Incorporating the Right to Health into Health Workforce Plans

Key Considerations

Health Workforce Advocacy Initiative
Using an easily accessible format, this document offers guidance to policymakers and advocates on how to ensure that human rights, and in particular the right to health, inform the process of developing, funding, and monitoring health workforce plans, and the content of those plans. Such an approach is an obligation of countries and recognized good practice. Moreover, it will contribute to country efforts to successfully develop a robust, accountable, effective, and equitably distributed health workforce that meets the health needs of the entire population.

These human rights considerations, presented in the form of questions, provide an overview of ways in which the right to health can – and should – be incorporated into health workforce plans, and should assist in guiding the development of these plans, as well as associated policies. These questions can also be used as a basis for evaluating existing health workforce plans to determine how well they conform to the right to health. In some cases, it may be that the plan itself does not provide a particular policy or intervention described below, but does establish a process and timeline for developing and implementing it.

These considerations are grouped in the following categories:

- Recognition
- Objectives
- Participatory process
- Equity and non-discrimination
- Comprehensiveness
- Quality
- Financing
- Accountability
- Sustainability

Recognition

1. Does the plan explicitly recognize the right to health?¹

Objectives

1. Is the plan designed to develop the health workforce that is needed to meet the health needs of the population, including by achieving national, regional, and global health commitments and obligations, such as the Millennium Development Goals and the African Union’s commitment to universal access to an essential health package for prevention, care, and treatment by 2015?²

2. Does the plan explicitly recognize the need to achieve universal access to primary, secondary, tertiary, and mental health services, and include benchmarks towards this goal, even if achieving this goal may be beyond the plan’s timeframe?

Participatory process

1. Is there a policy to ensure that all stakeholder groups, including civil society (including advocacy NGOs, service delivery NGOs, and members or representatives of marginalized populations), health workers, and the private sector, participate in developing the health workforce plan?

2. Has funding been provided for the planning process to ensure that it is a genuinely participatory process, involving a wide range of stakeholders?

3. Will funds be available to support participatory monitoring and evaluation of the plan’s implementation?

4. Is civil society engaged in the health workforce planning process from the first stages of developing the plan?
   a. Are national health consumer groups or their equivalents (representing health system users) included as part of this civil society engagement?

5. Do members of marginalized groups (and, as appropriate, their representatives) participate in the planning process? These groups include: people living with HIV/AIDS, people with disabilities (mental and physical), the rural poor, the urban poor, indigenous populations, ethnic and national minorities, the elderly, youth and children, women and girls.
   a. Have these members of marginalized groups been selected to participate through a fair process, one not controlled by the government? And do members of marginalized populations conscientiously represent these groups’ concerns? For example, the fact that women are part of the planning process does not automatically mean that women’s concerns are fully considered in the planning process, though a high proportion or number of women involved in the planning process would be indicative that such concerns have been voiced and are being taken into account.

6. Are civil society participants who might not be expert in health workforce issues treated respectfully during the planning process?


7. Are civil society members who are part of the planning process meaningfully informed on health and health workforce issues and the planning process in order to facilitate their effective engagement?

8. Is there a process to review how satisfied members of marginalized communities, health workers, and national health consumer groups are that their concerns were seriously considered and adequately addressed in the health workforce plan? If so, are they satisfied?

9. Did non-public sector health providers (including NGOs and other not-for profit providers, faith-based organizations, for-profit providers, and practitioners of traditional medicine) contribute to developing the plan?

10. Do health workers of all categories and levels (including home and community caregivers, community health workers, and traditional healers) have an opportunity to fully participate in the planning process?

**Equity and non-discrimination**

1. Has the country assessed what populations have reduced access to health services, and if so, why and what role health workforce-related factors (e.g., misdistribution, discrimination, unrepresentative workforce) may contribute to such reduced access?

2. Has research been conducted (e.g., surveys, focus groups, interviews of key informants) to determine the extent to which certain measures, such as different incentives packages, are likely to attract health workers to and retain them in rural and other underserved areas?

3. Are most or all of the following measures included in the health workforce plan?
   a. Incentives to health workers to serve in rural and other areas that have been identified as remote, hard-to-reach, or are otherwise underserved (this may include urban slums);
   b. Measures to ensure that rural health facilities have at least basic levels of infrastructure (e.g., running water, electricity, adequate supplies of medicine and equipment) (these may be part of an overall national health strategy, and not necessarily part of a workforce plan);
   c. Adequate opportunities for professional development;
   d. Measures to reduce professional and social isolation (such as Internet connections, distance learning programs, and visits by specialists or other health workers who can provide on-site learning opportunities);
   e. Strategies to recruit to health worker training institutions students from rural and other underserved areas;
   f. Strategies to recruit to health worker training institutions students from marginalized and disadvantaged populations, including indigenous populations;
   g. Pre-service training curriculum and programs that prepare students to work in rural areas (such as a curriculum that emphasizes primary health needs, and programs to enable students to serve in rural areas as part of their professional training);
   h. Measures to ensure that health workers in rural and other underserved areas receive regular, supportive supervision;
   i. Consideration given to what health worker cadres are most likely to serve in rural and other underserved areas when determining the appropriate skills mix (including, for example, community health workers, community nurses, and non-physician clinicians [e.g., clinical officers], and with respect to physicians, the balance between generalist and specialist physicians);
   j. Community service requirements for newly trained health professionals;
   k. Other measures aimed at increasing the number of health workers in rural and other underserved areas (such as special programs to hire health workers to serve in these areas, e.g., Kenya’s Emergency Hiring Program).
4. Is a comprehensive strategy in place to reduce discrimination by health workers against marginalized and disadvantaged populations, such as people living with HIV/AIDS, women, indigenous populations, injecting drug users, ethnic minorities, sexual minorities, and disabled (physically and mentally) people? Such a strategy will include such measures as:
   a. Pre-service and in-service training to address discrimination, stigmatization, gender sensitivity and equity, cultural diversity, and patients’ rights;
   b. Mechanisms for people who believe that have been discriminated against (or have otherwise had their rights violated by health workers) to file complaints and seek redress;
   c. Special training to ensure sensitivity to the rights of all people for health workers in leadership positions (e.g., in professional associations, at health ministries, at health facilities);
   d. Sanctions for health workers who do discriminate against patients;
   e. Training on universal precautions and provision of sufficient supplies and equipment (e.g., gloves, syringes with safety features, and sharps disposal boxes) to enable health workers to adhere to universal precautions.

If such measures are in place, is their effectiveness regularly monitored? If they are, where the effectiveness is unsatisfactory, is there a process whereby such measures will be revised and strengthened?

5. Are sufficient numbers of health workers being trained and deployed who speak indigenous languages?

6. Do the plans specifically recognize and address needs that may be most prominent for women? These may include opportunities for flexible working hours, availability of child care, and adequate security and transportation arrangements, particularly in rural areas.

7. Are women adequately represented in senior health leadership positions (e.g., professional associations, high-level health ministry positions)?

8. Does the plan address workplace violence and sexual harassment?

9. Is the wage structure and allowance structure equitable among the different categories of health workers, including not disadvantaging health workers who work with rural or other underserved or marginalized populations, and not discriminating against categories of health workers that are primarily filled by women (e.g., nurses)?

10. If user fees are being abolished, does the health workforce plan account for the increased utilization of health services that can be expected to result?

Comprehensiveness

1. Has a comprehensive national health workforce situation analysis been undertaken? Does the health workforce plan address the gaps in the situation analysis?

2. Does the health workforce plan encompass both physical and mental health, and the population's preventative, curative, and rehabilitative health needs?

3. Is the plan designed to address various dimensions of the health workforce, including health worker numbers, distribution, productivity, and quality?

4. Does the plan (and overall workforce response) address the six components of the Human Resources for Health (HRH) Action Framework (developed by the Global Health Workforce Alliance, WHO, and USAID), namely policy, finance, education, partnerships, leadership, and management?

5. Is the health workforce plan linked to and coordinated with the overall national health strategy, including to ensure that health workers have the medicines and other tools and equipment that they need to do their jobs and decent working conditions, and to develop the health workforce that can match the goals of the health strategy?

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3 This framework is available at: http://www.capacityproject.org/framework/.
6. Is the health workforce plan connected to improving underlying determinants of health, including clean water and adequate sanitation and an adequate supply of food? Approaches might include giving health workers roles in public education about nutrition and proper hygiene; enabling them to provide people products (e.g., special jugs and decontamination solutions to improve access to safe water) that can improve access to these underlying determinants; incorporating information about these underlying determinants in health workers’ own training curricula, and; ensuring that health workers have the proper knowledge to refer people to other services that directly address these underlying determinants, including income-generation programs, legal services, and nutrition programs.

7. Does the plan comprehensively address health workers’ needs, including safe working conditions, health care, adequate pay, sufficient supplies, and psychosocial support?

8. Does the plan provide for ensuring that health workers themselves have access to comprehensive, confidential health services, including HIV/AIDS prevention, care, treatment, and support?

9. Does the plan include measures, such as part-time work or long-term sick leave, to accommodate the needs of health workers living with HIV/AIDS and other chronic diseases (for example, part-time work opportunities or long-term sick leave)?

10. Does the plan seek to maximize the available human resources to address health needs by looking to all available or potentially available sources of health workers, including community members (i.e., community health workers), expanded use of mid-level health workers (e.g., clinical officers, surgical technicians), the country’s health professional diaspora, retired health workers, health workers who are unemployed or working in other fields, and foreign health professionals (consistent with ethical recruitment processes)?

11. Does the plan address non-public sector health providers, including containing information on their current profile, or does it include measures to gather information on non-public sector health providers, including to incorporate non-public health sector providers in national health information systems?

12. Does the plan incorporate strategies to leverage non-public sector health providers to contribute to national health goals (e.g., by contracting out certain services to private health providers, paying private health providers to staff public health facilities)?

13. Does the plan explicitly consider how the health workforce will meet the requirements for and respond to any unique workforce needs of particular diseases or health conditions, such as maternal mortality and HIV/AIDS? If needed, does the plan utilize innovative approaches (e.g., the use of mid-level health workers to provide emergency obstetrics care, or training nurses in additional competencies and developing adherence counselors and other community health workers to support HIV/AIDS treatment, prevention, care, and support) towards this end?

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**Quality**

1. Do the pre-service curricula and programs of health training institutions address the major health needs of the population and prepare students for the actual (often low-resource) environments in which they will work, including rural settings? If not, will the curricula and programs be revised?

2. Does the plan include or set into motion the development of (where one does not exist) a coherent program of in-service training that is based on the country’s health needs, will contribute to professional development and ensure that health workers have up-to-date skills and knowledge, and maximizes on-site training?

3. Does the plan include measures to enable all health workers to receive regular, supportive supervision?

4. If the plan includes performance-based standards, have they been evaluated or designed to minimize the risk of possible unintended, adverse consequences?

5. Does health worker training include training on ethical standards, and if not, does the plan provide for incorporating such standards into pre-service training?
6. Are measures in place to ensure that community health workers are able to provide quality care, including providing them training adequate to the tasks that they are to performing, ensuring adequate supervision and linkages to other parts of the health system, and having clearly defined roles?

7. Does the plan include adequate measures to assure the quality of private sector health providers, such as regulating private sector health training institutions and their accreditation, developing clear and transparent regulations on quality standards, and developing the capacity to enforce these regulations (such as through developing or strengthening regulatory bodies, improving training for and increasing the numbers of inspectors, and involving professional associations and counsels in enforcing quality standards)?

Financing

1. Does a budget, including estimates of funding gaps, accompany the plan?
2. If there are insufficient resources to fully implement the plan, have measures to improve the equitable distribution of health workers and increase access to health services by poor and marginalized populations been prioritized?
3. Is the country allocating the maximum of its available resources to the health sector and towards fulfilling the country’s right to health obligations?4
4. For African countries, is the country meeting its Abuja Declaration commitment to spend at least 15% of its budget on the health sector, or does it have a near-term timeline to achieve this level of spending?
5. Is the country actively seeking funds from all available potential external sources of financing to fill any funding gap in the plan, including the Global Fund to Fight AIDS, Tuberculosis and Malaria?

Accountability

1. Is the plan publically accessible, and are measures being taken to enable the population to know what to expect under the plan? Key information that people should know could include the planned staffing levels at local health facilities and what recourse they have if they suffer discrimination by health workers. Measures to inform the population might include translating the plan or major points into indigenous languages, disseminating key parts of the plan over radio, and posting pertinent information at health facilities.
2. Does the plan include a robust monitoring and evaluation strategy that will actively seek feedback from both health workers and health system users?
3. Does the plan include a formal process to review the implementation of the plan and to address any shortcomings in implementation?

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4 Factors in determining whether governments are spending the maximum available resources on fulfilling their human rights, and in particular their right to health, obligations include: comparing government health spending (including total spending, spending as a proportion of the Gross National Income [GNI], and spending as a proportion of overall government spending) to comparable countries (for example, countries in the same region or with similar per capita income levels); comparing government health spending levels to relevant government commitments; measuring how spending has changed over time, how changes in health spending compare to changes in GNI, how health spending compares to other areas of the budget (and how these other areas relate to advancing human rights), and what the government actually spends on health (and other budget areas) compared to what it budgets, and; examining government revenue and opportunities to increase the resources available to it, including the proportion of GNI that tax revenue constitutes (how this compares to international standards and comparable countries) and to what extent the government is actively seeking international assistance.
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1. Is domestic financing being prioritized for health worker interventions that will contribute to increased access for poor, marginalized, and otherwise underserved populations?

2. Is the health workforce plan linked to other national planning and budget processes, such as the overall national health strategy, Poverty Reduction Strategy Paper, and Medium Term Expenditure Framework?

3. Does the plan have multiple budget scenarios, including one aimed at fully implementing the plan and developing the workforce designed to be sufficient to meet the Millennium Development Goals and other health commitments?

4. Do civil society and health ministry officials have the opportunity to meaningfully participate in finance ministry, IMF, and central bank discussions that set macroeconomic policies (such as fiscal deficit and inflation targets)?

5. Does health worker pre-service training (across the range of health worker categories) include education on the right to health and other human rights?5

6. Will training on human rights, including the right to health, be provided through in-service training for current health workers?

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5 This education should include health workers’ own responsibilities, such as to treat all patients respectfully and without discrimination, and to respect confidentiality, but should be much broader than this. “Health professionals can use health-related rights to help them devise more equitable policies and programmes; to place important health issues higher up national and international agendas; to secure better coordination across health-related sectors; to raise more funds from the Treasury; to leverage more funds from developed countries to developing countries; in some countries, to improve the terms and conditions of those working in the health sector; and so on. It is crucial that many more health professionals come to appreciate that the right to the highest attainable standard of health is not just a rhetorical device, but also a tool that can save lives and reduce suffering, especially among the most disadvantaged.” Paul Hunt, Implementation of General Assembly Resolution 60/251 of 15 March 2006 Entitled “Human Rights Council,” Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. U.N. Doc. A/HRC/4/28 (Jan. 11, 2007), at para. 44. Available at: http://www2.essex.ac.uk/human%5Frights%5Fcentre/rth/docs/council.pdf.