHO

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The patient – provider interface

Rights, roles and responsibilities of health workers

People’s right to compassionate, respectful care
Quality-of-care approaches

The Sustainable Development Goals (SDGs) place a clear emphasis on achieving UHC, ensuring that all people and communities have access to the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose users to financial hardship. The WHO Framework on Integrated, People-Centred Health Services (IPCHS) presents a vision for the future in which “all people have access to health services that are provided in a way that responds to their preferences, are coordinated around their needs and are safe, effective, timely, efficient and of an acceptable quality” (36). Within this context, the quality of health services and systems is central to the UHC agenda.

The IPCHS framework recognizes that the comprehensive needs of people and communities must be placed at the centre of health systems. Compassion sees the face of end users and responds to their needs in a holistic way, including their mental, spiritual, emotional and psychosocial needs (37). Compassion can be a force that drives the delivery of quality health services in health facilities. It also has the potential to drive health systems away from a focus on diseases to a focus on people. Compassion is the human aspect that drives quality of care.

Health service delivery often falls short in achieving desired outcomes due to a lack of compassionate care. Indeed, patients, health workers and health organizations are suffering because of systems that lack compassion. As a result, the quality of service delivery suffers, staff burnout rates climb, and patients do not receive effective care. Precisely for this reason, SDG target 3.81 calls for a strong and deliberate focus on the quality of essential health services as part of the drive towards UHC. This effort also recognizes that compassionate systems are a critical component of quality care. Health care that is grounded in compassion, respect and dignity promotes people-centred health services that are administered effectively and safely while also striving to deliver timely, integrated, efficient and equitable care. Thus, any effort to embed compassion across a health system is likely to benefit from being incorporated into broader efforts to achieve quality. Multiple factors must co-exist and converge in the organization of health services and health worker capacities and the work environment to create the proper conditions for effective provision of quality health services. For example, action is required for quality planning, quality control, quality assurance and quality improvement (38). These requirements in turn imply the need for coherent and aligned national planning and formulation of policy to set directions, along with operational methods to ensure that critical health service delivery processes are designed to work and that targeted levels of performance are being achieved and sustained. Attention is also needed across each quality intervention area: shaping the system environment, reducing harm, improving clinical care, and engaging patients, families and communities (39). As outlined in the WHO–World Bank–OECD report Delivering quality health services, each country should have a national quality policy and strategy to underpin efforts at the national, district, facility and community level.

The working environment and decent work conditions of health workers are closely related to compassionate care and quality of care. Occupational burnout among health professionals is a major cause of medical mistakes and poor quality of care. Lack of patient handling equipment is an obstacle for compassionate care of patients with reduced mobility. Violence and harassment in health-care settings affect both workers and patients. It is difficult to expect compassionate care from health workers who are subjected to regular psychological, physical and sexual harassment as well as violence and occupational burnout. The duty of care of employers and facility managers is to ensure the safety of both workers and patients. WHO and the International Labour Organization have developed a global framework for national occupational health policies for health workers as well as a tool for improving working conditions at health-care facilities (HealthWISE).

Compassionate quality health services become even more critical in the context of strengthening the resilience of health systems to withstand shocks. Taking compassion into account as an integral aspect of public health emergency preparedness can foster and build the confidence of the community in the health system; strengthen governance by ensuring that guidelines and

policies are founded on principles of compassion, respect and dignity; and improve the knowledge of health workers so they can effectively anticipate, respond to and recover from the impacts of emergencies in a compassionate, people-centred manner.

Health workforce strategies geared to the development of a compassionate, caring and respectful workforce presuppose the existence of quality standards and regulatory systems and the mechanisms to uphold them. These standards and mechanisms in turn can be reinforced by appropriate management and recognition systems (Fig. 3).

**Fig. 3.** Inputs and processes that influence the provision of quality care. Source: WHO

<table>
<thead>
<tr>
<th>IMPACT</th>
<th>Improved health status</th>
</tr>
</thead>
<tbody>
<tr>
<td>EFFECTS</td>
<td>Improved performance &amp; productivity</td>
</tr>
<tr>
<td>OUTCOMES</td>
<td>Improved availability, Increased responsiveness, Improved competence</td>
</tr>
<tr>
<td>OUTPUTS</td>
<td>Examples: Increased supply and stock of health workers; improved skills mix; equitable distribution and retention; reduced absenteeism</td>
</tr>
<tr>
<td>PROCESSES</td>
<td>Management systems</td>
</tr>
<tr>
<td></td>
<td>Quality improvement</td>
</tr>
<tr>
<td></td>
<td>Regulation</td>
</tr>
<tr>
<td>INPUTS</td>
<td>Validated measurement tools</td>
</tr>
<tr>
<td>CONTEXT</td>
<td>Determinants and enablers of performance at:</td>
</tr>
<tr>
<td></td>
<td>Macro level: health systems level, socioeconomic/labour market and political level</td>
</tr>
<tr>
<td></td>
<td>Micro level: workplace and community level</td>
</tr>
<tr>
<td></td>
<td>Individual level: health worker and client level</td>
</tr>
</tbody>
</table>

Resources: Human, financial, informational, equipment, supplies and technical
Towards a unified health workforce framework to address determinants of CRC

A theory of change for enhancing the provision of CRC needs to be centred on its workforce dimensions but at the same time to go beyond them. Such a theory therefore must recognize the multiple layers of determinants of provider behaviour (Fig. 4).

**Fig. 4. A conceptual approach to multilayered interventions for CRC**

**Concentric layers of interventions for provision of quality CRC**

<table>
<thead>
<tr>
<th>Broader service delivery and organization</th>
<th>Broader workforce policy and management</th>
<th>Individual health workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Advocacy and accountability</td>
<td>• Curricula and licensing requirements</td>
<td>• Training to expand/refresh competencies</td>
</tr>
<tr>
<td>• Reducing harm</td>
<td>• Regulation mechanisms</td>
<td>• Mentoring</td>
</tr>
<tr>
<td>• Improvements in clinical care</td>
<td>• Supervision systems</td>
<td>• Incentives to improve motivation</td>
</tr>
<tr>
<td>• Patient, family and community engagement</td>
<td></td>
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</tbody>
</table>

In turn, identifying the required policy levers means recognizing that some interventions will be effective in targeting individual health workers, whereas others will require interventions at the level of an individual organization, facility or employer. Yet others will necessitate systemic interventions of a policy or governance nature (40), either focusing on the health workforce more broadly or on the organization and delivery of health services at large. Identifying the right targets helps to define the most appropriate implementation strategy. For instance, interventions that target individual health workers will require training, incentives at the individual level and so forth. Conversely, interventions targeting the broader system of workforce management (e.g. to reduce burnout due to overburdening) and supervision will need to be delivered at the aggregate level, targeting health facilities at large. Interventions requiring an even broader approach (e.g. reforming the education curricula, or introducing regulations to sanction disrespectful behaviour on the part of health workers) should be aimed at policymakers who have the relevant mandate to address them. The following section accordingly categorizes policy levers both by levels targeted in the health system and whether they are highly CRC specific or are of broader relevance for health workforce leadership and management.
4. Health workforce policy options towards CRC

Interventions to improve health workforce performance in general

Some interventions aimed at achieving CRC must be implemented as part of broader health workforce investment strategies that address the overarching architecture as well as the policy and governance of the health workforce. Examples of these systemic interventions include:

- Ensuring adequate overall workforce numbers in relation to workload, so that health workers are not overburdened and can dedicate appropriate time and attention to the qualitative and interpersonal aspects of CRC. Such an intervention requires action by national government at the planning and financing stage.
- Assuring a more sustainable and responsive skills mix by harnessing opportunities afforded by educating and deploying community-based and mid-level health workers. This intervention requires action when planning the education and deployment of health workers.
- Adopting more effective and efficient strategies and appropriate regulations for health workforce education, including licensing of individual health workers and individual health facilities, as well as accreditation of training institutions. This intervention requires action by regulators and professional councils.
- Selecting trainees from rural and underserved areas and delivering training in those areas, providing financial and non-financial incentives, and introducing regulatory measures or reorganizing service delivery.
- Improving deployment strategies and working conditions, including occupational safety; a positive practice environment; merit-based career advancement; elimination of gender-based discrimination; a working environment free from any type of violence, discrimination or harassment; and appropriate incentive systems. This intervention requires action by employers (both public and private) and public sector bodies (e.g. civil service commissions), which set the terms and conditions of employment.

Conversely, other interventions can be conceptualized and implemented as incremental modifications that require a more contained level of investment or that typically can be implemented in the context of existing policies and governance mechanisms. Examples of these interventions include:

- Enhanced social accountability mechanisms whereby the public can provide feedback on health worker performance and the acceptability of the services rendered. This can be operationalized by employers and by local health authorities.
- Inter-professional collaboration to embed a collaborative attitude among health workers beginning at the pre-service education stage. Such collaboration may result in more respectful relationships within health-care teams, which in turn may help to improve the quality and responsiveness of care rendered to the population. This intervention can be operationalized by health education institutions.
- Job security, a manageable workload, supportive supervision and effective organizational management. These elements can be operationalized by employers.
- Continuous professional development opportunities and career pathways tailored to gender-specific needs. This can be operationalized by employers, professional councils and professional associations, or national and subnational bodies responsible for continuous medical education.

These strategies, in combination, are effective in optimizing health worker motivation, satisfaction, retention, and equitable distribution and performance – in other words, in fulfilling health workers’ rights.
Specific policy levers for CRC

The more specific evidence surrounding interventions to ensure health workers fulfil their responsibilities and roles in relation to the provision of CRC indicates a multifaceted approach that recognizes the complex relationship among expectations, human rights, and the link between individual action and systemic conditions (42). An intervention package suited to addressing CRC should be a multipronged approach focused on three levels:

1. individuals in the system;
2. structures and functioning of the organizations; and
3. architecture and oversight of systems (43).

This approach mitigates the drivers of mistreatment at all three levels, improves the CRC policy environment and improves community awareness of rights that can be replicable in different contexts (44).

Interventions targeting individuals in the system

Activities targeting either patients or health workers themselves have been shown, for instance, to address mistreatment during childbirth. Further, identifying human rights norms and standards related to mistreatment is a first step towards addressing violations of human rights during facility-based childbirth, ensuring respectful treatment and improving the overall quality of maternal care (45). Working on this challenge, raising awareness and generating demand for CRC rights is essential within a system. Examples of relevant intervention areas include:

- establishing mechanisms to ensure that all patients and service users are made aware of their rights;
- ensuring that service users have access to a medium for raising and addressing complaints, for example by providing an audit and response mechanism that integrates and responds to users’ feedback; and
- developing a curriculum and implementing a programme – as part of broader performance enhancement strategies – for in-service and pre-service training for the health workforce to enable effective delivery of services that meet the social, cultural and linguistic needs of users (Table 3).

Table 3. Key elements to consider in competency-based training in CRC

<table>
<thead>
<tr>
<th>Element</th>
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<tbody>
<tr>
<td>Demonstrating compassion, empathy and respect for all people irrespective of age, sex, race or ethnicity, economic status, health status, disability or vulnerability to ill health, sexual orientation, gender identity and expression, nationality, language, asylum or migration status, or criminal record.</td>
</tr>
<tr>
<td>Reinforcing the rights of all people to be treated with respect and free from stigma, discrimination, violence, coercion, disrespect or abuse.</td>
</tr>
<tr>
<td>Adapting practice to respond to people’s needs, ability to access care, preferences and aspirations.</td>
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</tbody>
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In addition, soft skills relating to effective teamwork with other health workers have the potential to improve the overall quality of care in facilities, specifically, the quality of interactions both between patients and health-care workers and among health workers. These skills include:

- health worker teamwork
- effective communication
- problem-solving
- leadership, decisiveness
- time management and flexibility
- staff values, motivation and behaviour (46).
Interventions targeting the structure and functioning of organizations

Respectful care should be a characteristic not only of health-care providers but also of organizations and health service facilities. The ability to provide respectful care can be negatively affected when the conditions of infrastructure deviate greatly from standards of good-quality care. Examples of relevant interventions include, for example:

- addressing infrastructure and work environment deficiencies that can contribute to disrespectful care (e.g. conditions – or absence – of toilets and washing facilities, lack of privacy and overcrowded birth spaces);
- shifts in organizational and structural changes (e.g. reorganization of workflow processes, re-engineering of management and quality assurance systems, and upgrading or repurposing of health facilities);
- monitoring and evaluating the feasibility, effectiveness and sustainability of CRC interventions in the context of individual institutions and health facilities; and
- appointing dedicated facility leadership, management support and health workforce engagement for the well-being and morale of staff and the successful implementation and sustainability of CRC (47).

Interventions targeting the architecture and oversight of the health system

Systems should also have appropriate oversight, including policies and accountability mechanisms in place. Examples of relevant interventions include:

- establishing and implementing protocols for CRC detection, reporting and response in the event of reported mistreatment;
- creating formal mechanisms for civil society to engage in an advocacy and accountability role at the community level or to feed into policy development; and
- embedding CRC in national policy and governance frameworks, strategic documents, legislation, and resource allocation processes and mechanisms.
5. Discussion

This document has presented and discussed specific evidence and a range of conceptual frameworks to illustrate and organize the range of issues that should inform health workforce policy and management with the objective of ensuring that health workers provide CRC. The available evidence is limited in both scope and depth. More research, ideally mixed-methods studies originating in implementation research contexts, should be conducted to expand the range of policy options to be considered, as well as to assess their relative effectiveness, cost–effectiveness and optimal implementation modalities.

Translating the limited evidence base and the policy options presented in this document requires identifying context-specific challenges (including which groups are at higher risk in a given context to receive disrespectful and non-responsive care), the architecture of the health system and the most appropriate implementation modalities.

An effective strategy for enhancing the role of the health workforce in the providing CRC should be rooted in the broader context of determinants of health workforce availability, accessibility, acceptability, quality and performance. Such a strategy should also recognize that upholding health workers’ rights has a positive effect on ensuring that they, in turn, adequately fulfil their roles and responsibilities.

While some interventions may be highly specific to health worker knowledge of and skills and attitudes towards CRC, others will have to tackle more systemic issues at the organizational, institutional or health system level.

While it is individual health workers who provide services to the population, the challenges may reside at the level of health facility infrastructure, or in the regulation, governance and financing of the health system at large.

Accordingly, appropriate policy responses may include interventions targeting citizens and communities themselves, the health workforce, health facilities, health sector institutions, or the health sector policy and governance environment.

The interventions outlined in this document are of a variable level of complexity and feasibility. While the full range of interventions, and particularly those requiring some reorganization of the health system, may represent long-term objectives in some contexts, taking action on the most direct interventions at the operational level may be feasible and result in tangible improvements in a shorter time frame with a more limited level of investment.

Identifying clear and objectively verifiable performance metrics, and collating and analysing required data from both the health system and health worker perspective and that of end users of services, will make it possible to determine and track the effectiveness of the interventions adopted over time. In the context of large-scale programmes, implementation research can be crucial in guiding the execution of a CRC strategy by identifying and resolving bottlenecks at the programme and health systems level, based on the priorities identified by the planners and managers themselves (48).
References

17. Delivering high quality, effective, compassionate care: developing the right people with the right skills and the right values. London: Department of Health; 2013.


