

Global Strategy for Women's, Children's and Adolescents' Health

Technical paper: Health systems resilience and health workforce for women's, children's and adolescents' health¹

Abstract:

The development of a Global Strategy for Women's, Children's and Adolescents' Health (GS 2.0) represents an opportunity to reflect on the contemporary evidence on health systems' resilience and health workforce requirements for universal health coverage.

Weak health systems, health workforce gaps, and a verticalized focus of health interventions hinder the attainment of health goals and represent a threat to global health security, as evidenced by the recent Ebola outbreak in West Africa. Further, new health labour market analyses identify a fundamental and growing mismatch between population needs and market-based demands. Health system resilience, conversely, hinges on the institutional capacity and human capital to adapt and respond to emerging needs.

The delivery of essential interventions needs to reflect a holistic public health model for people-centred, integrated health services. Resilience capacity should be embedded in health system design through structural and policy reforms in service delivery and health workforce, so as to preserve the capacity to deliver essential health services for women and children also during a health shock.

Effective delivery of integrated health services for women and children demands a renewed focus on sub-national delivery systems, on quality improvement and on strengthening core public health capacities for disease surveillance and response. The health workforce stands out as an area warranting a particular focus for resilient health systems, and requires a paradigm shift, including: the optimization of the existing workforce, made possible by stronger national institutions, able to devise and implement more effective strategies to ensure a more sustainable and responsive skills' mix, and improved working conditions, reward systems and career pathways; a recognition that the creation of employment opportunities in health and social care can be a driver of socio-economic development and gender empowerment; and a substantive scale-up of domestic and international financing.

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1) Background and introduction

The United Nations Secretary-General's *Global Strategy for Women's and Children's Health* (GS1.0) was launched in 2010. It provided an impetus "to improve the health of hundreds of millions of women and children around the world, and in so doing, to improve the lives of all people" [1]. The strategy advocated comprehensive, integrated packages of essential interventions and services for women and children with a parallel strengthening of health systems and health workforce capacity to deliver these interventions. Five years later, an updated strategy is in development for launch in September 2015: *Global Strategy for Women's, Children's and Adolescents' Health* (GS2.0).

This paper on **health systems' resilience and health workforce** is one of 12 technical and cross-cutting papers informing the development of the GS2.0. The paper benefits from multiple inputs, including: contributions from an expert group; a consultation in Abidjan, Cote d'Ivoire (February 13, 2015); a 'Geneva Dialogue' with Ambassadors and Heads of Agencies² (February 23, 2015); feedback from the Delhi Stakeholders Meeting (February 26-27, 2015), and; internal review from the GS2.0 Steering Group.

The paper reflects on the broad context of the new global agenda for the Sustainable Development Goals (SDGs) and the General Assembly decision, in September 2014, that "the proposal of the Open Working Group on Sustainable Development Goals shall be the main basis for integrating sustainable development goals into the post-2015 development agenda..." [2]. The comprehensive nature of the SDGs, in particular the goals and targets applicable to nutrition³, health⁴, education⁵, gender⁶ and employment⁷ (see detail in Annex 1) are therefore considered.

The two elements of the paper – systems' resilience and human resources for health – are able to draw upon a body of contemporary evidence. The concept of resilience is not a new one: early work was based on organizational research methods, complexity theory and process engineering [3, 4]. In the domain of health systems research it has been used in the health systems, patient safety and outbreak response literature. The term generally refers to the ability of individuals, institutions or systems to cope with internal and external shocks [5,] and the ability of systems to return to normal operations despite challenges [6]. The concept has received much attention in 2014-15 in its application to the three countries in West Africa - Guinea, Liberia and Sierra Leone - that have suffered a protracted public health emergency with the Ebola Virus Disease (EVD) outbreak. In this context, resilience is used to describe a future health system that will recover to be stronger than its original state when first exposed to the shock. The specific context links the emergency outbreak response to early recovery of essential health services, future systems' resilience and the anticipated improvements in population health outcomes in the medium- to longer-term. This makes effective planning in the early recovery phase critical to population health outcomes in the long term.

In parallel, a considerable body of evidence has emerged on the workforce requirements of the Universal Health Coverage objective [7], [8] [9]. A WHO resolution in May 2014 [10] and a global, year-long consultation facilitated by the Global Health Workforce Alliance [11] are informing WHO's negotiations on a *Global Strategy on Human Resources for Health (2016-2030)* [12]. The 2011 and 2014 editions of *The State of the World's Midwifery* [13, 14] set out the present and future workforce challenges that will have to be addressed in order to achieve universal access to sexual, reproductive, maternal and newborn health services. The 2014 Lancet Series on Midwifery [15] covered new ground on the contribution of midwifery to the health and wellbeing of women and their families.

² Does the world have enough midwives? A Geneva Dialogue. 23 February, 2015. Information available at: xx

³ Goal 2: End hunger, achieve food security and improved nutrition, and promote sustainable agriculture.

⁴ Goal 3: Ensure healthy lives and promote well-being for all at all ages

⁵ Goal 4: Ensure inclusive and equitable quality education and promotion of life-long learning opportunities for all

⁶ Goal 5: Achieve gender equality and empower all women and girls

⁷ Goal 8: Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all

The combination of these evidence domains should ensure that aspirations for an ambitious GS2.0 take appropriate account of the health systems and workforce implications that will inform success or failure in the 49 Least Developed Countries in the next 10 to 15 years.

2) Stating the problem

Weak health systems have undermined the attainment of the health-related Millennium Development Goals (MDGs) and are a threat to global health security.

Health systems may make variable progress on crude coverage of some focused health interventions and targets promoted by the MDGs, but the sustainability of these gains is constrained by structural bottlenecks, and the resilience of health systems is insufficient to withstand unexpected shocks. The latter is most evident in the EVD outbreak in West and Central Africa where the number of EVD infections and the high percentage of health workers who have lost their lives have demonstrated that verticalized, MDG-focused health systems and the health workforce within them (including personnel employed outside of the civil service) lack the institutional capacity and human capital to provide patient-centred, integrated health services outside of a typical package of clinical interventions focused on maternal health, HIV/AIDS, tuberculosis and malaria (see panel 1).

In fragile health systems ability to respond to unplanned needs is limited, and gains can easily be reversed. During the recent outbreak of EVD in Liberia, despite an earlier positive trend in coverage of essential services, skilled birth attendance fell from 52% to 38% and at the height of the outbreak, 64% of all Liberia health facilities were not operational. Similarly, vaccination rates for measles declined to 45% and (DTP3) to 53%. Sierra Leone reported a 21% decrease in children receiving basic immunization. In Guinea, DTP3 coverage dropped by 30% between 2013 and August 2014. These systems were not resilient to the shock it faced, resulting in preventable childhood morbidity and mortality.

Panel 1: fragile health systems lack resilience.

A key feature that influences the resilience of health systems is the capacity of both its clinical and public health workforce to adapt and respond to emerging needs.

The 2006 World Health Report - Working together for health – identified a crisis in HRH and set an agenda for a decade of global action [16] focused on overcoming shortages of skilled health professionals in fifty-seven low- and middle-income countries, paving the way for a global discourse on addressing the supply, education, retention and management of the health workforce in order to support the attainment of the health-related Millennium Development Goals (MDGs). Despite considerable advances, the progress, especially in LDC, has been uneven and fell short of population needs: the available evidence [17] - demonstrates that the biggest bottleneck to achieving MDGs 4, 5 and 6 is the continuing absence and inequitable distribution of a pool of qualified health workers to deliver promotional, preventive, curative, rehabilitative and palliative health services.

The health-related MDGs are credited with catalysing action and investments on highly effective sexual, reproductive, maternal, newborn and child health interventions, contributing to notable achievements in reducing maternal and child mortality. However, the limitations of this selective approach have also become apparent [18b], and the era of the SDGs requires a true paradigm shift by the global community, to incorporate the logic of delivering essential clinical interventions into a holistic approach that moves beyond averting deaths to one that also promotes healthy lives and has the following key elements:

1. Public health, social determinants and healthy behaviour that prevent or reduce demand on costly medical services are critical components of a resilient health systems approach.
2. People-centred, integrated health services are required catering to the life cycle, from early infant and child development, through adolescent, adult and ageing populations.
3. Access to high-quality health and social care services, providing the essential clinical interventions when needed, remain a core feature.
4. The health and social care workforce are men and women with needs and rights, operating in dynamic labour markets and their opportunities for decent work, protection and safety and an

enabling environment correlate with the wider SDG goals, including economic opportunity, education, employment and gender.

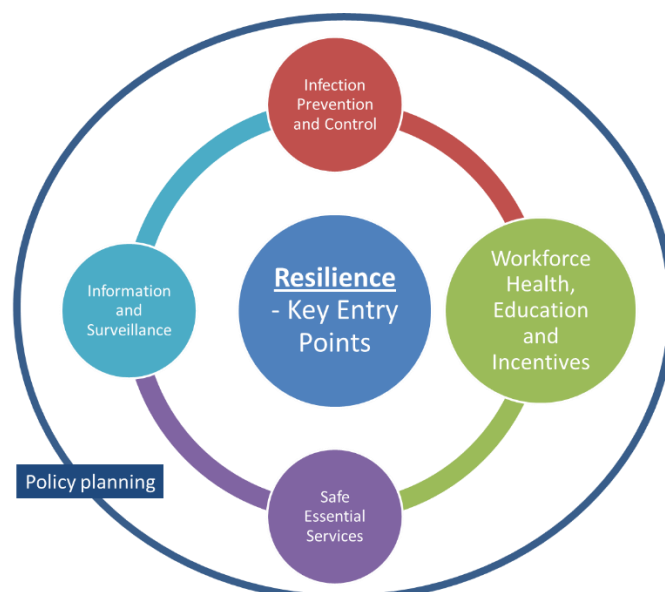
Considerable new evidence has emerged on the dynamic nature of health labour markets and the mobility of health workers, which allows to understand the key drivers of the health workers' "crisis", and to design the appropriate policy responses in relation to the supply, demand, need in health labour markets at sub-national, national and global levels. Recent analyses [11] identify a projected needs-based gap of skilled health professionals of 10.1 million by 2030. Sub-Saharan Africa is the most affected region in both absolute and relative terms, with a projected deficit of 3.7 million. Conversely, projected demand (in economic terms) for health workers, fuelled by economic growth and population ageing, will increase significantly in upper-middle- and high income countries. Global demand for health workers will rise to 45 million additional professionals by 2030. The SDGs squarely reflect this reality, and Goal 3.c calls to "Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries"[2]. There is however a fundamental mismatch between population needs and market-based demands, as those countries where basic health needs are the greatest have the least economic resources to create employment positions in the public health sectors: their economic conditions (current and projected fiscal space) are not anticipated to allow for the necessary number of additional health care providers that the future SDG agenda requires. While the nature and consequences of the health workforce deficits differ between low and high income countries, the projections clearly suggest that the proposed goals and targets in the SDGs (and which are implicit in the GS2.0) will not be achieved unless this economic reality is positively disrupted with unprecedented international governance and solidarity, together with innovative and new approaches at national level to maximize the efficiency of spending of available resources

3) Response and priority interventions

The global discourse of sexual, reproductive, maternal, newborn, child and adolescent health and rights brings in new dynamics and higher aspirations. The ambition of "zero targets" (e.g. ending preventable maternal mortality; ending preventable newborn deaths; ending the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases) and 100% targets (e.g. universal health coverage) in Goal 3 of the SDGs is a major departure from the MDGs, requiring an unprecedented level of ambition. The GS2.0, with the multilateral partnerships that can be convened by the UNSG, can catalyse the necessary positive disruption and create a new contemporary agenda on resilient health systems and health workforce in support of maternal, child and adolescent health goals.

Embed resilience capacity in health system design

There is significant learning from the current EVD outbreak in West Africa on the role of health workforce strengthening for ensuring resilient health services for women and children. Structural and policy reforms to drive improvements in service delivery and health workforce require policy and planning that are evidence-based and implementation informed.



Health workforce strengthening is a core element of building system resilience, and it must encompass both short-term measures, such as health and safety programmes, continuing training, mobilization of community based workers, and recovery measures, including adjusting the fiscal space, adopting education strategies, locally appropriate incentive systems and skills mix, to effectively address long-term population needs. In addition, infection prevention & control represent a cornerstone of a functioning health system delivering safe and quality services. The development of integrated mechanisms to ensure continued delivery of essential health services during a health shock has to include the capacity to cater to the special needs of women and children. Just in time surveillance and information systems, using new technology such as mobile phones and rapid data collection forms, are the key to geographically targeted, locally owned data for decision making and improvement of care. Community engagement and ownership of local health services are required to establish a compact of trust between patients and the health system, and thus enhance appropriate utilization and sustainable provision of health care in the face of shocks.

Adopt a paradigm shift in how we perceive, plan, educate, deploy and reward health and social care workers.

The health workforce will be critical to achieving health and wider development objectives in the next decades. Addressing health workforce challenges effectively will reinforce the cohesion of societies and accelerate social and economic development. The GS2.0 can set the agenda in support of the SDGs: health workers are agents of sustainable development [20] and a catalyst for a life of dignity for all. The present language of Goals 2, 4, 5 and 8 require a commensurate paradigm shift in the future health and social care workforce to be created and sustained to achieve these ambitious goals.

The known 'obstetric transition' [21] that is inherent in Goal 3.1 of the SDGs has immediate implications to prepare a health workforce that is able to provide emergency obstetric and newborn services and access to family planning. Similarly, accelerated reductions in maternal and newborn mortality will require an accelerated increase in the number and distribution of skilled health professionals, with a particular focus on the midwifery workforce. New evidence on the potential of community-based and mid-level practitioners at the same time points to the potential for these cadres to contribute to a more diverse and sustainable skills mix, and to accelerate the coverage of essential SRMNCIAH interventions [21b, 21c]. Optimizing the competence and capacity of the health work force may not only bring key services such as contraceptive technologies closer to the communities but also improve coverage of key evidence-based interventions such as interventions to reduce morbidity and mortality from obstetric complications such as haemorrhage and pre-eclampsia/eclampsia. Although recommended internationally in many countries midwives are not empowered

to use vacuum extraction for difficult childbirth. In addition, the GS2.0 discussion paper on Sexual and Reproductive Health and Rights highlights the need for services for adolescent health and reproductive cancers, requires additional, advanced capacity and competence and a health workforce that is fit for purpose, award and practice.

Evidence-based planning and forecasting of workforce requirements, informed by reliable and updated health workforce information, health labour market analyses, and scanning of future scenarios will be required to inform the development and implementation of workforce strategies. A measurement and accountability framework for the SDGs can provide the foundations for new investments in national and sub-national health workforce information systems, [22] and enable the adoption of a National Health Workforce Account to produce the required information to facilitate health labour market analyses and health workforce planning. Critical to the effective implementation of health systems and health workforce strategies is adequate institutional capacity. Resilient health systems need, among other features, to have the capacity for analysing workforce data and labour economics; leading short- and long-term health workforce planning and development; advocating better working conditions, reward systems and career structures for health workers; strengthening the institutional environment for the design, development and delivery of pre-service and in-service education of health workers; supporting development of health professional associations; facilitating the collaboration with and regulation of private sector educational institutions and health providers; overseeing the design of effective performance management and reward systems; and monitoring and evaluating HRH interventions [11].

Take into account population growth and service need

Progress towards equitable access to quality health services requires addressing the unmet need for health services, including ensuring that all essential interventions in SRMNCAH are provided and reaching all population segments and geographical areas. Planning this service coverage expansion requires factoring in demographic changes. By 2050, 1 in every 3 births will be African [7]; yet there are huge inequities across the African continent and both historical trends and future projections indicate that equity can only be reached through specific and determined actions in support of vulnerable and underserved groups. The State of the World's Midwifery 2014 applied the concept of 'unmet need' to assess the capacity of the existing health workforce to deliver the recommended essential interventions for reproductive, maternal and newborn health (RMNH) in 73 countries. Additional comparative analysis of those data for the 49 LDCs shows an average unmet need for the RMNH essential interventions of 14.5 per cent (ranging from 1 to 68 per cent) by 2030⁸. The average masks, however, the inequity across or within countries. When further analysis is undertaken of the same data, many countries can be seen to be regressing. In these countries, public sector education, deployment and management of the health workforce are unable to keep pace with population growth and universal access to RMNH services. This requires a shift from a supply-driven approach to women's, children's and adolescents' health that leaves gaps of 'unmet need' to a needs-based approach, which provides services based on the principle of universal access to essential care.

Actions in non-health sectors impact on health systems, health workforce and RMNCAH outcomes, calling for greater attention to partnerships and harmonized platforms for tracking commitments, evaluating impact and assuring accountability for the production of the skilled and competent health workforce required for systems to be resilient. Multi-sectoral action and accountability platforms will be required to promote investments and to track impact. Much can be achieved if a global and comprehensive approach to tackle market failures and create the conditions for future health employment (particularly for women) and economic growth is implemented. This must be informed by improved intelligence in countries in order to undertake and act on robust labour market analyses.

4) Conclusion

In 2011, the World Health Assembly agreed a resolution on strengthening national health emergency and disaster management capacities and resilience of health systems. In 2014, fragile and poorly

⁸ Authors' calculations.

integrated health systems were key contributors to the Ebola crisis in West Africa. The need to re-design the delivery of health services with people at the centre was clearly apparent during the initial response, the early recovery phase as well as in long term planning for health systems resilience in the affected countries. A renewed focus on sub-national delivery systems, on quality improvement and on strengthening core public health capacities for disease surveillance and response that are fully integrated into the national health system also became evident as part of the reconstruction efforts. The experience has clear implications for integrated health services for mothers and children across the world and in particular fragile settings.

The health workforce is the backbone of any health systems, and it stands out as an area warranting a particular focus in designing and investing in resilient health systems. The past decade has increased recognition of the crucial importance of HRH, as reflected in numerous resolutions of intergovernmental bodies and global action plans endorsed by the United Nations. These provide the mandate, political framework and evidence-based guidance for action on the health workforce. In parallel, the UNSG has launched a call to action to people and leaders across the world in support of a truly transformative agenda beyond 2015 in order to ensure a life of dignity for all [23]. The attainment of the health targets under consideration in the SDGs requires substantive and strategic investments in the health and social care workforce. The on-going challenges of health workforce deficits and imbalances, prevalent in countries at all levels of socio-economic development, combined with ageing populations and epidemiologic transitions, require the global community to re-appraise and re-evaluate the effectiveness of past efforts to increase the health workforce, and rapidly develop a new, contemporary agenda for HRH. This presents an opportunity to ensure that much needed investments in the health workforce also lead to the creation of qualified employment opportunities, in particular for women, spurring economic growth.

Such transformation encompasses a redefinition of the scope of practice and functions of different categories of health workers, new team compositions, a well-balanced distribution of health workforce between different levels of care, improved management systems for enhanced motivation, quality and performance of the health workforce, appropriate incentive structures and transformation of pre-service and in-service training to build the resilient health systems required. A radical transformation of implementation efforts at country level is required which:

- Recognizes health and social care as an opportunity for growth, and the workforce necessary for implementing the SDGs as a commensurate investment.
- Recognizes that the creation of employment opportunities in health and social care is particularly beneficial to women, improving gender equity and a driver of socio-economic development;
- Over-hauls national and global governance to deliver a substantive scale-up of domestic public sector and international financing to meet systems and workforce needs;
- Moves towards optimization of the existing systems and workforce, made possible by stronger national institutions, able to devise and implement more effective strategies to ensure the resilience of healthcare systems, with a more sustainable and responsive skills' mix, flexible deployment of the health workforce, and improved working conditions, reward systems and career pathways.

Securing the needed political will, ensuring effective governance in countries, aligning the required efforts of different sectors and constituencies in society, and accountability are critical to achieve the radical transformation. A fit for purpose mechanism for global governance for health systems and health workforce is needed that aligns international support to needs of national health systems: the scale of the challenges and magnitude of the ambitions require a global approach underpinned by a commitment to international solidarity. Many LDC will lack the resources needed for resilient health systems able to deliver on the vision of the GS 2.0: in these contexts it is necessary that the required investments should be co-funded by the international community to complement domestic resources mobilised; channelled through enhanced financing mechanisms that enable sustainable and long-term investment in capital and recurrent costs for the health workforce, in alignment with national needs; and target capacity-building efforts at institutional, organizational and individual levels [11].

To accelerate implementation of this agenda, global accountability mechanisms should be put in place, effectively linked with UN system processes and mechanisms for monitoring of Universal Health Coverage (UHC) and SDGs.

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Annex 1: SDG goals and targets relevant to health systems resilience and health workforce.

To follow.