
Guiding Principles for National Health Workforce Strategies



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Developed by
the Health Workforce Advocacy Initiative

The Health Workforce Advocacy Initiative
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With global targets for major health improvements fast approaching, including universal access to HIV services by 2010 and achieving the health-related Millennium Development Goals by 2015, and the recognition that these goals cannot be achieved without building health workforce capacity, many countries are developing or re-assessing national health workforce plans. The development of health workforce plans, as well as broader health sector strategies, is receiving particular attention through such regional and global initiatives as the Africa Health Strategy 2007-2015 and the International Health Partnership, as well as the Global Action Plan on Human Resources for Health.

The following guidelines are intended primarily for the policymakers and other people involved in developing and evaluating these plans, including ministry of health officials, health workers, civil society advocates, development partners, and technical advisors. What should these plans – which should be country-developed and country-led – contain? How should they be developed to give them the best chance of significantly improving health outcomes and moving countries as rapidly as possible towards universal access to essential health interventions? The guidelines should serve as overarching principles that will promote the success of health workforce plans, while ensuring that they are consistent with human rights. The right to the highest attainable standard of physical and mental health requires that these plans adhere to principles including equity, participation, and accountability, that they are based on major health needs of the population, that they make quality health care available, affordable, and accessible for everyone, that they represent continued progress towards filling this right, and that states spend the maximum of available resources towards meeting this and other human rights.

These principles begin with key considerations for the health workforce plan itself. The principles conclude with the context in which the plan should be developed and implemented, including financing and coordination with a broader health sector strategy. Many of the principles – such as those related to participation, monitoring and evaluation, and targets – also apply to that broader health strategy.

Targets

- ❖ **Aim for goals:** The health workforce plan should be aimed at ensuring that all people, in all places, have access to a skilled health worker who is equipped, motivated, and supported. Further, the plan should be targeted towards achieving health goals, commitments, and obligations, including the health-related MDGs and universal access to HIV/AIDS treatment, care, prevention, and support by

2010¹. This entails calculating the levels of services required to achieve these goals, determining what cadres (registered nurses, enrolled nurses, nurse practitioners, midwives, doctors, clinical officers, pharmacists, nutritionists, social workers, laboratory technicians, community health workers, etc.) of health workers will provide these services, the knowledge and skills these health workers will require, and how many of these workers will be needed, and then developing a plan that will develop, sustain, and equitably distribute these health workers. As a general rule, plans should both be ambitious – aiming to achieve these goals – and feasible, so with adequate support, they can in fact be implemented.

Comprehensive approach

- ❖ **Cover all aspects:** A comprehensive health workforce plan should address and, as appropriate to country circumstances, take measures to improve:
 - 1) health workforce finance (such as salaries and incentives and the total budget for health workforce);
 - 2) policy (such as the scope of practice for different types of health workers, guidelines on health workplace safety, and accountability of health workers, including management);
 - 3) education (including pre-service and in-service health worker training);
 - 4) partnership (including community mobilization and linkages between public and private sectors);
 - 5) leadership (including leadership skills among HRH managers and leadership to ensure full implementation of the health workforce strategy), and;
 - 6) human resource management systems (including systems for the collection and use of accurate information on the health workforce, supportive supervision, and improved productivity).These are elements of the Global Health Workforce Alliance/World Health Organization HRH Action Framework.
- ❖ **Cover all cadres:** The health workforce plan should cover all cadres of health workers, both clinical staff, such as nurses, doctors, midwives, and pharmacists, and non-clinical staff, such as managers and support staff, and including all members of the care providing team, including nutritionists, social workers, and mental health professionals.
- ❖ **Cover all sectors:** The health workforce plan should cover all recognized health care providers, including public, NGO/faith-based, and private for-profit, and seek to utilize all providers in ways to achieve equitable, quality health services for all and that creates an integrated and coordinated health sector. It should also, as relevant, recognize the significant role that traditional healers play, and identify ways to effectively engage them, such as through counseling and referrals.
- ❖ **Link to broader development strategy:** The plan should incorporate ways that the health systems and health workers can contribute to broader development goals (such as through health workers educating communities on clean water, sanitation, and nutrition).

¹ Health-related MDGs include reducing maternal mortality by three-quarters between 1990 and 2015, reducing child mortality by two-thirds between 1990 and 2015, and combating HIV/AIDS, malaria, and other major diseases. Other commitments include the African Union commitment to a package of essential health services for prevention, care, and treatment by 2015. The right to health has additional and complementary requirements, including creating the conditions to make medical services available to all, and focusing on certain health priorities such as maternal and child health.

Equality and non-discrimination

- ❖ **Equitable distribution:** The health workforce plan should prioritize a more equitable distribution of health workers. The plans and planning process should assess the various aspects of the plan from perspective of equity and, wherever possible, incorporate measures to strengthen the health workforce in underserved areas, including through incentives; developing or expanding cadres of community-based health workers (including nurses and community health workers) and other cadres most likely to practice in rural areas (e.g., clinical officers/nurse practitioners); using the education system to enhance equity, such as through recruitment strategies, scholarships, and curricula, and; focusing resources on improving health infrastructure in rural areas.

Along with prioritizing equitable geographic distribution, the plan should promote a distribution of health workers among different levels of health facilities (health centers, district hospitals, referral hospitals, etc.) and professional practice areas (e.g., generalists, specialists) in ways that will enhance equity. Well-staffed primary level health facilities and adequate numbers of generalists are particularly important for reaching underserved populations.
- ❖ **Marginalized populations:** The health workforce plan should be aimed at meeting the needs of often marginalized groups, including women, youth, elderly people, migrants, refugees and internally displaced people, gay, lesbian, and transgender people, people with physical and mental disabilities (including developing and retaining sufficient number of mental health workers, ensuring marginalized populations' participation in developing the plan, and training health workers on the rights of people with disabilities, impoverished people, people living with HIV/AIDS, and rural dwellers).
- ❖ **Combating stigma and discrimination:** Programs should be developed and human resources assigned to address the stigma and discrimination within the health sector itself against marginalized populations, including people living with HIV/AIDS, injecting drug users, sex workers, and health workers providing care to stigmatized populations.
- ❖ **Gender:** The plan should be address physical and sociocultural gender differences, including harms that may particularly affect women such as inequitable pay, unequal access to professional development opportunities, sexual harassment, and workplace violence.

Workplace health, safety, supplies, and infrastructure

- ❖ **Health worker health and safety:** The plan should secure health workers' health and safety, including through measures to ensure consistent use of universal precautions as well as other forms of infection prevention and control, to provide health care to health workers including comprehensive HIV services, to provide for health workers' physical safety, and to meet health workers' psychosocial needs. Measures to identify and treat HIV-positive health workers should be taken in recognition of special confidentiality concerns that health workers face.
- ❖ **Adequate supplies and basic infrastructure:** The overall national health sector strategy in which the health workforce strategy is embedded should include measures to ensure that health workers have the medicines, supplies, and equipment they require to do their job, and that health facilities have meet basic infrastructure requirements, such as having electricity and clean water.

Compensation and support, including for community health workers

- ❖ **Living wages:** Health workers in all cadres should receive an adequate package of salary and benefits, including those at the community level such as community health workers. Different health worker cadres should be treated equitably.
- ❖ **Retention incentives:** Plans should include financial and/or non-financial incentives (such as housing allowances, lunch allowances, car loans, child care facilities, and increased recognition) and other strategies to improve retention (as addressed elsewhere), including attention to supportive supervision, good and safe working conditions, professional development, and respect of workers' rights. Incentives should be designed to avoid unintended distortions, which may happen when they cover a particular disease area or segment of the workforce.
- ❖ **Home-based and community health workers:** The plans should include measures to support home-based and other informal caregivers, as well as community health workers (e.g., HIV peer counselors, adherence support counselors). Community health workers should be compensated for their work, and should receive ongoing training, adequate supervision, supplies, and other support.

Education and training

- ❖ **Human rights and ethics education:** The health workforce plan should incorporate human rights education into pre-service training curricula for health workers. This education should include health workers' role in advancing these rights and should promote non-discrimination and respect for the rights of the diverse populations that health workers will serve. Health education should also address professional ethics including confidentiality, patients' rights, and other such issues.
- ❖ **Task distribution:** The health workforce plan should address task-distribution and task-shifting in a manner that will ensure quality while increasing service delivery. Task-shifting may include creating or expanding new non-physician clinicians/clinical officers and community/lay health worker cadres, and, if so, it must strengthen related supervision and referral systems. Health-related education should address any resulting redistribution and mix of required skills and competencies. One consequence of task-shifting and the development of strong referral systems may be the need to expand the workforce to deal with newly identified patients with more complex needs. The plan should address recruitment, training, and retention of this additional workforce.
- ❖ **Pre-service education:** Pre-service education planning should be aimed at producing enough health workers, in conjunction with other measures, to achieve MDGs, Universal Access, and other health goals and commitments. Training should be aimed at national health needs, including primary health needs, and countries should consider innovative methods that might be used to accelerate expansion of pre-service training, if needed.
- ❖ **In-service training:** The health workforce plan should strengthen in-service training mechanisms so that health workers can be adequately informed and skilled to provide high quality care, including mechanisms to ensure training, especially on-site training, for health workers in rural areas (including possible use of information technology). The in-service training should contribute to continuing professional development.

Supervision and referral systems

- ❖ **Supportive supervision:** The plan should include measures to ensure that all health workers receive supportive supervision which in turn requires well-trained and well-prepared supervisors. The plan should address the resources required to provide regular supervision and to do so on site whenever possible. Supportive supervision is one way of providing quality assurance.
- ❖ **Connections to higher-level health services:** The plan should ensure that there is a highly functional, transparent, and dependable referral system that permits health workers to diagnose patients' health care needs, and then know how and to whom to refer patients promptly for more specialized or expert care when it is needed. This will be impacted by the skills mix and service delivery models, as well as factors like transportation and communications, which will likely be beyond the health workforce plan, and part of the broader health sector strategy.

Re-engaging health workers

- ❖ **Unemployed and retired health workers:** The plans should identify measures and policies that may be able to draw non-practicing health workers back into the workforce, including unemployed, underemployed, and retired health workers, and where appropriate to engage the country's health professional diaspora.

Ensuring quality

- ❖ **Quality in education:** As health worker pre-service education is scaled up, as required in many countries, measures should be taken to ensure quality.
- ❖ **Regulating private sector:** Plans should include regulation of private health providers to ensure that they are delivering quality health services.

Ready to implement

- ❖ **Specific steps:** The health workforce plan should provide specific actions and timeframes for those actions that will be needed to implement the plan. If the health workforce plan does not have such specificity, a separate action plan should be developed.
- ❖ **Costing:** The health workforce plan should be costed. It may include several levels of costing, in the event that external resources that may be required are not forthcoming. If several costing scenarios are included, one should be the resources required to fully implement the plan and achieve health goals. All aspects of the plan should be costed, unless accompanied by a fully costed plan of action.

PROCESS OF DEVELOPING AND IMPLEMENTING NATIONAL HEALTH WORKFORCE PLAN

Participation

- ❖ **Broad participation:** The health workforce plan should be developed in a genuinely participatory and transparent manner, involving informed and wide participation of stakeholders that include

NGOs, health workers, patient/health consumer groups, and representatives of often marginalized populations, such as women, youth, migrants, refugees and internally displaced people, people with physical and mental disabilities, people living with HIV/AIDS, impoverished people, sex worker and sexual minorities, and rural dwellers. This participation should inform the development of the plan.

- ❖ **Multi-sector collaboration:** The plan should be developed through multi-sector collaboration, including ministries of health, education, finance, and public service.
- ❖ **Communication with health workers:** Along with their participation in developing the plan, health workers should be widely educated about the health workforce plan and how it will impact them and their work.

Evidence base and flexibility

- ❖ **Best available evidence:** Planning should take into account the best available evidence. Evidence should include the nature of the existing health workforce – including current numbers, migration patterns, and workloads – as well as disease burdens, including expected trends and the impact of emerging health issues like climate change. The effect of HIV/AIDS, including on health workers themselves, on workloads, on the need for chronic care, and on health workers’ tasks, should be taken into account.
- ❖ **Gather evidence:** The planning process should include activities to gather more evidence where current evidence is inadequate.
- ❖ **Flexibility:** Mechanisms should exist to revise the plan as necessary. As new evidence is developed, the plans should be adjusted based on the best available evidence.

Monitoring and evaluation

- ❖ **Monitoring and evaluation:** The health workforce plan should incorporate a monitoring and evaluation (M&E) process to monitor the plan’s implementation, to determine obstacles to implementation, to determine the effectiveness of the plan and its various elements (e.g., is the retention strategy working?), and to determine how the plan may need to be revised to improve its effectiveness in achieving its goals and improving health outcomes.
- ❖ **Information systems:** The plan should strengthen health information systems if they are not presently adequate to allow for effective M&E (and are one of the buildings blocks of health systems in their own right), as well as to gather evidence that will inform the plans.
- ❖ **NGO and health worker involvement in M&E:** NGOs and health workers should be meaningfully involved in the monitoring and evaluation process. Funds should be provided to enable broad stakeholder participation in both the initial planning process and in the subsequent monitoring and evaluation of the plan. People involved in other sectors related to the health workforce, such as education and agriculture, should also participate in M&E.
- ❖ **Public availability and accessibility:** The health workforce plan should be made publicly available and accessible to all, including by communicating it through accessible media and translating it into minority languages.

- ❖ **Link to right to health indicators:** The plan should include right to health indicators and benchmarks that permit monitoring to ascertain whether it is promoting the achievement of the essential elements of the right to health, namely, availability, accessibility, acceptability, and quality, and addressing both preventative and curative health services.

Connection to broader health strategy to meet population's health needs

- ❖ **Linkages between overall health sector plan and health workforce strategy:** The health workforce plan should be linked to and harmonized with a broader health sector strategy (e.g., national health sector strategic plans). The connection to other health sector improvements is needed to help ensure that health workers will have the training, supportive supervision, and referral systems, and the medicines, supplies, equipment, and other tools that they require to effectively perform their responsibilities. Changes in other areas of the health sector should be factored into the health workforce plan, such as the impact the abolition on user fees will have on increased utilization of the health services. The priorities, goals, and service delivery models in the health sector strategies will also impact the health workforce plan. For example, integration of health services will maximize the ability of health workers to contribute to comprehensively meet people's health needs.

Financing

The health workforce plan and the broader health sector strategy will have to be fully funded. The following are benchmarks, strategies, and policies that should guide this financing.

- ❖ **Increased domestic financing:** The national health sector plan should receive the maximum available domestic financing, including at least 15% of the government budget, as African governments have committed themselves to spending on the health sector. In many cases international financing will be required to supplement domestic resources, but such increases in domestic financing are a necessary step towards achieving full financing for the health workforce plan and national health sector strategy. An increase in domestic financing should not come through inequitable strategies that impede access to health services, such as point-of-service payments (user fees) on basic health services. Sustainable financing schemes should be designed to enable all people, including the poor, access to quality health services.
- ❖ **International financing:** Countries should coordinate their health sector and health workforce strategies and domestic funding with funding from bilateral and multilateral development partners (e.g., the Global Fund, GAVI). Development partners should commit to sustained funding that is predictable, long-term, rooted in national health strategies, and in conjunction with domestic resources, sufficient for full implementation of the health sector and workforce strategies. Development partners should also commit to paying recurrent costs.
- ❖ **Reformed macroeconomic policies:** The national health sector plan should be developed in concert with an evaluation and revision of existing macroeconomic policies, such as wage ceilings, deficit targets, and inflation targets, which may unnecessarily restrict the government's overall fiscal space, thus limiting necessary investments and spending of domestic and donor resources.

Growth evidence demonstrates that a wide range of policies are consistent with macroeconomic stability. Country reviews of macroeconomic policy should present the range of possible alternative policies, and include an honest assessment of the risks and benefits of each possibility. Countries should choose those policies that will enable them to maintain macroeconomic stability while making the investments in health, education, and other sectors as required to achieve the MDGs and fulfill governments' human rights obligations. Civil society members should be actively involved in these discussions.