



People First:

African solutions to the health worker crisis



About AMREF

The African Medical and Research Foundation (AMREF) is Africa's leading health development organisation, saving and transforming the lives of the poorest and most marginalised people in Africa.

Founded in Kenya in 1957, AMREF is a truly African organisation. Its headquarters are in Nairobi and there are health programmes in Kenya, Ethiopia, South Africa, Somalia, Sudan, Tanzania and Uganda. 97% of its 700 employees are African.

Over the past 50 years, AMREF has worked with the poorest and most marginalised people, in rural and urban areas, targeting disadvantaged communities that lack access to adequate health care and that have little opportunity to engage with policy and decision makers to identify and advocate for their health priorities. AMREF's credibility as a health development organisation in eastern and southern Africa is unrivalled. As such, AMREF is well positioned to act as a facilitator in linking communities to formal health systems.

AMREF strengthens the capacity of health and health-related professionals and institutions across eastern and southern Africa to provide support and incentives to health care workers. This is achieved through basic and intermediary training, continuing professional development and knowledge and information management. AMREF has developed a number of innovative methodologies to increase the numbers and skills of health workers and to motivate those in remote and isolated areas.

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Executive Summary

Sub-Saharan Africa (SSA) will meet few of the health Millennium Development Goals (MDGs) by 2015 if current rates of progress continue. Despite health and poverty eradication being high on the international agenda with significant achievements in some countries, progress remains extremely slow throughout Africa. This is primarily due to weak health systems characterised by severe shortages and low capacity and motivation of health workers at all levels across the continent.

The health worker crisis is particularly acute in rural and hard to reach areas, where 80% of the population in Africa live. The resultant low capacity at the peripheral level of the health system is a crucial barrier to good health. AMREF believes that developing capable, motivated and supported health workers at all levels of the health system is essential in ensuring the delivery of accessible and effective health care across Africa.

With the knowledge that the poorest communities in Africa often do not seek health care outside of the home, this briefing draws on AMREF's experience to look at three key issues: the importance of appropriate training, task-shifting to lower cadres of worker, and training and supporting community health workers (CHW) in order to bring health care closer to communities. AMREF recognises the need to address infrastructure and financial constraints in addition to these areas.

Strategies to improve the performance of health workers must ensure that workers are provided with appropriate training to equip them with the skills necessary to provide relevant preventative and curative health care at community level, as well as incentives to ensure motivation and commitment. This should be central to national workforce strategies.

In many parts of Africa, the skills of health care professionals do not match the actual health needs. Task shifting – giving more responsibility to lower cadres of health workers - and ensuring sufficient training and support is vital, particularly in post-conflict countries with extreme shortages of health workers such as South Sudan and Mozambique.

In countries where formal health workers are too few, CHW have an important role to play in providing services to the poorest and most vulnerable communities. AMREF has learnt important lessons about the impact on health that CHW can have; about how to train, support and motivate CHW and about the importance of ensuring effective referral systems and links with formal health care workers.

Evidence of innovative and effective responses to the health worker crisis exists; there needs to be global

commitment to collaborate to scale up proven good practice models at a national level across Africa. This process must be led and owned by African governments with appropriate levels of financial investment and technical assistance from donors.

Summary of key recommendations

UK and donor governments should:

- **Lead on delivering funding support** for ten year national health plans and increase bilateral and multilateral support to the health sector to allow the rapid scale up of health workers and community health workers.
- **Work in partnership** with the private sector and NGO partners to support the development and use of new technologies to increase the numbers and capacity of health workers in Africa.
- **Work with African governments** to develop comprehensive costed workforce plans which focus on matching the skills of workers to the local profile of health needs and provide incentives to retain workers where the need is greatest.
- **Increase investment** in, and support African governments' investment in, the successful use of community health workers through the provision of training, supervision, incentives and links to formal health care professionals.

African governments should:

- **Meet the 2001 Abuja target** to commit 15% of their national budgets to health.
- **Task-shift to increase the cadres of workers** with basic clinical and community health competencies, such as enrolled nurses and clinical officers at community level.
- **Increase investment** in the successful use of community health workers through the provision of training, supervision, incentives and links to formal health care professionals.

Background:

The health worker crisis in Africa

Human resources are at the very heart of a health system. Health systems cannot function effectively without sufficient numbers of skilled, motivated and supported health workers; yet estimates suggest that there is a shortage of 4.2 million health workers worldwide¹. The shortage is most severe in SSA; it has been estimated that Africa will need one million more health workers in order to meet the Millennium Development Goals (MDGs) for health. Africa bears 24% of the global burden of disease but has only 3% of the world's health workforce; paid for with less than 1% of global health expenditure.

The health worker crisis has been accelerated by a variety of factors, of which labour migration and decades of chronic under-investment in health systems and health workers are the most important causes².

The health worker crisis is fast rising up the health and development agenda, due in part to the scale of the problem and in part to new political priorities and greater financial allocations for health. Over the past ten years there has been a dramatic increase in funding for health-related programmes in the developing world. Several sub-Saharan African governments, such as Tanzania and Zambia increased spending on health care to equal over 12% of their budgets by 2003. Kenya has doubled its spending on health care from \$6.50 to \$14.20 per capita in the past five years.³

Despite increased expenditures on health, this has primarily been channelled to major diseases, with insufficient resources directed towards strengthening health systems. Health spending remains woefully insufficient; the international community has the resources needed to tackle health challenges, yet health systems remain weak and unable to provide equitable and accessible health care for those who need it most. If the numbers and capacity of health workers are to be rapidly scaled up there must be

increased investment, not only from the international community but from African governments themselves. African governments must honour the Abuja declaration to allocate 15% of their national budgets to health.

In 2006 the World Health Assembly passed a resolution (59.23) on rapid scaling up of the health workforce. The vision is to scale up production of:

“A health workforce which is matched in number, knowledge and skill sets to the needs of the population and which contributes to the achievement of health outcomes by utilising a range of innovative methods”

Getting the right workers with the right mix of skills to areas where they are needed most is key to improving health. The low number of health workers across Africa is a significant bottleneck to the provision of health care. This is most apparent in remote, hard to reach parts of the continent. The geographical imbalance of workers within countries and the lack of appropriate skills, training and support for existing workers are at the crux of the health worker crisis in Africa.

In many countries the skills of limited and expensive professionals such as doctors are not well matched to local health needs. In almost all sub-Saharan countries there are far higher concentrations of workers situated in urban areas than in rural areas⁴. In Uganda some 70% of medical doctors and 40% of nurses and midwives are based in urban areas, serving only 12% of the population⁵, meaning that many rural facilities are served by untrained or less skilled workers.

There is no escaping the fact that the absolute numbers of skilled workers needs to increase. However, addressing the appropriate skills mix for African countries and ways to train, motivate and retain lower to middle-cadres of workers, including CHW, should be an immediate priority. This briefing therefore focuses on the importance of training and deploying health workers where they are needed most, at community level, and the ways in which proven models can be scaled up to address the health worker crisis.



Jennifer Mchangi, nurse, Kenya

People First:

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It is the poorest and most vulnerable communities in Africa who bear the brunt of the health worker crisis. The low numbers, limited skills and lack of support for health workers in rural and marginalised parts of Africa contribute significantly to the gap between communities and formal health systems which means that people are often unable to access the health services they need.

AMREF's experience has highlighted particular challenges facing health workers in hard to reach areas and the resultant impact on communities. Challenges include the lack of skilled workers in remote areas, poor community engagement with health systems, low motivation and retention of workers where they are needed most, and a lack of appropriate training and training institutions.

To tackle the immediate health worker crisis it is important to find alternative models which can quickly deploy and retain workers and ensure they get appropriate training and support. Responses need to expand the cadres of workers with basic clinical and community health competencies, such as enrolled nurses, clinical officers and CHW. Where these cadres exist, the numbers and quality should be enhanced. Where they do not exist, a concerted effort should be made to introduce them in areas where scarcity is particularly acute.

Poor training, motivation and retention of health workers where they are needed most

The low capacity of health workers at the peripheral health system in SSA is a crucial barrier to good health amongst the most poor and hard to reach communities. The lack of support and both financial and non-financial incentives are a significant obstacle to keeping workers in remote areas.

This briefing focuses specifically on training, whilst implicitly recognising the importance of increasing financial incentives such as salaries. Training capacity is extremely low and often does not equip workers with the necessary skills. Two thirds of sub-Saharan African countries have only one medical school and some have none⁶. Moreover, medical training has often focused on tertiary facilities and not the skills needed to work at primary health facilities and community level where they are needed most⁷.

Many health workers therefore find themselves ill-equipped and unsupported to deliver services. The disparity between training curricula and the challenges workers face can lead to low morale and motivation. Alongside the lack of training institutions, inappropriate training curricula, and lack of supportive supervision and continuing professional development opportunities, there are real challenges in offering appropriate training at the scale necessary.

Solution: delivering appropriate training and support to motivate and retain health workers

Helping the workforce to perform better must be a key priority as the possibility of increasing the supply of health workers will always be limited. Moreover, a motivated and productive workforce will encourage recruitment and retention of workers⁸. Strategies to improve the performance of workers must ensure that they are provided with sufficient training and support to enable them to carry out their work effectively.

Motivation at work is a key factor in the good performance of individuals and organisations. There is clear evidence that incentives are one of the main factors influencing health worker performance; opportunities for professional development and continuing education represent positive, motivating incentives and should therefore be prioritised and strengthened. In Uganda, AMREF, in partnership with the Ministry of Health, has designed and implemented a primary health care training programme to strengthen the pre-service and in-service training of primary health care workers, including clinical officers, registered and enrolled comprehensive nurses, and nursing assistants.

The comprehensive nurses training curriculum equips the nurses with the skills necessary to provide relevant curative,

preventative, emergency and rehabilitative services at community level. It is comprehensive and cost-effective training, tailored to the specific health needs of the population in Uganda, and takes less time than regular training. Ensuring the nurses are provided with appropriate continuing professional development boosts their motivation and morale. Tailoring training specifically to the African context means that the nurses are very marketable across Africa but not in the West and are therefore more likely to stay within the continent.

This experience resulted in national level policy reforms on training, training curricula and improvements in health workers' environments and motivation. The Ministry of Health institutionalised comprehensive nurse training across Uganda in 2001.

In Kenya, the vast majority (over 85%) of nurses are currently only qualified to the lowest 'enrolled' status. Enrolled nurses are unable to deliver many essential basic health services and are not qualified in the management and treatment of diseases such as HIV/AIDS, malaria, and tuberculosis. In response to this, AMREF was asked by the Ministry of Health and Nursing Council of Kenya (NCK) to

upgrade the status of 22,000 nurses from 'enrolled' status to 'registered status'.* To do this, AMREF is working with Accenture, a global management consulting, technology services and outsourcing company, to deliver an innovative electronic learning programme.

Upgrading the skills of workers to rapidly impact on the health of the population needs an innovative approach. Kenya currently has the resources and classrooms to train only 100 registered nurses a year using traditional classroom methods. At this rate it would take over 100 years to certify Kenya's enrolled nurses; using e-learning will enable Kenya to train and certify these nurses in just five years. The pilot and roll-out phases have generated evidence supporting this ground-breaking model for continuing medical education in Africa, leapfrogging the need to develop extensive traditional classroom-based centres for further education and doing so on a national scale.

There are real opportunities for African countries to educate, train and deploy health workers on a large scale using technology such as e-learning. This provides enormous scope to support rural and remote health workers and to ensure that the latest knowledge is available locally. Training needs to equip workers with the skills they need to deliver effective health care, including leadership and management skills. If training of this nature is to be scaled up then new and innovative modes of training delivery such as those which use information communications technology (ICT) must be used to the best effect.

* An 'enrolled' nurse is a certificate level nurse, whilst a 'registered' nurse is a diploma level nurse.



Jenipher Kidala, nurse, Kakamega General Hospital, Western Kenya

"Though I have been a nurse since 1990, I have always felt the need to upgrade my skills and experience by going back to college. I have been trying for so long, but there are too few colleges in Kenya and not enough teachers. The e-learning programme allows me to study without having to take leave from work, and I am able to practice my new skills immediately in the ward. Already, my supervisor has commented on my improved attitude and care of patients."

Recommendations

- **Training curricula must be revised** to ensure they equip health workers with the specific competencies they need to deliver health care in Africa, particularly basic clinical and community-based competencies.
- **African and donor governments should work in partnership with the private sector and NGO partners** to support the development and use of new technologies to increase the numbers and capacity of health workers in Africa.
- **African and donor governments should invest in health training institutions** in Africa to attain the desired number of health workers with the right skills in the medium and long-term.

The lack of skilled health workers in remote and hard to reach areas

In many countries training strategies have tended to focus on highly skilled health workers such as doctors and nurses, for the purpose of disease treatment rather than health promotion and disease prevention, and to prioritise initial training over continued professional development.⁹ It takes at least five years to train a doctor and three years to train a nurse, yet there is urgent need for greater numbers of health workers, particularly in post-conflict situations.

Task shifting to lower cadres of worker is a feasible response to this and can serve as a key motivator for lower level workers by giving them more responsibility and scope for professional development. There is much divergence between countries regarding which tasks it is acceptable for health workers of different levels to carry out. Task shifting to lower cadres of workers is often limited by national level policies and those of professional medical or nursing councils¹⁰.

Solution: getting health care to those who need it most; task shifting to lower and middle-level workers to deliver health care

It is imperative that strategies focus on matching the skills of workers to the local profile of health needs. This includes delegating work to, and effectively training and supporting, lower and mid-level cadres of formal workers to deliver health care at community level.

The World Health Organisation recognises the importance of task shifting. Doctors should continue to provide care that they are uniquely equipped to provide. However, in situations of extreme shortages of health workers, it is necessary to consider assigning additional roles to lower cadres of workers, provided they have adequate training and supervision.

South Sudan is an example of a country where increasing the cadres of workers with basic clinical and community health competencies is vital. South Sudan has some of the worst health indicators in the world as the primary health care system has been ravaged by 20 years of conflict. Huge numbers of health workers have fled the country and health facilities, services and training institutions have seriously deteriorated or are non-existent.

The total trained health workforce in South Sudan is currently estimated at 4,600, far below the 17,300¹¹ required to deliver health care for the current population of approximately eight million people. This does not include the three million refugees expected to return following the end of two decades of conflict. In view of such massive need, focusing on lower and middle cadres of workers is a critical strategy.



Silvana Nabole, clinical officer, Maridi, South Sudan

“The training I received at the National Health Training Institute in Maridi has made a big difference to the way I handle my patients. Before I came to the school I was trained in maternal and child health, but there were a lot of medical cases that I could not handle. If a child was convulsing, I would think it was epilepsy, and that there was nothing to do but wait for the attack to pass, yet most likely the child had severe malaria. When someone came and complained of difficulty in breathing, convulsing and with a cough, I would have concluded that it was tetanus, but now I know that these are signs of pneumonia and I will make a correct diagnosis.”

Since 1998, AMREF has been operating the National Health Training Institute (NHTI) training clinical officers in Maridi, South Sudan, the only training college for clinical officers in the country. The institute aims to ensure that the country is equipped with trained health professionals who can cope with the country's health needs and demands, as well as training others to do so.

Clinical officers form a cadre of mid-level health professional, between a doctor and a nurse, who provide preventive and curative services to rural populations in health centres and hospitals. They are essentially the doctors of South Sudan, but predominantly trained at one tenth of the cost of training a doctor in approximately half the time.

Cadres such as clinical officers and midwives have a vital role to play in providing essential services. Available studies are limited but suggest that in some circumstances, where health systems are extremely weak and under-resourced, well trained clinical officers can safely substitute for doctors in the provision of important but well understood procedures¹². In Maridi, the students begin practical training and supervision in the very first year of the course. Once they have finished their training they undertake a full year of practical work experience which is heavily supervised

before they qualify as clinical officers. The thorough nature of this training, and ongoing support and supervision, ensures high quality and safe service provision.

Concerns have been raised about the safety of services provided by lower and middle-level cadres of health workers; however the majority of evidence concerning quality of care shows that with appropriate training and support, this level of health worker can respond effectively to most emergency problems in general surgery and obstetrics. In Mozambique, the lack of doctors combined with the urgent need for emergency surgical care and skills for maternal health necessitated a reorientation of the training of health staff. A comparison of 1,000 consecutive caesarean sections conducted by medical assistants with the same number conducted by obstetricians and gynaecologists showed no differences in quality for this type of delivery or in the surgical interventions themselves¹³.

Task shifting to lower cadres of health workers has proved a feasible way of ensuring and improving delivery of health services in weak and under-resourced health systems.

Training can be delivered at a lower cost and more quickly than training new professionals. Providing appropriate supervision and support is in place, evidence suggests that there are no reductions in quality of care. Donors should support policies which enable task shifting in order to make essential health services more widely available.

Recommendations

- **National strategies should focus on matching** the skills of workers to the local profile of health needs; the numbers of cadres of health workers with basic clinical and community health competencies should be increased and training and support for them increased and enhanced.
- **Ministry of Health and Professional Medical Association policies** should allow task shifting to lower cadres of health workers. Resultant increases in responsibility should be accompanied by increased salaries and other incentives.

Poor community engagement with health systems

Not only are there simply not enough trained health workers in the areas in which they are most needed, there are also missed opportunities to increase health promotion and preventative care at community level. This is often due to the considerable disconnect between community members and the formal health sector. A recent study showed that 53% of the poorest households in SSA do not seek care outside of the home¹⁴.

Barriers preventing people using health facilities include: user fees; long distances to health centres; community knowledge and beliefs on illness, and attitudes and skills of health workers. As the disease burden is felt most strongly in the home and many illnesses are easily preventable, highly specialised skills are not always necessary for health promotion. Unless the barriers to preventative and curative care are addressed and care is brought closer to communities then poor populations will not be reached.

Solution: making the most of the community

CHW have real potential to provide the vital link between communities and formal health systems as they know and understand the health needs of the communities within which they live and work. Moreover, they can be trained and deployed quickly and are unlikely to emigrate.

The evidence from available data on the use of CHW from Gambia, South Africa, Tanzania, Zambia, Madagascar and Ghana suggests that these workers enhance the performance of community level health programmes and that they are cost effective¹⁵. CHW with minimal additional training can deliver treatment for important diseases, such as malaria, HIV and TB. A variety of trials have shown substantial reductions in child mortality with case management of children by CHW. One such trial in Tigray, Ethiopia, showed a 40% reduction in under-five mortality after local co-ordinators were trained to teach mothers to give anti-malarial medicines to their sick children in the home¹⁶. This mirrors evidence generated by AMREF across Africa.

In Uganda, AMREF piloted a model in three districts supporting local administrations and communities to promote and implement best practices for malaria prevention and control. With support from GlaxoSmithKline's Africa Malaria Partnership Programme, AMREF trained a network of community medicine distributors (CMD) to administer malaria treatment at community level. This training enabled CMD to recognise symptoms early and ensured that they have adequate knowledge and skills to respond appropriately. This increased the numbers of children getting treatment for malaria within 24 hours, children sleeping under ITNs and pregnant women utilising intermittent preventive treatment (IPT).

AMREF found that maintaining high levels of CMD motivation, performance and retention required a modest, cost-effective support package. In districts where CMD have been supported by the programme, the drop-out rate was 1-2%, compared to 33% in districts not supported by the programme. Feedback has shown that recognition, appreciation, regular supervision and technical support are the main incentives for community volunteers to carry out their work. Providing incentives to retain CHW is vitally important as high attrition rates can contribute to reductions in the stability of the programme, increased training costs due to the need for continuous replacement and can make programmes difficult to manage¹⁷. This model of providing incentives for CMD has been adopted and scaled up nationally by the Government of Uganda.

In Kibera in Nairobi, Africa's largest slum, AMREF has generated evidence supporting the feasibility of training CHW to significantly increase adherence to HIV and TB treatment. Health care in Kibera is extremely limited, poorly resourced and difficult to access. Despite being situated in the heart of Nairobi, Kibera has few formal health workers. Nurses and doctors who are posted there view it as a punishment.

AMREF trained and supported CHW to improve the quality of life and prolong the lives of HIV/AIDS-infected residents and to develop, implement and evaluate simplified and standardised treatment regimes. CHW are trained to work with individual patients and their families to support compliance, to organise additional support from communities and to give nutritional advice and supplements. Strengthening community mechanisms to support adherence in this way has resulted in over 90% adherence to directly observed therapy: short course (DOTS) for TB and 92 % adherence to anti-retroviral treatment (ART), exceptionally high in a setting such as Kibera.

CHW interventions must ensure that CHW are integrated into formal health systems, in order to avoid the development of a two-tiered system and to ensure consistency in the quality of services. AMREF's "Umkhanyakude" Traditional Health Practitioners (THP) project in South Africa recognises the potential value of THP as a resource in the health system and links the MOH with traditional healers to the benefit of both, and the communities they serve.

In South Africa, over 60% of rural inhabitants seek health advice and treatment from a traditional healer before visiting a primary health care service. THP are therefore an important resource based in the community. Among other things, traditional healers have been trained on how to avoid transmitting HIV, to avoid contracting TB from their patients, and how to keep health records.

Literacy levels proved challenging: 60 of the 80 THP could not read or write in Zulu or English. This posed a challenge to the THP's training and the development of appropriate

George Olali, community health worker, Kibera slum, Nairobi

"I have been living with HIV for the past 10 years and have been trained as a counsellor and peer educator. I spend my days talking to those who come to the centre for testing and treatment, and going out into the community to check on those who are ill. I encourage those who have not been tested to go for testing and ensure that those who are on treatment are taking their medication as required.

I am a role model for positive living. My openness about my status has helped many to overcome their fear of stigma, to seek help and to take steps to improve their lives."



Louise Orton

systems for referral and record keeping. Training programmes must consider local illness beliefs and be tailored to the literacy level of CHW¹⁸. AMREF developed a training manual, patient record form and referral letter using pictures. Tailoring the training content and presentations to literacy levels greatly improved acceptance of the training. The MOH has recognised the healers' competencies and now works with them to track and refer patients, especially those living with HIV and TB.

AMREF has found that, in the short term and at a local level, CHW can improve health outcomes if they are provided with appropriate support and training. However, there needs to be thorough and robust research into how the potential of CHW can be scaled up effectively at a national level.

CHW are a part of the solution to the health worker crisis and should be integrated into overall assessments of health worker requirements. However, there needs to be far greater recognition that CHW are currently playing a crucial role in the support and delivery of services such as health education, and that they will be critical in efforts to tackle the health worker crisis. This recognition must be combined with policy makers' consideration of training and incentives.

Recommendations

- **Formal health care providers and African and donor governments** must recognise and prioritise the role of CHW and contribute to significant research and investment to scale up CHW interventions.
- **Ministries of Health should provide CHW** with appropriate training, incentives, and ongoing support and, in the process, should ensure the development of strong referral links and integration into formal health systems, including health planning and budgeting.

Conclusion and recommendations: Developing and scaling up African led solutions

Health care in Africa is in a critical state. There is a pressing need for approaches which can quickly improve the training and capacity of workers on a large scale if the health MDGs are going to be met. AMREF believes the primary engine for this lies in African-based and led solutions which prioritise efforts to bring health care closer to communities.

For these proven, cost effective models to be scaled up there must be increased financial investment and support from African governments themselves and from donors. African governments, with the support of the international community, need to meet their Abuja commitments. Financial ceilings placed on public sector expenditure, alongside international macro-economic policies have had an extremely detrimental effect on health spending. International financial institutions should enable African governments to create enough fiscal space to invest in their health workforce, and particularly in scaling up effective solutions.

African countries need long term solutions to address the health worker crisis and this includes increasing the absolute numbers of health workers. As an immediate priority, however, African countries should be supported, both financially and technically to develop national plans which focus on matching the skills of health workers to local needs. This should involve increasing the numbers,

responsibilities and skills of lower and middle level cadres of health workers such as clinical officers, empowering and supporting community health workers to deliver preventive and curative care at community level, and ensuring that workers are provided with appropriate training and support to help motivate and retain them where they are needed most. Focusing on health workers and CHW at this level addresses barriers to preventative and curative care locally, where it is most needed.

Evidence suggests that the poorest households in Africa do not often seek health care outside of the home. Moreover, many illnesses are easily preventable through education and health promotion, which do not require specialised skills. CHW therefore have real potential to provide the vital link between communities and formal health systems. Fully assessing how to scale up CHW interventions is an urgent requirement. Determinants of success will vary from place to place, however, investing in greater research into this potential is essential, as is ensuring political commitment to providing CHW with necessary training, support and incentives.

Appropriate and accessible African curricula tailored to local health needs and the challenges that health workers face should be scaled up. It is vitally important that serious consideration is given to the testing and scaling up of technological innovations such as e-learning. Given the necessary investment, technological innovations can provide health worker training almost anywhere at a lower cost and at a much quicker rate than traditional classroom based methods. Such innovative and cost effective technologies makes training materials more accessible, particularly in remote and hard to reach areas, and are especially important in providing continuing in-service training that is relevant and accessible.

All of the proven models for building up the numbers and skills of health workers and CHW, highlighted in this briefing must be rapidly scaled up on a large enough scale to truly impact upon the health worker crisis which is significantly contributing to poor health across Africa.



Dr Chris Rakoum, Chief Nursing Officer, Kenyan Ministry of Health

Recommendations

UK and donor governments should:

- **Lead on delivering funding support** for ten year national health plans and increase bilateral and multilateral support to the health sector to allow the rapid scale up of health workers and community health workers.
- **Support changes in macro-fiscal policy** to grant African countries greater flexibility to increase investment in scaling up training and support for lower and middle level cadres of health workers and community health workers.
- **Work with African governments** to develop comprehensive costed workforce plans which focus on matching the skills of workers to the local profile of health needs.
- **Work in partnership with the private sector and NGO partners** to support the development and use of new technologies to increase the numbers and capacity of health workers in Africa.
- **Invest in health training institutions in Africa** in order to attain the desired number of health workers with the right skills in the medium and long-term.
- **Increase investment** in and support African government's investment in the successful use of CHW through the provision of training, supervision, incentives and links to formal health care professionals.

African governments should:

- **Meet the 2001 Abuja target** to commit 15% of their national budgets to health.
- **Conduct comprehensive training needs assessments** to determine actual in-country human resources for health needs.
- **Develop in-country human resources for health observatories** to provide information and knowledge required to improve the quality of education and training to meet the skill and development needs of the workforce in changing workplace environments.
- **Increase the cadres of workers with basic clinical and community health competencies**, such as enrolled nurses, clinical officers and CHW.
- **Invest in CHW** and provide them with appropriate training, incentives, and ongoing support and in the process and ensure the development of strong referral links and integration into formal health systems, including health planning and budgeting.
- **Invest in health training institutions** in Africa in order to attain the desired number of health workers with the right skills in the medium and long-term.

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