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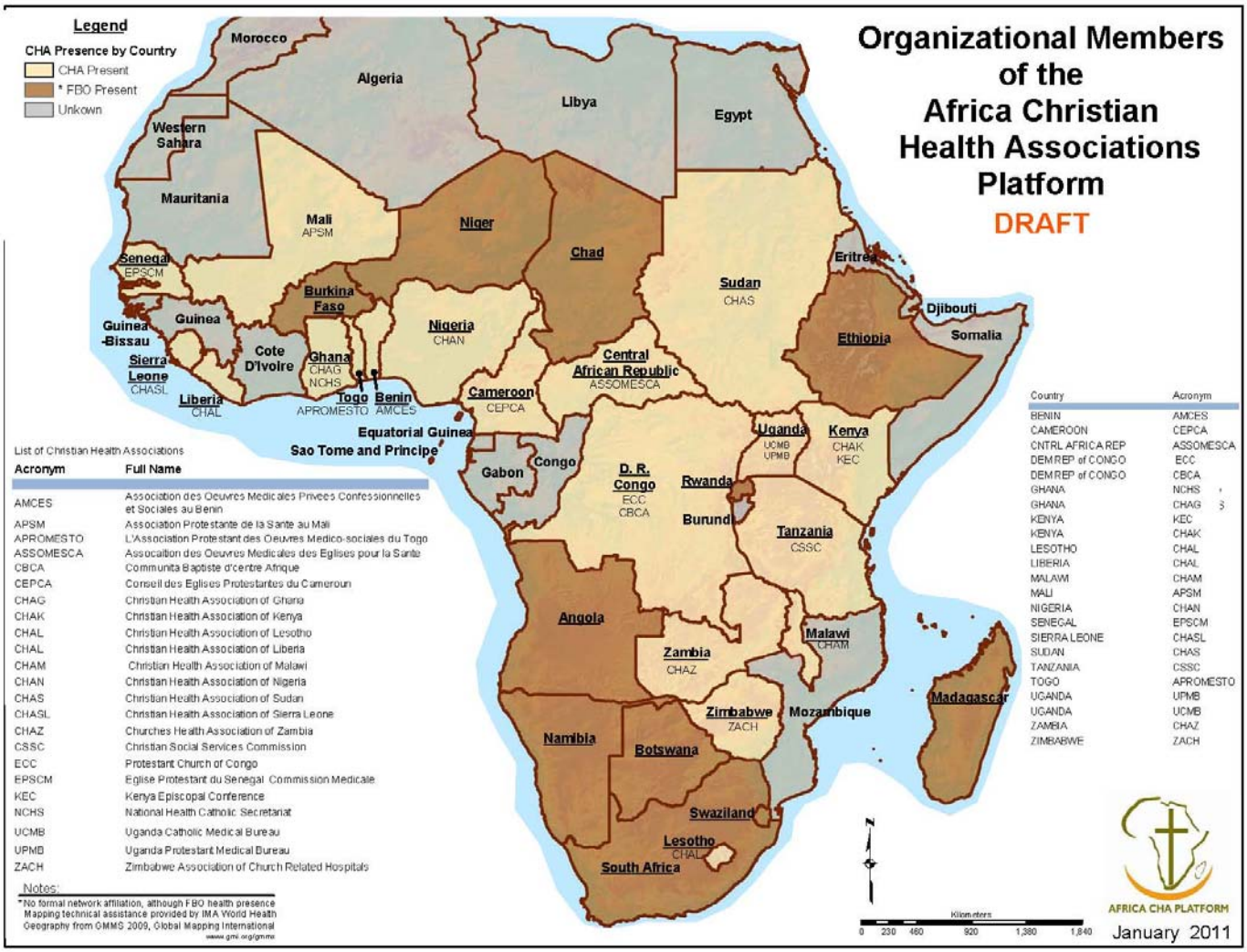
Hotline HRH



A Human Resources for Health publication of the Africa Christian Health Associations Platform

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RESOURCES

Enhancing nursing and midwifery capacity to contribute to the prevention, treatment and management of noncommunicable diseases

Many interventions for noncommunicable diseases (NCDs) exist and are well known. In order to scale up action, involvement of nurses and midwives, the largest category of health workers in most countries, is critical. Evidence shows that nursing and midwifery involvement in NCDs can go beyond prevention, screening/early detection and treatment to include promotion of health. Primary disease prevention is essential to any strategy combating NCDs. Documentation on the role of nurses and midwives in NCDs is an important contributor to the WHO HRH Observatory series.

This document presents interventions in the areas of policy, advocacy, research and education and practice, and the roles that nurses and midwives play. The evidence and intervention options outlined in this document provide an important reference point on NCDs for policy-makers, researchers, educationists, nurses and midwives, and other health-care workers.

To access the document: http://www.who.int/hrh/resources/observer12/en/index.html

A bibliometric review of pharmacy education literature in the context of low- to middle-income countries

This review systematically identified published literature on pharmacy education in low- and middle-income countries. Specific aims were twofold: Firstly, to systematically identify and quantify published literature on pharmacy education in the context of low- and middle-income countries. Secondly, to explore and understand the major patterns of dialogue in this literature.

For resource: http://www.pharmacyteaching.com/article/S1877-1297(13)00008-7/abstract

TRAINING/WORKSHOP INFORMATION

International Health Consultancy
7 - 24 May 2013

The Liverpool School of Tropical Medicine is delighted to announce that recruitment is now open for its highly acclaimed Short Course in International Health Consultancy from 7th – 24th May 2013. The course is an executive/senior level professional development programme, and is of value to health, management and social development specialists working in government, non government and academic settings worldwide who want to work in a technical assistance role in middle and low-income countries.

This highly intensive 3-week post-graduate course provides emerging national, regional and international consultants with an opportunity to enhance and improve their professional knowledge and

skills in the provision and management of consultancy services within the context of international health and deliver technical assistance that is robust, evidence-based and grounded in the reality of resource-poor settings.

For further information and to register please visit:
http://www.lstmliverpool.ac.uk/learning--teaching/lstm-courses/short-courses/mg01---international-health-consultancy

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Procurement and Supply Management (PSM) for Global Fund PRs and Related Consultants
22 –2 27 July 2013

Pharmasystafrica and the Churches Health Association of Zambia (CHAZ) are offering a one-week course on responding to PSM bottle necks and challenges. The course will be tailored to address actual in-country PSM challenges based on a collection of case studies. Training of programs staff to address their own challenges based on country needs and priorities is essential for building sustainable capacity.

For additional information: http://www.pharmasystafrica.com/index.php?option=com_content&view=article&id=67:procurement-and-supply-management-psm-for-global-fund-prs-and-related-consultants&catid=3:events&Itemid=58

Gender, Rights and Health *e-learning course*
Course date: September 2 – November 8, 2013

Health programmes and health policies are often developed without taking into consideration the gender dimensions and rights perspective into consideration. This course equips participants with concepts, tools and analytical frameworks to analyze health programmes, policies and research from a gender and rights perspective. The course will take place in a Virtual Learning Community – a web-based learning arrangement.

For additional information: http://www.kit.nl/kit/Gender,-rights-and-health-(e-learning)

Gender equity in value chain development
Course date: November 4 – November 15, 2013
NFP scholarship deadline: May 7, 2013

Drawing from a multitude of practiced based case material, this 10-day course offers strategies and tools to design value chain interventions that have positive impact both on gender equality and business development of the value chain itself. This participatory experience based course offers you a framework to help plan and implement value chain interventions in such a way that women benefit more from value chains, while at the same time increasing business development opportunities within the chain as a whole. For this course and a number of other advanced courses, participants can apply for funding from the Netherlands Fellowship Programme (NFP).

For additional information: http://www.kit.nl/kit/DEV-Training-Value-chain-development-Gender-in-value-chains

ARTICLES OF INTEREST

Working for Health Equity: The Role of Health Professionals

This report demonstrates that the healthcare system and those working within it have an important and often under-utilised role in reducing health inequalities through action on the social determinants of health. The health workforce are, after all, well placed to initiate and develop services that take into account and attempt to improve the wider social context for patients and staff.

The report discusses the best ways to reduce inequities through workforce education and training, practical actions to be taken during interactions with patients, ways of working in partnership, and the role of advocacy. It also includes a section on the health system, which analyses which mechanisms and structures are supportive of actions to reduce health inequality, and where further development might be needed.

Throughout the report, we have gathered a series of commitments by health workforce and other organisations to embed and develop action on the social determinants and these form the basis for an on-going programme of work led by IHE in partnership with royal colleges, the Academy of Medical Royal Colleges, the BMA, and other organisations and institutions. The report also provides statements for action developed by health professional organisations which seek to give practical accessible tools for particular professionals to develop and use in their roles.

For full document: http://www.instituteofhealthequity.org/projects/working-for-health-equity-the-role-of-health-professionals

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Deployment of community health workers across rural sub-Saharan Africa: financial considerations and operational assumptions

The evidence is overwhelming that community-based interventions are an effective platform for extending health care delivery and improving health outcomes. Such evidence indicates that a well-implemented community-based health programme can: (i) reduce infant and child mortality and morbidity; (ii) improve health-care-seeking behaviour (e.g. increase rates of institutional delivery and immunization); and (iii) provide low-cost interventions for common maternal and paediatric health problems while improving the continuum of care. Such community-level programmes can be particularly effective for addressing the most common causes of paediatric mortality and morbidity, such as pneumonia, diarrhoea, undernutrition, malaria, human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS) and measles. These community-based health programmes are often successfully executed through community health workers (CHWs). These are lay people who live in the communities they serve and who function as a critical link between those communities and the primary-health-care system. The well-documented success of CHW programmes over the last few decades has increasingly pushed investment in CHW subsystems to national and international policy platforms as part of coordinated efforts to improve health-care systems.

Although several reviews have documented the positive impact of CHWs on health outcomes, CHW programme costs have barely been examined, probably because cost data are much less widely available than data on programme outcomes. In one revealing review of 53 studies on CHW programmes in the United States of America, only six studies referenced costs and the authors considered such data to be insufficient to draw any conclusions. When included, costs are generally associated with interventions rather than with comprehensive CHW programmes; furthermore, estimates

do not account for economies of scale or year-on-year efficiencies. To date, the official costs of national CHW programmes in pioneering countries such as Ethiopia, Malawi or Rwanda have not been estimated, partly because tracking unit costs is difficult and because methods for isolating the CHW subsystem from an integrated primary-health-care system have been elusive.

This paper provides cost guidance for one adaptable configuration of a CHW "subsystem": a provider system housed within a larger primary-health-care system that includes clinics and referral hospitals. Costing is done by function (e.g. diagnosing and treating malaria) and by local epidemiologic characteristics (e.g. each country's prevalence of HIV infection), so that components and assumptions can be easily modified. National scale-up of CHW programmes and of primary-health-care systems more broadly is likely to reduce the incidence of many of the diseases discussed in this paper. This model allows costs to be easily recalculated as incidence rates change. New functions, such as the care of patients with chronic conditions, could be added and costed once a vetted CHW protocol for these functions has emerged.

For full document: http://www.who.int/bulletin/volumes/91/4/12-109660/en/index.html

Health workforce remuneration: comparing wage levels, ranking, and dispersion of 16 occupational groups in 20 countries

This article represents the first attempt to explore remuneration in Human Resources for Health (HRH), comparing wage levels, ranking and dispersion of 16 HRH occupational groups in 20 countries (Argentina, Belarus, Belgium, Brazil, Chile, Colombia, the Czech Republic, Finland, Germany, India, Mexico, the Netherlands, Poland, Russian Federation, Republic of South Africa (RSA), Spain, Sweden, Ukraine, United Kingdom (UK), and United States of America (USA)). The main aim is to examine to what extent the wage rankings, standardized wage levels, and wage dispersion are similar between the 16 occupational groups and across the selected countries and what factors can be shown to be related to the differences that emerge.

The pooled data from the continuous, worldwide, multilingual WageIndicator web survey between 2008 and 2011 (for selected HRH occupations, n=49,687) have been aggregated into a data file with median or mean remuneration values for 300 occupation/country cells. Hourly wages are expressed in standardized US Dollars (USD), all controlled for purchasing power parity (PPP) and indexed to 2011 levels.

The wage ranking of 16 HRH occupational groups is fairly similar across countries. Overall Medical Doctors have the highest and Personal Care Workers the lowest median wages. Wage levels of Nursing & Midwifery Professionals vary largely. Health Care Managers have lower earnings than Medical Doctors in all except six of the 20 countries. The largest wage differences are found for the Medical Doctors earning 20 times less in Ukraine than in the US, and the Personal Care Workers, who earn nine times less in the Ukraine than in the Netherlands. No support is found for the assumption that the ratio across the highest and lowest earning HRH occupations is similar between countries: it varies from 2.0 in Sweden to 9.7 in Brazil. Moreover, an increase in the percentage of women in an occupation has a large downward effect on its wage rank.

This article breaks new ground by investigating for the first time the wage levels, ranking, and dispersion of occupational groups in the HRH workforce across countries. The explorative findings illustrate that the assumption of similarity in cross-country wage ranking holds, but that wage dispersion and wage levels are not similar. These findings might contribute to the policies for health workforce composition and the planning of healthcare provisions.

For full article: http://www.human-resources-health.com/content/11/1/11/abstract

Healthcare Inequity and Physician Scarcity - Empowering Non-Physician Healthcare

The massive scarcity of physicians in India, mainly in rural areas, prompted the Union Ministry of Health and Family Welfare to propose a three-and-a-half year Bachelor of Rural Health and Care degree designed exclusively to serve rural populations. The fierce opposition by powerful medical lobbies forced the proposal to fade away.

This paper emphasises the importance of “task shifting” and “non-physician prescribing” in the global context and argues that non-physician healthcare providers would not only increase availability and accessibility to rural healthcare, but also provide an empowered second line of authority, adding to the checks and balances to the exploitative prestige-based hierarchy that pervades this knowledge-intensive service.

To download article: http://www.epw.in/system/files/pdf/2013_48/13/Healthcare_Inequity_and_Physician_Scarcity.pdf

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Human resource governance: what does governance mean for the health workforce in low- and middle-income countries?

Background: Research on practical and effective governance of the health workforce is limited. This paper examines health system strengthening as it occurs in the intersection between the health workforce and governance by presenting a framework to examine health workforce issues related to eight governance principles: strategic vision, accountability, transparency, information, efficiency, equity/fairness, responsiveness and citizen voice and participation.

Methods: This study builds off of a literature review that informed the development of a framework that describes linkages and assigns indicators between governance and the health workforce. A qualitative analysis of Health System Assessment (HSA) data, a rapid indicator-based methodology that determines the key strengths and weaknesses of a health system using a set of internationally recognized indicators, was completed to determine how 20 low- and middle-income countries are operationalizing health governance to improve health workforce performance.

Results/discussion: The 20 countries assessed showed mixed progress in implementing the eight governance principles. Strengths highlighted include increasing the transparency of financial flows from sources to providers by implementing and institutionalizing the National Health Accounts methodology; increasing responsiveness to population health needs by training new cadres of health workers to address shortages and deliver care to remote and rural populations; having structures in place to register and provide licensure to medical professionals upon entry into the public sector; and implementing pilot programs that apply financial and non-financial incentives as a means to increase efficiency. Common weaknesses emerging in the HSAs include difficulties with developing, implementing and evaluating health workforce policies that outline a strategic vision for the health workforce; implementing continuous licensure and regulation systems to hold health workers accountable after they enter the workforce; and making use of health information systems to acquire data from providers and deliver it to policymakers.

Conclusions: The breadth of challenges facing the health workforce requires strengthening health governance as well as human resource systems in order to effect change in the health system. Further research into the effectiveness of specific interventions that enhance the link between the health workforce and governance are warranted to determine approaches to strengthening the health system.

For full article: http://www.human-resources-health.com/content/pdf/1478-4491-11-6.pdf

Commitments for “every Woman, every child”: a Human Resources for Health perspective

head of the Third Global Forum on Human Resources for Health, where the Global Health Workforce Alliance and other partners are working to elicit new Human Resources for Health (HRH) commitments to accelerate progress towards attainment of the health MDGs and universal health coverage - Alliance member ICS Integrare has issued a technical brief, with an analysis of the Every Woman Every Child (EWEC) commitments from an HRH perspective. EWEC analysis confirms, no plans or commitments will be achieved without strengthening the health workforce, in particular the midwifery workforce.

The brief outlines, that 23% of the EWEC statements from countries specify strengthening the health workforce, including additional numbers, education, training and deployment. 73 (91%) of the 80 statements are from low-income countries, emphasizing their priority to strengthen the Inputs and Processes of their health systems to expand services and coverage. In addition, 65 countries account for 254 action statements that are “enabled” by, or dependent upon access to a skilled, motivated and supported health workforce to achieve them. 94% of the statements within the existing EWEC commitments addressing key women’s and children’s health issues either target HRH or are dependent on the availability, accessibility, acceptability and quality (AAAQ) of the health workforce to achieve them.

For full report: http://www.who.int/workforcealliance/media/news/2013/ICSIntegrare_EWEC_Technical_Brief_Apr2013.pdf

South Africa: Gauteng Health Not Relenting On Overtime Management Despite Threats of Resignations

"The only 'looming crisis' at Charlotte Maxeke Academic Hospital is only in the minds of those who want government to turn a blind eye to the abuse of overtime and getting less value for public money," said Health MEC Hope Papo to journalists who quizzed him on the allegations that some doctors have threatened to live the department.

According to the journalists, some doctors at Charlotte Maxeke Hospital have warned of a "looming crisis" as they are threatening the department with resignations, after the department tightened its controls over overtime and the granting of permission to healthcare workers to do Remunerative Work Outside of the Public Service (RWoPS).

"One of the priorities in the Ten Point Plan is overhauling the healthcare system and improve its management," Papo explained. "This means ensuring that government gets value for its money and we therefore cannot allow healthcare professionals to be paid for not being at work."

The Gauteng Health Department decided to strengthen the management of overtime and RWoPS following evidence that many professionals were abusing these. The professionals involved are full time employees of the department who are expected to be at work for all paid hours including commuted overtime in the case of clinicians. However; many would demand overtime and also that they be given permission to leave their work posts and be working, for remuneration, elsewhere whilst receiving full pay from government.

For full article: http://allafrica.com/stories/201304190871.html

Nigeria: Midwives Scheme Reduces Maternal Mortality

The Executive Director and Chief Executive of the National Primary Health Care Development Agency (NPHCDA), Dr. Ado Mohammed has disclosed that the introduction of the Midwives service scheme has drastically reduced maternal mortality in the country.

Speaking in an interview with journalists after the launching of the 2013 edition of the scheme on Tuesday in Kaduna, Mohammed said that in the last three years, the NPHCD had recruited over 6,250 midwives which were deployed to 1500 health facilities in about 450 local government areas across the country.

According to him, there is zero maternal death in those locations where the midwives were deployed, adding that the system has improved primary health- care system in those areas.

"What this means is that the midwives service is working very well and we will continue to contribute towards Nigeria meeting the MDGs goals," he said.

For full article: http://allafrica.com/stories/201304181285.html

ACHA MEMBERS—IN THE NEWS

Please check out the YouTube interviews of ACHAP members: Leonard Onana (www.capacityplus.org/imahealthworker/), Lazarus Filiya (www.capacityplus.org/imahealthworker/content/lazarus-filiya-health-worker-nigeria), and Samuel Nugblega (www.capacityplus.org/imahealthworker/content/samuel-nugblega-health-worker-ghana). These were done during the Biennial. We thank them for taking the few minutes for the interview.

A blog by Doris Mwarey focusing on the HRH TWG meeting that was held on February 25 has also been published — http://www.capacityplus.org/responding-to-the-rise-in-ncds

Hotline HRH 2012 Monthly Schedule

January 30, 2013	July 31, 2013
February 27, 2013	August 28, 2013
March 27, 2013	September 25, 2013
April 24, 2013	October 30, 2013
May 29, 2013	November 27, 2013
June 26, 2013	December 25, 2013

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Documents

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Document Section

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