SolidarMed Position Papers

SolidarMed establishes position papers on strategic key topics. The purpose of the position papers is to learn from our own and our partners' project experiences as well as from the available international evidence. Position papers reflect global policy debates and define the SolidarMed principles in the respective area of concern. SolidarMed incorporates these standards into the programmes and projects and into the policy dialogue with partners and stakeholders.

Available SolidarMed Position Papers:

2010_1 HIV/AIDS (2010, by Jochen Ehmer)
2010_2 Community-based health interventions (2010, by Thomas Gass)
2011_3 Human Resources for Health (2011, by Ethel Grabher)
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Abbreviations

AMOs    Assistant Medical Doctor  
ART     Antiretroviral therapy  
CHW     Community Health Worker  
CO      Clinical Officer  
HR      Human resources  
HRTWG   Human Resources Technical Working Group  
IHI     Ifakara Health Institute  
IMCI    Integrated Management of Childhood Illness  
MDGs    Millennium Development Goals  
ML      Medical Licentiate  
MM      Medicus Mundi  
MMI     Medicus Mundi International  
PETS    Public Expenditure and Tracking Survey  
PMTCT   Preventing mother to child transmission of HIV  
TTCH    Tanzanian Training Centre for International Health  
WHO     World Health Organization

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Human Resources for Health.

Strengthening health systems – assuring service delivery – improving health

Getting the right workers with the right mix of skills to areas where they are needed most is key to improving health service delivery outcomes.

Sub-Saharan Africa will not meet any of the health Millennium Development Goals (MDGs) by 2015 if current rates of progress continue. This is primarily due to weak health systems characterised by the limited capacity, low motivation, absenteeism and overall severe shortage of health workers at all levels.

This paper highlights some of the reasons behind the HR crisis and presents the experiences, lessons learned and future strategies of SolidarMed to strengthen the health workforce in SSA.
1 The health workers crisis: A major bottleneck to achieve the MDGs

The good news first! International health enjoys a higher position on the political agenda than ever before. Over the past ten years there has been a dramatic increase in funding for health-related programmes in the developing world. Three out of the eight Millennium Development Goals (MDGs) are directly related to health. Particularly the Aids epidemic has fuelled public concern and social activism. Strong political commitment has emerged. Investments and technical assistance were scaled up tremendously.

Now some sobering facts behind the success stories: The increased expenditure on health have primarily been channelled into vertical programs fighting major diseases but with insufficient resources directed towards strengthening health systems. Yet, a strong and well-functioning health system is prerequisite to achieve the MDGs. Success depends not only on money, vaccines and drugs. Efficient and measurable results can only be produced if a skilled, motivated and well-managed health work force is present to administer the required treatment, offer services related to reproductive health or implement a prevention campaign. The systems do not work without health workers as the ultimate resource.

The WHO suggests that achieving an 80% coverage rate for skilled birth attendance and child immunization – two basic primary health care targets – requires a minimum of 2.5 health care professionals per 1,000 residents. Currently, there are about 750,000 health workers in Africa, or 0.8 health workers for every 1,000 people. In Mozambique, for instance, 600 doctors serve a population of 18 million people. That translates into one doctor for 30,000 people. In comparison: In Switzerland, one doctor caters for 489 people. Although the WHO guidelines are valid there has been some lenience in the ratio in developing countries.

Information box:

Sub-Saharan Africa…

- is home to 9 percent of the world’s population
- shoulders 25% of the global disease burden
- is equipped with 3% of the world’s health workforce operating on less than 1% of the world’s financial resources for health
- lacks 1 million trained health workers in order to come close to achieving the MDGs for health – that would mean tripling the current numbers of health workers through retention, recruitment and training.

"Worldwide, one billion people never see a health worker all their lives."

Sigrun Mogedal on the Second HRH Forum held in Bangkok, January 2011

The correlation between the lack of health personnel, quality of care and health outcomes is reflected in grim figures. The lifetime risk of a woman to die from pregnancy or childbirth is 1 in 16 in Sub-Saharan countries. The rates of births attended by skilled birth attendants remain low, averaging only 42%. One in seven children die before their fifth birthday, mostly from preventable or curable diseases like pneumonia, diarrhoea, Malaria and Aids.
1% increase in health professionals is associated with an almost 5% increase in maternal survival and an over 2% increase in both infant and child survival.


1 million missing health workers: The low number of health workers across Africa is a significant bottleneck to the provision of health care. An estimated one million health staff are lacking across the spectrum, from doctors and nurses to laboratory technicians and pharmacists, at all levels of care.

A major challenge is the exodus of health workers in search of better working conditions, remuneration and job security. The flow follows a hierarchy of wealth, from rural to urban areas, from public to private sectors, from lower to higher income countries within southern Africa and from African countries to high-income countries. The consequences become most apparent in remote, hard to reach parts of the continent, where those most in need of health care are often the least likely to get it.

The reasons for these problems are manifold. Adequate national and international resources committed to address the health care worker crisis are lacking. Inadequate salaries and poor working conditions lead to attrition and an inability to attract new health workers. The health sector is characterized by an endemic lack of workforce organisation, weak people and performance management and insufficient education and training systems. It is therefore not surprising that the productivity and performance of health workers is inadequate as they are poorly motivated (and poorly managed), not sufficiently qualified or simply absent from work (malingering, attending training, ‘moonlighting’ or on the very generous sick leave benefits of up to 180 days in some countries).

Shortages are expected to increase sharply in the coming years, primarily due to HIV/Aids. The disease has not only created extraordinary demands for health care in areas where health systems are already weak and overwhelmed, but is also decimating the health workforce. In Lesotho and Mozambique, death is the leading cause of health worker attrition, with a significant proportion being HIV-related. With the international focus on the implementation of extensive HIV/Aids care and treatment programmes during the past years, the issue of severe HRH shortages appears to be worsening, given the combination of all of the above-mentioned variables. Significant numbers of skilled staff are needed to provide ARV treatment to people living with HIV/Aids, whereas the health systems presently lacks the personnel needed to provide even the most basic health services.
2 Strengthening Human Resources: A key component of the SolidarMed health strategy

During the past years, SolidarMed has consistently worked towards broad-based improvements in population health, following a comprehensive primary health care approach. The organisation tackles health problems through the creation of an accessible, permanent institutional infrastructure for general health services. HR development does not stand alone but is an integral element of broader health system strengthening efforts.

Systems Strengthening: A core principle underlying the interventions of SolidarMed is to supplement – not supplant – the public policy role of host country governments and local institutions to strengthen and expand health systems. This principle is also applied in individual disease programmes such as SMART, the SolidarMed HIV/Aids treatment and prevention programme. The key factor in fighting HIV/AIDS is to build the capacities of local health systems.

++ Example from SolidarMed – incorporation of vertical programmes into health systems strengthening ++ SMART: Exploring a diagonal approach: Integrating ART into primary health care

In 2005, SolidarMed started running an HIV/Aids treatment and prevention programme called SMART in ten district sites in Tanzania, Mozambique, Lesotho and Zimbabwe. Managing HIV/Aids requires money for drugs, but even more important is a strong health workforce, reliable health services that reach out to rural communities and adequate district health management capacities. In an effort to mitigate the drawbacks of vertical health programmes, SolidarMed pursued three strategies:

- Integration of SMART into existing SolidarMed primary health care programmes and long-standing hospital partnerships.
- Harmonization of SMART with existing HIV/Aids programmes and alignment with national health policy. SMART projects are designed with district health authorities to complement government ART programmes.
- A share of the SMART budget is earmarked for general capacity building interventions such as infrastructure and salary top-ups that are not specifically related to HIV/AIDS services.

As a result, SMART pursues a ‘diagonal’ programme approach – one where ART-specific interventions are embedded in wider primary health care support.


3 Conceptual Framework

In order to create a common understanding of how attraction and retention interventions work, a conceptual framework on human resources for health is presented in this section. It is based on models proposed by the WHO and serves as a model to systematically develop, implement and monitor strategies to achieve an effective and sustainable health workforce. The framework points out the importance of placing health workforce issues in a broad perspective that considers many interrelated factors including the influence of contextual factors.

The proposed framework is based on a systems approach and differentiates between inputs, outputs, outcomes and impact with regards to the results of interventions to attract and retain health workers in underserved areas. It proposes indicators to measure progress in various strategies.
4 What works?

In May 2011, SolidarMed conducted an internal workshop with the goal of optimizing the selection, design and implementation of its HR interventions. Selected SolidarMed country representatives, desk officers and project managers were invited to share their experiences and to analyse challenges and opportunities. This document summarizes lessons learned, best practices and future working principles that SolidarMed perceives as effective, efficient and adequate in relation to the local contexts but also includes it’s organizational expertise and capacity.

The discussions during the workshop were guided by WHO Global Policy Recommendations which were launched in 2010: “Increasing access to health workers in remote and rural areas through improved retention”. The report encompasses a set of sixteen evidence-based strategies to increase the availability of health workers in remote and rural areas through improved attraction, recruitment and retention (See Annexe 1, Page 25) The comprehensive set of recommendations serves as practical tool to help countries or development partners encourage health workers to live and work in remote and rural areas.

The following sections introduce some of the key WHO suggestions which are combined with insights drawn from other sources and crucially, from the extensive experiences gained by SolidarMed in the field.
A. Education

Increase the production of qualified health personnel: Training institutions in Sub-Saharan Africa are not producing a sufficient supply of health workers to replenish the dwindling human resources for health. Years of underinvestment in institutional capacity have resulted in inadequate training infrastructure, insufficient numbers of teaching staff and an inappropriate skills mix. Meanwhile, considerable funding is spent on training workshops for priority health programmes (which many staff members attend continually to access the allowances paid as an additional source of income). Often, the budget for training institutions fall under a different ministry such as Education, making it more difficult to access funds.

Training and continuous education

In a self-regulation initiative, a group of key organizations passed the "NGO Code of Conduct for Health Systems Strengthening" in 2009. The code serves as a guide for NGO practices that contribute to building public health systems and which support the primacy of the government's responsibility for organizing health care delivery. One of the six core strategies is strengthening of educational institutions that train health workers. A follow-up study among the NGOs that were involved in developing the code of conduct suggests that this pledge has remained a paper promise. Most NGOs still focus almost exclusively on short training courses.

Short courses of health staff are also a core measure in the SolidarMed programme. The objective of this training is primarily to improve the quality of health service delivery. The target group is government health functionaries or health institution personnel such as nurses, assistant medical doctors or doctors. Professional development is necessary to maintain competencies and improve performance. There is strong evidence that increasing the ability of health workers to offer quality health services to their patients has a considerable impact on their professional satisfaction. Continuing education therefore not only plays a direct role in productivity and performance but also represents a positive, motivating incentive that contributes to the retention of health workers.

++ Example from SolidarMed – in-service training/continuous professional development ++
Tanzania – Lugala Hospital Development Plan:

Capacity building by the SolidarMed project manager, for instance in the form of continuous in-service bedside teaching during case management or death audits, improve the knowledge and competency of the health professionals at the hospital. It also motivates and encourages the health staff gaining know-how and having such sessions. Such knowledge transfer is a defined outcome within the Lugala Development Plan. On a daily, weekly and monthly basis it is part of the routine. In a remote hospital like Lugala it is an important factor to retain health staff.

Henry Nyangi (33), AMO at Lugala Hospital: “My surgical skills improved so much since I started to work with Dr Peter. I’m very glad and happy that I got the chance to work with him. With the knowledge I gained from Dr. Peter I could save many lives.”

Some of the rural communities in SolidarMed’s intervention areas have a health facility in their vicinity but due to a lack of health personnel, these facilities are virtually idle. In Tanzania, for instance, a dispensary serving a population of 10’000 persons should have two nurses and two clinical officers. Many dispensaries do not even have one qualified nurse present let alone a clinical officer, but are run by an unqualified nurse assistant. The core underlying problem is that health workers are unwilling to work at some rural health posts as they prefer the better working and living conditions in urban areas.

To address the most critical health personnel gaps in rural health centres or partner hospitals, SolidarMed sends selected candidates to pre-service training. Scholarships are usually provided to candidates that are willing to work in an
underserved, rural area after graduation for a certain period of time. Whenever possible, targeted admission policies are applied to enrol students with a rural background. Evidence suggests that they are more likely to continue to practice in rural areas on completion of the compulsory service.

The quality of health services depends not only on the inputs of clinicians like nurses or physicians. Many other cadres of health workers are equally important for health service delivery. SolidarMed therefore includes professionals in all levels of the health system in pre-service and on-the-job training such as public health workers or paramedical and support staff such as laboratory technicians or radiographers.

Support of training institutions

Sponsoring shorter or longer individual training courses can only fill the gap in emergency situations but does not substantially contribute to a long-term alleviation of the health workers crisis in a sustainable manner. Countries need to strengthen the capacity of training institutions to scale-up the production of health workers, including mid-level cadres. In line with the previously mentioned core recommendations of the “NGO Code of Conduct for Health System Strengthening”, SolidarMed invests in pre-service training, mostly on the level of nursing/midwifery or non-physician clinicians where the greatest shortages are found relative to staffing requirements.

The goal of expanding the capacities of training institutions is to increase student enrolment and output. It is critical that increasing trainee numbers does not overload existing training programs and endanger training quality. A lack of tutors, for instance, represents a critical challenge for increased training output in the short run. Therefore, continuous investments in teacher development as well as in measures addressing needs in extended infrastructure and growing running costs are required.

++ Example from SolidarMed – strengthening educational training institutions ++
Zimbabwe – Support to nursing schools at Musiso and Silveira:

Due to massive brain drain, Zimbabwe has a very critical human resource problem. SolidarMed has therefore not only been supporting the hospitals at Musiso and Silveira but also the nursing schools attached to them. Grace to SolidarMed’s investments into infrastructure and procurement of educational equipment, the nursing school at Musiso could be reopened in 2009 after 5 years of inoperability. The Silveira Nursing School was since 2005 assisted with contributions to running costs and infrastructural maintenance. Both nursing institutions offer quality training according to the MoHCW curriculum. Today, Silveira is one of the leading schools for the education of “primary care nurse” and the one with the highest rate of successful exams in the entire country. In addition, the school now plans to offer a training for registered nurses and a midwifery training (in line with the plans of the MoHCW to improve maternal and child health services by increasing the number of skilled nurses). In both schools, tutors benefit from a favourable working environment and regular training in order to improve the quality of teaching.

In 2010, a total of 119 students benefited from the training and additional 55 graduated in 2010 from the two nursing schools. Even before graduation, the students serve during their practical trainings as valuable human resources in the hospitals and the attached rural health centres. In the long-term, the magnitude of this support is assumed to be large as many of the students are expected to remain with the hospitals or one of the health facilities in the surrounding area.

Mutsetsa O.R. (38), Tutor Musiso School of Nursing: “As with support from SolidarMed we have been able to reopen the Musiso School of Nursing we can now contribute to relieve the shortage of Nursing staff as well as at our hospital and local community as for the country as a whole. At the same time it helps us to improve the quality of nursing care at our hospital by keeping all staff up to date with current information and to reduce the workload in the wards, where nurses where being affected by burnout syndrome previously due to staff shortages.”
B. Different types of cadres

There is no escaping the fact that the absolute numbers of skilled workers needs to increase. However, the resources to fund such an increase will not be available in the foreseeable future. To contribute to an amelioration of the problem in the coming decade, SolidarMed prioritizes an appropriate skills mix and the training, motivation and retention of lower and mid-level cadres. Approaches involving non-physician clinicians or paraprofessionals like community health workers help save money and training time. The ultimate aim is to achieve the right mix of health workers and professional skills through qualitative and accredited curricula.

Task shifting to lower cadres

One of the most successful coping mechanisms in the face of acute shortages of professional health care workers is task-shifting. The goal is to increase the availability of services through the delegation or shifting of specific tasks from highly qualified health workers to health workers with shorter training and fewer qualifications or to newly created cadres who receive specific, problem-adapted training. Task shifting is a strategy to make more efficient use of the currently available human resources for health and to ease bottlenecks in service delivery.

One prominent example of successful task shifting is the decentralization of HIV-care in Lesotho. With one fourth of the adult population being HIV-positive and less than a hundred doctors available in the entire country, rigorous task shifting was the only option to scale up HIV/Aids treatment. Care was moved down from hospitals to primary care clinics and community health posts where nurses perform tasks previously done by medical doctors. In order to free nurses from most non-medical tasks a lay cadre was introduced to take up responsibilities in counselling, testing and follow-up of patients and this relieved the nurses of these tasks.

Policy framework: National policies play a determining role in the extent to which task shifting and the decentralization of care can be implemented. In Zambia or Lesotho for instance, the scope of practice for nurses was extended to enable them to initiate and prescribe ARVs and the rules amended to allow lay workers to carry out testing and counselling.

++ Example from SolidarMed – task shifting ++

Lesotho: Decentralization of SMART and introduction of lay counsellors:

Lesotho’s HIV/AIDS program was brought to scale through vigorous task shifting of clinical management competence and ART initiation from doctors to nurses. Nurses were freed from non-medical tasks through the introduction of a supportive staff cadre. 26 HIV/TB Counsellors were recruited and trained and allocated to health facilities according to
a counsellor client ratio. Facility services as well as community outreach and tracing services form the scope of duties assigned to the individuals. Their contributions in non-clinical tasks have made this cadre indispensable with a back-bone function in efficient PHC service delivery. Living with HIV infection has qualified them as expert patients with high impact on treatment compliance and drug adherence.

**Maleemisa Ntlamelle (47), Lay HIV/TB Counsellor for SolidarMed, based in Seboche Hospital:** “I have been an expert patient for almost 5 years. My job specifically involves HIV testing and counselling, adherence and tracing of defaulters. A lot of clinical and non-clinical work has been shifted to me, especially in ART. Without the support by us Lay Counsellors, the nurses would be overwhelmed by the workload. We have to serve a huge community and we face many challenges such as the reluctance of men to get tested or poor PMTCT adherence. It takes a lot of time, knowledge and experience to handle these difficulties. We Lay Counsellors are very useful because we can relate to the patients.”

If task-shifting is to improve the overall quality of care, there must be agreed upon standards governing the recruitment, training and supervision of these health workers to ensure that they are appropriately qualified for their new tasks. The significant increases in responsibility and workload must be accompanied by appropriate salary increases and access to continuous training.

Of course, task-shifting is only a pragmatic response to the HR crisis and should not become an olive branch for accepting the existing staff shortages. Task-shifting should be implemented alongside other strategies that are designed to increase the total number of health workers in all cadres. There should also be a standardized approach to the training and remuneration of these cadres, together with an accompanying policy

### Introduction of new cadres

**Relevant curricula:** Medical training has often focused on urban and tertiary facilities and not on the skills needed to work at primary health facilities and community level in line with the Basic Health Care Package. Many graduate doctors are confronted by a disparity between what they’ve been taught and the challenges they face in a rural setting. They find themselves more capable of serving in a hospital in Europe than to delivering services appropriate to rural areas in their home countries. The WHO therefore strongly recommends a revision of training curricula to ensure that health workers are equipped with the context-specific competencies they need to deliver basic clinical and community-based care. The inclusion of modules from an M.P.H. program, management, leadership and performance management should be mandatory as it will provide much-needed insight into health facility conditions other than teaching hospitals.

**Rural attachments:** Positive clinical and educational experiences in rural settings during training are another factor strongly contributing to health workers practicing in rural areas after graduation. One way to achieve this is exposure to clinical practice and conditions of service in the rural areas, as part of the training experience, making health workers more receptive and responsive to the health needs of rural communities.

**Non-physician clinicians:** One example that set a precedent was the introduction of assistant medical doctors (AMOs) in Tanzania as a positive response to an absolute shortage of medical doctors after independence. AMOs hold an advanced diploma in medicine and are an intermediary between the clinical officer and the university-level medical doctor. Since their degree is not internationally recognized their retention rate is much higher than that of medical doctors who tend to emigrate. The strategy is to produce a cadre that provides health services to the rural population and involves field practicals in peripheral health facilities. Each of the five AMO training institutions in Tanzania has an annual
output of 40 graduates, giving a total of 200 graduates per annum. AMOs provide obstetric services, administer anaesthesia, undertake minor surgery and respond to medical emergencies. AMOs have almost the same practical skills as a physician but they are more cost-effective due to a shorter training and lower salaries. Studies show that in rural settings, there is little difference between the results achieved by AMOs and by surgeons with university degrees.

During the past years, the very successful approach of substitute medical doctors was taken up by many neighbouring countries. What is known as “AMOs” in Tanzania is called “Tecnicos de cirurgia” in Mozambique or “Medical Licentiates” (MLs) in Zambia.

++ Example from SolidarMed – Introduction of new cadres ++

**Zambia: Medical Licentiates**

In Zambia, the ML programme was introduced in 2002 as a national strategy to address the critical shortage of medical doctors particularly in rural areas. The ML-programme is specifically geared especially towards this need and it includes clinical rotations in rural areas. A strong focus is on first aid and emergency care, particularly for women and children. That this is a step in the right direction becomes evident by the available data that shows very promising results: 80% of MLs work in rural health facilities five years after their degree.

However, the only training institution offering the course struggled until 2009 to manage a biennial output of 24 students – only a drop in the ocean by more than 1’000 doctors required in the country to fill the ‘gap’. To accelerate the progress, the Ministry of Health in Zambia created a Human Resources Technical Working Group (HRTWG), to which SolidarMed was invited to participate as a partner organisation.

SolidarMed’s support towards the Chainama College of Health Sciences in Lusaka is, to admit 24 students into the ML programme on an annual basis. The Ministry of Health has the goal of training 40 students a year and eventually placing them at district hospitals. To achieve this, the necessary structures in future first need to be created at Chainama College. SolidarMed supports the college in its strategic and operational development, in improving training quality, and in upgrading teaching materials and learning equipment.

**Mr Roderick Samungongi (29), Medical Licentiate student:** “I was working as Clinical Officer (CO) at Chavuma Rural Health Center, Chavuma District in the North Western Region. As CO I belonged to the highest medical cadre in the District! There was no doctor, no Medical Licentiate, even the District Officer was only a CO. I chose this training programme in order to upgrade my knowledge in view of the above challenges. In order to help my district I want to do procedures like correctly treating obstetric emergencies.”

**Integration of community health workers**

There is often a considerable gap between community members and the formal health system. Studies show that up to 50% of the poorest households do not seek care outside of the home. Barriers preventing people using health facilities include user fees, long distances to and/or poor services offered at health centres. Many illnesses such as malaria or diarrhoea are easily preventable - highly specialized skills are not always necessary for health promotion.

SolidarMed agrees with the WHO that community health workers (CHWs) should be recognised and promoted as distinct cadre of health professionals, who - by the nature of their position in the community - can access disadvantaged populations well beyond the reach of the health system. CHWs are trained to work with individual patients and their families in health promotion, disease prevention, basic curative care and referrals, and in the monitoring of health indicators. A variety of trials have shown substantial reductions in child mortality with case management of children by CHWs. They can be trained and deployed relatively quickly, and are unlikely to move to the urban areas or to want to emigrate. Moreover, CHWs can take over tasks from formal health workers and thus have the potential to alleviate the health worker crisis through the task-shifting strategy.
An effective community health programme needs to have a standardized approach to training, learning standards, and to create monetary and non-monetary incentives to mobilize, motivate and recruit CHWs. Having a standardized curriculum and training, getting these workers a standardized remuneration package, giving them formal job descriptions and getting them on to the formal payroll of the Ministry of Health, will go a long way towards their retention. Having their training registered with the General Nursing Council will ensure that clinical protocols and performance standards are met. The inclusion of this cadre at Health Post and Community levels will mean setting up a reporting structure and ensure the continual on-the-job training and supervision at their places of work. Further factors that can make CHW programmes work better include: appropriate selection from the rural areas in which the applicants live, continuing education, and supportive supervision. It is also important to link this training in a sequence of training whereby, after a fixed period of work as a CHW, they can apply for further training to become an enrolled nurse.

++ Example from SolidarMed – community health workers as one component of care ++
Tanzania: Revitalization of a community health worker scheme embedded in national HRH framework:

In the current health strategy, the Tanzanian government declares a clear need for community-driven health care and in the HR plan a necessity for community health workers is stated. However, a standardized training and certification as well as legal framework for CHW to work appropriately in the Tanzanian health system are still missing.

In alignment with key stakeholders in the health scene such as the Ifakara Health Institute (IHI) or the Tanzanian Training Centre for International Health (TTCH), SolidarMed has engaged in establishing a CHW scheme tailored to national context. Lessons learned from past CHW programmes that collapsed for many reasons were carefully considered and success factors reflected on. A competency-based pilot curriculum was developed as fundament for a training involving theoretical blocks as well as practical field attachments in the home villages of the trainees. The focus of the work of the CHW is on the health of mothers and children.

The set-up of this innovative pilot project is oriented towards the long-term goal of accrediting the CHW as official Tanzanian health cadre. Only their regulation and integration in the formal health system will grant independency from direct donor support and therefore long-term sustainability of the programme. In the meantime, SolidarMed and other donors manage the programme and fund trainings as well as remunerations. Advocacy work accompanies the programme in order to establish a strong lobby that accelerates the process of formalizing the CHWs within HR policy.

The project tries to ensure local ownership and the inclusion of the CHW in the system from the very beginning and at all levels. The CHW are selected by and answerable to their communities. To create a defined position of the CHW in the district health organization and to pave the way for later inclusion in the formal health system, the CHW are attached to health facilities from which they receive regular supportive supervision.

Even though the CHWs are not yet considered an official health cadre the district health authorities already now assume overall responsibility for the management and for annual continuous education of the CHWs. Besides of regular training, supervision and monetary incentives, the CHW are equipped with working tools such as a well-assorted first aid box, educational material and a bicycle that enables them to reach remote households.

Mr. Zakayo Andrea (28), CHW student: “My village, Landa in Mbulu District, selected me to become one out of two community health workers. We just returned to the school after a practical back home in Landa. During three weeks we applied what we were taught before, such as basic clinical skills. Teachers regularly visited us to see how we are doing. It was a very motivating experience to be able to help and to feel that we will be welcome with our new skills.”
C. Attraction and retention of health workers

The health sector is not only characterized by inadequate HR training and education systems which result in the insufficient production of various categories of health workers. The problems are aggravated by factors such as insufficient funding allocations to health ministries, a lack of strategic human resources planning, insufficient staff audits, comprehensive recruitment and retention strategies, weak management and a global competition for scarce human resources for health. Just increasing the stock of health workers and their skills will not change the fact that vacancies in rural health facilities remain unfilled while many of the best clinicians either end up in industrialized countries, private practice or in NGOs most likely in the urban areas. More of Malawi’s doctors are practicing in the British city of Manchester than in Malawi itself! Staff members serving at rural health facilities are often only nominally available full-time. The rest of the time they moonlight other jobs or work in agriculture or in private practice. Studies from Tanzania indicate that in some settings, health workers spend only 50 to 60 percent of their time on productive public health activities. Looking at the working and living conditions and the salary levels many health workers endure, particularly in rural governmental facilities, one may wonder that any staff members remain at all, and that seeking bribes from patients is not even more common. The Public Expenditure and Tracking Survey (PETS) by the World Bank conducted in Zambia in 2008 showed that there was a 57% absenteeism rate in the rural areas – for various reasons such as attending trainings, moonlighting, malingering, attending funerals and taking extended sick leave.

SolidarMed has not only developed a number of interventions to increase the numbers of health workers in underserved areas but also works to motivate doctors, nurses and other staff to work in remote areas. SolidarMed considers investments in remuneration, the improvement of working- and living conditions, and supportive management practices to be particularly effective for increasing and retaining the numbers of health workers in rural areas. Organizational investments have had a significant impact on the preference of health professionals for working in a rural workplace as well as on their performance and retention for a certain period of time.

Better working and living conditions

Many health workers appear demotivated and frustrated because they are unable to offer effective care to patients due to inadequate resources in health facilities, especially in rural areas where the infrastructure is worse. Inappropriately applied management and supervision tools add to their dissatisfaction.

Helping the workforce to perform better is a key priority of SolidarMed – not only by increasing their technical qualifications but also in the area of creating enabling work environments. Workforce motivation not only has a direct positive influence on their service delivery but also encourages long-term retention.

Infrastructure and equipment: Many rural health facilities lack the basics like running water and the most basic clinical equipment. A dysfunctional work environment severely limits the ability of health workers to practice what they’ve been trained to do.

SolidarMed therefore invests a significant portion of its funds in the improvement of working conditions of rural staff and thus in service delivery. In terms of costs, equipping and refurbishing health facilities may be resource-intensive, but the benefits are long-term.

Management and supervision: HR management covers matters related to the deployment, use and motivation of health workers and it largely determines the capacity of the health system to retain staff. Supportive supervision is a key element in job satisfaction, morale and performance.

There is a significant potential for improvement in overall HR management and in supervision in particular. Health
workers criticize the lack of a comprehensive management system, the irregularity of supervision as well as a top-down, checklist-driven approach focusing on mistakes while individual efforts go unnoticed. The only way in which to support this is to ensure that formal performance management systems are implemented and the appropriate training provided to managers, supervisors and health workers themselves. These tools are objective and provide annual training plans to address the identified skills and knowledge gaps.

SolidarMed does not run health facilities and has only an advisory function in regard to managing staff at facility- or district-level. For that reason, SolidarMed’s influence on HR policies and their implementation is limited. Nevertheless, the organization encourages district authorities to ensure that an effective performance appraisal system is in place. In the context of task-shifting, supervision and performance management play a particularly important role in maintaining an acceptable level of quality. The success of innovative approaches, like introducing new cadres such as community health workers largely depends on their proper management and supervision.

SolidarMed supports a number of training institutions and hospitals with comprehensive development plans. These facilities are strengthened in their capacity for workforce planning in line with national guidelines, as well as in recruitment, selection and retention of appropriately qualified staff.

**Financial remunerations:** Adequate salaries have a significant impact on clinical performance and the incentive structure is essential to retaining staff. Insufficient remuneration is one of the major reasons for job dissatisfaction. SolidarMed works in countries with governmental salary levels that are considered insufficient to assure a minimal living standard for many health cadres. Health facilities owned by FBOs are usually unable to compete with governmental salary levels. The salaries of civil servants would have to be multiplied several times to bring them to the level of incomes from private practice.

In the long-run, it is unlikely that the HR crisis can be solved without a significant increase in the remuneration packages of employees deployed at governmental and FBO health facilities. However, raising public sector salaries to close the salary gap is not a realistic option in most of the poorest countries. In order to fill key positions, SolidarMed steps in with top-ups or by providing salaries. The objective is to increase the number of qualified health staff in remote areas by providing financial compensation to professionals willing to relocate and work there. Another frequent intervention is providing bridging funds to pay the salaries of newly recruited staff until the administrative procedures for inclusion on government payroll have been completed. The SolidarMed-financed doctors usually work in tandem with an expatriate doctor who ensures capacity-building and knowledge transfer to the local medical professionals before being phased out of the program.

**Better living conditions:** While financial incentives and a decent working environment are important, it is also the living environment that has a significant influence on a health worker’s decision to locate to and remain in rural areas. The difficult living conditions, such as the lack of appropriate housing, is cited as one of the main reasons for not wanting to work in remote and underserved areas. The ability to offer comfortable accommodation is an essential precondition for rural institutions to attract and retain qualified health professionals. SolidarMed therefore increases the attractiveness of selected hospitals and training institutions as employers by constructing staff houses that include amenities like running water, proper sanitary installations and electricity.

Where budgetary limitations do not allow for such major investments in infrastructure, other suitable non-monetary incentives are assessed. These may include motorcycles that increase the mobility of staff attached to remote health facilities.
++ Example from SolidarMed – attraction, recruitment and retention of health workers ++
Mozambique - Better living and working conditions:

To increase service quality by strengthening human resources for health at district level is one of the core missions of SolidarMed in Mozambique. SolidarMed supports its partners to attract and retain qualified staff by various mechanisms. Since shortage of human resources is closely linked to shortage of infrastructure, SolidarMed rehabilitates and constructs staff houses. The project furthermore supports temporary payments and other retention measures in order to improve working and living conditions. Satisfaction and motivation are increased through continuous training and the provision of platforms for better communication between central and peripheral levels. A maintenance project was set up in the intervention district Chiure in order to improve the health facilities. A majority of the rural health posts have now running water and electricity. The interventions pay off: The staff increase in Chiure between 1993 and 2008 had been 65% higher than in the provincial average.

Mr. Latifo Jassine (25), pharmacy technician: “I finished college in 2010 and then came here to Anacube to replace the former pharmacist who was put to prison due to mismanagement. I tried my best to improve the drug situation and the service. However, until SolidarMed started to support me, I had to live for seven months without salary. I lived in a hut which let the rain in and I went to work hungry. Then, SolidarMed gave me food and mattresses and incentives that kept me going. Now, due to SolidarMed support, Anacube pharmacy is one of the best in Capo Delgado Province. We have adequate essential and ARV drugs supply.”

D. Policy Dialogue

In the North: SolidarMed contributes to the sensitization of the Swiss public and policy makers for global health related issues by maintaining public relations, organizing information events and engaging in multi-stakeholder dialogue.

One of our aims is to foster awareness of the negative effects of international recruitment of health staff, as this undermines health systems strengthening efforts in developing countries. By bringing in health professionals to countries, it removes the onus on them to increase their own production of health professionals. It is not only developing countries which are confronted with an increasing lack of health professionals. Switzerland has an annual production deficit of 1500 doctors and 4500 nursing staff. Taking increasing life expectancy and attrition into account, it is estimated that manpower requirements will increase by 25% by 2020. Currently, the shortage is compensated through the recruitment of foreign health personnel, mostly from neighbouring countries. These in turn import personnel from even poorer countries. This domino effect has a devastating impact on the health systems of source states in developing countries. Poor countries spend millions each year to educate health workers who leave their home countries for Europe or North America. This “Brain Drain” impedes maternal, neonatal, and child health and the fight against HIV/AIDS in countries with already fragile health systems. Driving forces are not only the economic interests of the recruiting countries but also the right of the migrants to seek better salaries and working conditions.

Switzerland has a responsibility to contribute to solutions for the global maldistribution of health personnel – also in order to prevent the positive effects of development aid from being undermined by the negative effects of practices which focus solely on the needs of domestic labour markets.

In 2010, the World Health Assembly adopted the “WHO Global Code of Practice on the International Recruitment of Health Personnel”. The Code sets forth ten articles advising both source and destination countries on how to regulate the recruitment of health personnel in a way that mitigates damage to health systems in low-income countries. By supporting the code, richer members like Switzerland agreed, for instance, to give high priority and adequate funding to train and recruit sufficient personnel from within their own country. Since the Code is non-binding, an improvement of the situation largely depends on its active voluntary implementation by WHO member states.
Through membership with Medicus Mundi (MM) of Switzerland, SolidarMed participates in the efforts of networks like Medicus Mundi International (MMI). The alliance joins forces and pools expertise from a wide range of actors of development cooperation to promote the initiatives that are required for strengthening health systems worldwide. After strongly advocating for the adoption of the Code, MMI nowadays plays a key role in holding Swiss stakeholders accountable by monitoring compliance with existing commitments and encouraging concerted and coherent policies at Swiss, European and global levels.

**In the South:** In 2008, the first Global Forum on Human Resources for Health took place in Kampala, Uganda. The stakeholders passed a declaration including 12 commitments leading to a resolution of the accelerating crisis in the global health workforce.

The governments in the South were called on to provide leadership to resolve the health worker crisis and to place the health workforce crisis on the national agenda. It is the duty of health ministries to act as stewards of health and to lobby for health systems and HR strengthening. A stable political, regulatory and strategic framework needs to be put in place by national authorities in order to lay the groundwork for ways out of the HR crisis.

Unfortunately, only slow progress has been observed in translating this declaration into action. A main bottleneck is the lack of country commitment, insufficient institutional capacity in HR governance as well as inadequate national investment in human resources for health production, delayed education reforms, and finally ineffective incentive and retention strategies. One major challenge is the mobilisation of the requisite additional financial resources from both domestic and external sources, and their appropriate use to reverse the current human resources crisis. A couple of years ago, it was argued that providing ART to people in Sub-Saharan Africa was too complicated and costly. The refusal to accept that people with HIV/AIDS in the developing world would die because the drugs were too expensive forced a sea of change in attitude and policy. The lack of health staff is a deadly impediment to the provision of primary health care and calls for a similar refusal to accept the status quo.

The Kampala Declaration prompts development partners to provide support to formulate and implement comprehensive national HR plans. In cooperation with other stakeholders and partner organizations, SolidarMed advocates at the level of district- and national decision making bodies for suitable strategies. A central focus is on adapting health legislation and administrative regulation that can both enable and regulate task-shifting practice.

In 2010, the Swiss Tropical and Public Health Institute conducted an inventory of Swiss cooperation practices. The study stated a need to harmonize the investments in human resource development made by the different stakeholders such as SDC and various Swiss NGOs. SolidarMed supports the conclusion that with an increased information exchange and collaboration among the organizations, that synergies and a stronger presence in the international forum could be achieved.
5  

**Strengths and weaknesses of SolidarMed approaches, lessons learned**

During SolidarMed’s internal workshop on human resources for health, a SWOT analysis of the organization’s current HR approaches was conducted. This was done in order to identify successful strategies, promising opportunities but also to critically assess risks and challenges. Some of the issues discussed are reflected in the following sections.

**Partner relations:** Drawing from over 80 years of experience, SolidarMed has considerable professional expertise in health service delivery and health systems strengthening. Many other organizations support projects only for short funding cycles. SolidarMed considers project durations of one to three years as too short for measurable impact in the area of health systems strengthening. Sustainable system reforms heavily rely on local ownership and capacity. Building institutional capacity and stakeholder commitment on various levels take time. SolidarMed therefore engages in long-term cooperation with local partners. A timeframe of at least five to ten years allows SolidarMed to engage in constructive dialogue with country level counterparts and to jointly develop and implement appropriate solutions that address local needs and context-specific challenges. By virtue of SolidarMed’s high level of professionalism, reliability and credibility, the organization enjoys great public confidence on all levels - from the communities to partnering institutions to the local health authorities. Since a substantial proportion of health service delivery is provided by non-state actors such as churches, they constitute important partners for SolidarMed.

SolidarMed concurs with the governments of the host countries within which it works that a primary health care approach and functional health systems at district level are central to quality health care. SolidarMed therefore considers that cooperation with district health authorities is the most relevant and effective for sustainable changes of the health system.

**Donor relations:** The long-term perspective required for health system strengthening contradicts the tendency of many donors to fund projects that produce results visible in the short-term period. In addition, many areas in health attract funding easier than the rather abstract concept of health systems strengthening. SolidarMed is thus all the more proud that its efforts are rewarded with increasing contributions from private and public donors willing to support its endeavours. SolidarMed prides itself on its low administration costs. Naturally, rigorous accountability measures are in place to ensure that funds are spent effectively. In addition, monitoring and reporting tools help SolidarMed to meet donor expectations for qualitative and quantitative information on achievements and effective resource use.

A challenge is to use reporting as a tool for reflection and to enhance project capacity, rather than only demonstrating “value for money” to satisfy donors’ concerns. SolidarMed counteracts the risk of a too-narrow focus on activities and indicators in applying project cycle management tools with an increased focus on outcome monitoring.

**Piloting:** SolidarMed delivers within the system by strengthening available structures. However, its relatively small size, combined with the significant levels of trust from both local partners and the donor community allows it to flexibly adapt its programme to changing local conditions, to occupy niches and to pilot innovative models that complement existing structures of the health system. However, its small size can also impact on its ability to mainstream, replicate and scale-up of innovative approaches. Such interventions can be a challenge for a small organization with a limited budget. SolidarMed certainly has the capacity to develop interventions on a smaller scale, but at this stage is not able to deliver large-scale pilots. SolidarMed will always provide support to those organizations which are better placed to lobby and advocate for reforms at ministerial level.

New insights can be gained in a piloting approach. Ideally, successful models are not only continued within the organization but integrated in the formal health system. Lessons learnt from the careful evaluations of SolidarMed’s pilot
projects are fed back to the decision makers, as a basis from which to decide whether and how to roll out a certain change or reform at national level.

**Systemic approach:** SolidarMed’s range of interventions targeting the human resource crisis is representative of its general systemic approach. There are a variety of reasons for the shortage of health staff. As causes are interrelated and rooted in personal and work-related factors, strategies must address these multiple causes simultaneously and at different levels of the health system. Delivering bundles of linked and coordinated HR interventions are more likely to achieve sustained improvements than single and uncoordinated interventions.

In delivering context-adapted and comprehensive solutions, there is a potential to drift into arbitrariness and to dissipate resources by implementing piecemeal interventions instead of applying coherent and systemic strategies. The dearth of quality information and research on the effectiveness of attraction, retention or productivity-improvement measures plays a role here. SolidarMed thus advocates for a renewed focus on outcome monitoring, knowledge management and evidence-based decision making.

**Sustainability:** Financial sustainability is a recurring topic in the discussion of appropriate HR strategies. SolidarMed tries to build self-sustaining systems and to apply clear exit strategies in the form of sustainability plans and a gradual withdrawal of resources. However, in settings of absolute poverty, it is unrealistic to assume that capacity can be built up to a level that local institutions in rural areas are able to fully meet all operational costs for personnel, drugs, equipment and transport.

**Responsible hiring practices:** NGOs have to meet their obligations to donors and demonstrate success as well as having to operate in a competitive marketplace for skilled resources. They have the means to offer health and managerial professionals attractive employment conditions. Increasingly, NGOs are accused of undermining the public health sector by siphoning off much-needed staff. In doing so, they exacerbate the very health problems they are attempting to solve.

To secure high-quality project implementation, SolidarMed relies on skilled field staff. Key positions such as Country Coordinators or Project Managers are publicly advertised. Often, it is European applicants that meet the selection criteria better than international competitors. Among local staff, it is not always avoidable that some candidates for clinical or programmatic positions would otherwise be working in the public sector. However, SolidarMed remains in line with the “NGO Code of Conduct for Health Systems Strengthening” in that salaries offered are kept as close to the public sector as possible. If recruitment of staff to health facilities of remote, rural areas is not otherwise possible, SolidarMed, in individual cases, pays top-ups and incentives in order to secure the services of selected health professionals. In many contexts incentives remain a way to avoid tackling the fundamental problem of low remuneration packages. Also, top-up schemes must be fair and transparent; otherwise it discriminates against staff already working for regular salaries at the respective facilities.
6 Summary: SolidarMed core strategies

Based on the presented evidence and lessons learned, SolidarMed considers the following strategies to be the most effective, efficient and relevant approaches for it to address the human resource crisis in the health sector.

**Strengthen pre-service training programmes**

SolidarMed supports health training institutions in order to produce sufficient health workers with appropriate skills. Preference is given to educational programmes that are in line with national health strategies. An emphasis is put on mid-level workers such as nurses and assistant medical doctors.

**Key interventions:**
- Expanding the physical capacity of training institutions
- Training of tutors to enhance quality of training
- Supporting the development of standardized, competency-based curricula driven by evidence of PHC needs
- Strengthening management capacities of institutions to promote training and attracting new funding and students
- Supporting rural field attachments

**Continuous education**

SolidarMed promotes in-service training because continuous education, by improving job satisfaction, plays a key role in motivating health workers and improving service quality.

**Key interventions:**
- Courses targeted at the needs arising from primary health care practice in rural settings (i.e. IMCI)

**Better living conditions**

As this has a significant impact on their decision to locate to and remain in the rural areas, SolidarMed investments in improving the living conditions for core health workers.

**Key interventions:**
- Construction of suitable staff accommodation

**Improve the working environment**

A professionally attractive workplace that enables health workers to deliver quality services facilitates recruitment and retention of staff at remote areas. SolidarMed invests in improved working environments at rural health posts and hospitals.

**Key interventions:**
- Construction and renovation of basic infrastructure, including sanitation
- Purchasing of adequate equipment and supplies
Financial incentives

SolidarMed pays financial incentives to outweigh the opportunity costs associated with working in rural areas. In some cases, SolidarMed sometimes temporarily funds salaries on a bridging finance basis.

Key interventions:
- Top-ups
- Bridging-salaries
7 Summary: SolidarMed guiding principles

Our initiatives in human resource strengthening are guided by the following principles:

**Equity**
SolidarMed adheres to the principles of primary health care and therefore incorporates measures to strengthen the health workforce particularly in underserved and usually rural areas. SolidarMed prioritizes those approaches that enhance equitable access to basic health care. This therefore promotes well-staffed primary level health facilities and ensures adequate numbers of generalists as they are particularly important for reaching underserved populations.

**Bundles of strategies**
SolidarMed agrees with the WHO that neither a blueprint approach nor any single intervention will work. It therefore continues to follow a holistic approach and to adapt workforce strategies to local contexts and in appropriate combination.

**Evidence- and outcome based interventions**
SolidarMed strives to maximize the use of the best available evidence when planning workforce strategies. As a learning organization, SolidarMed takes previous experiences and best practices into account when clarifying objectives, indicators and targets for measuring progress. The outcomes are defined on the basis of impact rather than project activity. Through regular monitoring, SolidarMed’s outcomes are assessed, analyzed and the strategies adjusted for effective programme implementation.

**Task-shifting**
SolidarMed considers task-shifting an important concept to increase service delivery. This includes the creation or expansion of cadres such as non-physician clinicians and community/lay health workers. When implementing task-shifting schemes, SolidarMed addresses important issues such as recruitment, training, and retention of this additional workforce.

**Complement and supplement national efforts**
SolidarMed complements and supplements governmental efforts and its interventions are designed to overcome human resources gaps by investing in existing structures in alignment with the national health sector framework. SolidarMed fosters the capacities of local health authorities to assume stewardship for workforce strengthening. The aim is to use synergies and increase consistency with national health sector plans, and to facilitate the integration and coordination of activities between faith-based health service providers and district health departments.

**Piloting innovative models**
SolidarMed continues to pilot innovative, scalable models with a bearing on national strategies of workforce strengthening. Based on its experience, substantial pilots are conducted only in close cooperation with counterparts. Key health personnel at district and ministerial level and other crucial stakeholders are engaged from the project design phase onwards because shared ownership increases the potential to bridge the pilot-to-policy gap.
Annexe 1: Recommendations

to improve attraction, recruitment and retention of health workers in remote and rural areas

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A. EDUCATION RECOMMENDATIONS

Use targeted admission policies to enrol students with a rural background in education programmes for various health disciplines, in order to increase the likelihood of graduates choosing to practise in rural areas.

Locate health professional schools, campuses and family medicine residency programmes outside of capitals and other major cities as graduates of these schools and programmes are more likely to work in rural areas.

Expose undergraduate students of various health disciplines to rural community experiences and clinical rotations as these can have a positive influence on attracting and recruiting health workers to rural areas.

Revise undergraduate and postgraduate curricula to include rural health topics so as to enhance the competencies of health professionals working in rural areas, and thereby increase their job satisfaction and retention.

Design continuing education and professional development programmes that meet the needs of rural health workers and that are accessible from where they live and work, so as to support their retention.

B. REGULATORY RECOMMENDATIONS

Introduce and regulate enhanced scopes of practice in rural and remote areas to increase the potential for job satisfaction, thereby assisting recruitment and retention.

Introduce different types of health workers with appropriate training and regulation for rural practice in order to increase the number of health workers practising in rural and remote areas.
Ensure compulsory service requirements in rural and remote areas are accompanied with appropriate support and incentives so as to increase recruitment and subsequent retention of health professionals in these areas.

Provide scholarships, bursaries or other education subsidies with enforceable agreements of return of service in rural or remote areas to increase recruitment of health workers in these areas.

C. FINANCIAL INCENTIVES RECOMMENDATION

Use a combination of fiscally sustainable financial incentives, such as hardship allowances, grants for housing, free transportation, paid vacations, etc., sufficient enough to outweigh the opportunity costs associated with working in rural areas, as perceived by health workers, to improve rural retention.

D. PERSONAL AND PROFESSIONAL SUPPORT RECOMMENDATIONS

Improve living conditions for health workers and their families and invest in infrastructure and services (sanitation, electricity, telecommunications, schools, etc.), as these factors have a significant influence on a health worker’s decision to locate to and remain in rural areas.

Provide a good and safe working environment, including appropriate equipment and supplies, supportive supervision and mentoring, in order to make these posts professionally attractive and thereby increase the recruitment and retention of health workers in remote and rural areas.

Identify and implement appropriate outreach activities to facilitate cooperation between health workers from better served areas and those in underserved areas, and, where feasible, use telehealth to provide additional support to health workers in remote and rural areas.

Develop and support career development programmes and provide senior posts in rural areas so that health workers can move up the career path as a result of experience, education and training, without necessarily leaving rural areas.

Support the development of professional networks, rural health professional associations, rural health journals, etc., in order to improve the morale and status of rural providers and reduce feelings of professional isolation.

Adopt public recognition measures such as rural health days, awards and titles at local, national and international levels to lift the profile of working in rural areas as these create the conditions to improve intrinsic motivation and thereby contribute to the retention of rural health workers.
## Annexe 2: Glossary

**Assistant Medical Doctor (AMO)** Several years ago, Tanzania created the AMO degree to fill the void of medical doctors in rural areas. Several schools offer the 2-year programme for clinical officers who have at least three years of clinical training. Aims candidates to practice independently and provides primary care level training in General Medicine, Surgery, Pediatrics and Obstetrics/Gynecology.

**Attraction** Strategies to attract candidates to fill a vacant position.

**Brain drain** Outflow of health professionals to other countries, or from the public to the private sector within a country, or out of the health sector, usually in search of more employment opportunities, and better working and living conditions.

**Bridging salary** A salary support paid by SolidarMed to newly recruited staff at governmental or faith-based service providers during the transition period until administrative procedures for inclusion on government payroll have been completed.

**Cadre** A set of people (i.e. CHWs) who are not specialist health workers but are given quite specific training so that they can undertake health-related activities in contexts where there is a severe shortage of fully-qualified workers.

**Clinicians** Clinician are any medical practitioner with clinical practice (i.e. medical doctors, clinical officers or nurse/midwife).

**Community Health Worker (CHW)** CHWs are members of a community who are trained to provide basic health and medical care to their community.

**Competences** Knowledge, skills and attitudes which an individual possesses. Competencies are accumulated and developed through education and training and experience.

**Competency-based training** Training opportunity which is designed around "competencies" which are established for the respective job title. A "competency" is a cluster of related knowledge, skills, and attitudes that affects a major part of one’s job (a role or responsibility), that correlates with performance on the job, that can be measured against well-accepted standards.

**Continuing professional development** Process of systematic learning that allows health professionals to continue to meet the needs of the population being served by updating and enhancing their skills, whilst addressing health professionals’ career and educational aspirations.

**Curriculum** A curriculum is a reading programme including a series of lectures dealing with a subject. Standardized curricula are the first step in the approval process for newly introduced health cadres.

**Health management and support workers** Includes other categories of health systems personnel, such as managers of health and personal-care services, health statisticians, ambulance drivers, building maintenance staff, and other general management and support staff.
Health System  System by which health care is made available to the population and financed by government and private enterprise. In a larger sense, the elements of a health care system embrace the following: (1) personal health care services for individuals and families, available at hospitals, clinics, health posts, and in the clients' own homes; (2) the public health services such as control of water (3) teaching and research activities related to the prevention, detection, and treatment of disease

Health workforce  All the persons employed in the health sector.

Human resource management  Process of creating an adequate organizational environment and ensuring that the personnel perform adequately using strategies to identify and achieve the optimal number, mix and distribution of personnel in a cost-effective manner. It aims at getting 'the right people with the right skills and motivation in the right place at the right time'.

Human resources  The term describes the individuals who make up the workforce of a sector or an organization. Human resources can also stand for the the overall responsibility for implementing strategies and policies relating to the management of individuals (i.e. the human resources).

In-service training  Training – maintenance and adaptation of the competencies of existing personnel within the context of their current position.

Medical Licentiates (ML)  In Zambia, non-physician clinicians are referred to as MLs. Currently, only one school (Chainama College) offers the programme that comprises 25% theory and 75% practical experience at various hospitals of the country. The 3-years programme enrolls qualified Clinical Officers General with a minimum of two years clinical experience.

Non-physician clinicians  Mid-level providers of care such as AMOs or MLs. Non-physician clinician are usually more (formally) qualified than nurses but less (formally) qualified than doctors, because they have not been trained at a school of medicine and as such no academic degree. Practically they are recognized and valued almost equally with holders of first degree clinical medicine (doctor of medicine) in many countries in Africa. They are less likely to migrate to industrialized countries as their diplomas are not internationally recognized.

Nursing and midwifery personnel  Licensed nursing professionals whom are produced through basic or advanced nursing education (usually 2 or 3 years), such as nurses and/or midwives. Traditional birth attendants and community health workers are not included.

Physician/Medical doctor (MD)  The terms medical doctor and physician can be used interchangeably. It stands for a health professional who has earned a degree of Doctor of Medicine (M.D.).

Pre-service training  Pre-service training is instruction which takes place before a person begins a job or task (as opposed to in-service training).

Primary care  The usual point at which an individual enters the health care system. Its major task is the early detection and prevention of disease and the maintenance of health. This level of care also encompasses the routine care of individuals with common health problems and chronic illnesses that can be managed in the home or through periodic visits to an outpatient facility.
**Primary Health Care**  Primary Health Care as defined by the World Health Organization in 1978 is essential health care; universally accessible to all in the community through their full participation; at an affordable cost; and geared toward self-reliance and self-determination

**Recruitment**  Process of searching for personnel to enter a particular job or position. To strengthen or increase the supply of personnel to perform services.

**Remuneration**  Payment of an equivalent to a person for a service or expense.

**Retention**  Maintenance of health personnel by offering adequate opportunities for re-training and career management assistance (see career management).

**Skills mix**  Refers to the mix of posts in the organization, the mix of employees in a post, the combination of skills available at a specific time, or it may also refer to the combinations of activities that comprise each role, rather than the combination of different job titles. Skill mix is a strategy used to ensure the most cost-effective combination of roles and staff.

**Systems of incentives**  Sets of rewards and sanctions to improve staff performance and motivation by providing financial and non-financial benefits such as flexible working schedule and training, education and career development opportunities.

**Task-shifting**  One method of strengthening and expanding the health workforce to rapidly increase access to health services. Task shifting involves the rational redistribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health.

**Top-ups**  Cash payments health servants receive on top of their basic salary. It is a motivation strategy to health workers to move to positions or locations that they would normally not want to accept.
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