Global Health Writes Citizen Journalists

Loice Epetiru, Kampala, Uganda

Loice Epetiru is a Development Communicator who recently completed a Post Graduate Diploma in Project Planning and Management at Uganda Management Institute in Uganda after graduating with a Bachelors of Arts in Mass Communication. Loice loves communicating development related issues with a keen eye on health: human resources for health, leadership, governance and financing for health. She is currently working as a Communications' Specialist at African Centre for Global Health and Social Transformation (ACHEST).

Jenny Y.C. Lee, Dublin, Ireland

Recently graduated with a BSc from the University of British Columbia in Canada, Jenny is a young professional working at the Swiss Research Institute for Public Health and Addiction. As a previous intern at the World Health Organization (WHO), she shares the same collective vision that universal health coverage is an ethical imperative and understands the importance of health workforce as health workers are the core of our health systems.

Tsion Fikre, Boston, US

Tsion Fikre is a senior at Boston University, majoring in Health Science, and is currently studying at Dublin City University for the semester. She is a research intern at Concern Worldwide in the Strategic Advocacy & Learning - Health & HIV Unit.

Moy Bracken, Dublin, Ireland

Moy Bracken recently graduated from the Masters in Global Health Programme at Trinity College Dublin. Moy's interests cover the areas of epidemiology, access to medicines, and achieving health equity. She is currently working as a locum pharmacist in Dublin.

Ifunanya Ikhile, Nottingham, UK

Ifunanya is a Pharmacist, a passionate educator, has worked as a lecturer at the University of Port Harcourt, Nigeria for four years and is currently pursuing a PhD at the University of Nottingham, United Kingdom, Division of Pharmacy Practice and Policy. Her current goal is to improve Pharmacy Education in Lower and Lower-Middle Income countries through a needs-based approach. She had acquired broad professional experience spanning Oncology with Pfizer, Community Pharmacy, Urban and Rural Hospitals, Specialized Pharmaceutical Care, Pharmacy Administration, Industrial Pharmacy, Charity Organizations, and Academia. She loves reading, and meeting people.

Margarite Nathe, Chapel Hill, US

Margarite Nathe is senior editor/writer at IntraHealth International. As part of IntraHealth's communications team and editor of the blog VITAL, she writes about global health, international development, and making the world a healthier place for all 7.6 billion of us.

Jennifer Trainor, Dublin, Ireland

Jennifer Trainor is a registered nurse from Montreal, Canada, with experience in neonatal and obstetrical nursing. She is currently pursuing a PhD in nursing and global health at Trinity College Dublin, Ireland, with a focus in maternal and child health. In her spare time, Jennifer enjoys SCUBA diving and horseback riding.

Global Health Writes Citizen Journalists

FINGER ON THE PULSE

Views from the Fourth Global Forum on Human Resources for Health

VOLUME 01

Acknowledgements

The Irish Forum for Global Health would like to gratefully acknowledge the work of the Global Health Writes Citizen Journalists, whose insight, creativity and passion for global health made this project possible. They are:

Laice Epetiru, Uganda
Jenny Y.C. Lee, Ireland
Tsion Fikre, US
Moy Bracken, Ireland
Ifunanya Ikhile, UK
Margarite Nathe, US
Jennifer Trainor, Ireland

We would also like to thank our team of editors, coordinators and administrators for their hard work in facilitating this project, from the drawing board all the way to this publication.

We are particularly grateful to the work of our lead editor Ian Hodgson, who provided invaluable training sessions to the Citizen Journalists and whose work in bringing these articles together is greatly appreciated. As coordinator, Steve MacDonald was instrumental in realising this project, with the help of our layout and design editor Eimhin O'Reilly.

The WHO was a huge source of support for this project, and we would like to acknowledge the work of Sonali Reddy in particular. We would also like to thank our operations director, Nadine Ferris-France, and David Weakliam of the HSE and the IFGH board, for their tireless work in bringing the Fourth Forum together, and facilitating the work of our citizen journalists.

Finally, we would like to thank all the speakers and attendees of the Fourth Global Forum on Human Resources for Health for their enriching perspectives and contributions to the debate on HRH.

Global Health Writes Programme

Global Health Writes Programme is an initiative by the Irish Forum for Global Health to support young professionals in developing their writings and journalism skills for advocacy in matters of global health and international development. GHW workshops are held twice per year, focusing on timely and relevant topics. Participants are taught writing and messaging skills, and explore new media creation such as video blogging. The Citizen Journalists then produce articles using the writing format and media of their choice. The GHW team provides collaborative editorial support and feedback to the writers, and the IFGH hosts the finished articles on its website, and promotes them via its social media and email channels.

For more information, please contact info@globalhealth.ie.

Republication

Note from the Editor

Over five days last November, the Fourth Global Forum for Human Resources for Health brought over 1,000 delegates to Dublin's RDS Hall. Hailing from over 70 countries, and with a wealth of experience in a wide range of fields, the attendees were united in their desire to build a strong and sustainable global health system.
They were joined by a team of citizen journalists, a group of people with diverse skills, backgrounds and interests, but a common passion for the challenges and opportunities of global health work. Although most of them had never received prior journalistic training, their clear enthusiasm for the role and their impressive writing skills shine through with every word.

The following twenty articles were selected from their contributions for the diversity of perspectives and insights they offer. While they have been grouped together under the four headings **Taking a Toll, Cross-Cutting Issues, Filling the Gaps and Looking Ahead**, each story invites its own comparisons, and helps to build a clear picture of the state of Human Resources in Global Health today.

The challenges we face are considerable. If present trends continue, there will be a shortfall of 18 million health workers by 2030, a situation that will only exacerbate existing inequalities between North and South, urban and rural (as described in Tsion Fikre's **Equip and Send**). At the same time, security concerns (like the attacks described in Margarite Nathe's chilling **The Humanity behind Frontline Healthcare**) and burnout (**Nursing and Midwifery Leaders, I am Listening**) are driving young, talented health professionals away from their careers of choice, and often to other countries.
But the good news is that the solutions are there. As the articles in **Filling the Gaps** point out, increasing investment in healthcare will not only improve health outcomes, UN research shows that it will actually boost the economy as well. And while there is no panacea, the kinds of intersectoral partnerships proposed in this section are a very good place to start.

The Fourth Forum concluded with the unanimous adoption of the **Dublin Declaration**, a cross-sector and transformative accord to set to improve the lives of health workers and their patients at global, regional and national levels through a holistic approach across both education and job creation, particularly for women and young people.
This declaration sends a powerful message in solving the Human Resources for Health crisis, but it was only made possible through health workers at all levels coming together to share their ideas, their experiences, and most of all their stories. We hope that sharing these stories with you will inspire you just the same.

Eimhin O'Reilly

Contents:

TAKING A TOLL

From security to simple burnout, what are the factors driving health workers away from their professions?

What Exactly Motivates and Retains Health Workers–and How Do We Measure It?

By Margarite Nathe

Human beings do weird things sometimes. Or maybe the things we do as individuals only seem weird to others because they don't know our particular quirks, preferences, and priorities. Think about it: Why do you live where you live? How did you choose your job? What makes you go back to work day after day? The answers are different for us all.

Maybe we want to live close to our family. Maybe we love the city life, or our hometown is the only place we want to live. Or maybe we choose our jobs based on what pays the best, or what feels the most rewarding, or what works with raising our kids. People's potential motivations are myriad. And health workers are no exception.

Here at the Fourth Global Forum on Human Resources for Health, the motivations of health workers have been a topic of special interest, from what it takes to entice them to live and work in rural Kenya to what subtle circumstances might cause a nurse in India to refer a client away to another facility—despite having the skills and resources to treat her in the moment.

The researchers, policy-makers, and global health experts assembled in Dublin want to know the answers to these questions in part to help solve the vast maldistribution of health workers in countries around the world, where many—particularly specialists—tend to be clustered in cities, leaving rural or remote populations with less access to much-needed health care.

But more than that, attendees at the Forum want to know how to answer these questions. How exactly do we measure happiness at work? How do we measure how much likelier an employee might be to stay if given a raise, or an award, or a different boss?

The questions start the moment a student graduates from a health professional program and enters the workforce. The Royal College of Surgeons in Ireland, for instance, wants to understand when and why new doctors leave Ireland to practice in one of five main destination countries (Australia, Canada, New Zealand, the United States, or the United Kingdom). In fact, at the time of their graduation, one in five Irish trainees says they intend to practice medicine elsewhere. And once they leave, even if they're thinking of it as temporary, the chances that they'll return home become slimmer.

Ruairi Brugha, a professor at the Royal College of Surgeons in Ireland who led the Doctor Emigration Project during 2014–2016, notes that, "one shouldn't be seeing these kinds of emigration rates in early-career doctors." According to the project's survey results, only 53% of respondents who had already moved abroad to work in fellowship positions intended to eventually return to Ireland. (Surveys, Brugha points out, are not really ideal for long-term data collection. And this is the type of data countries ought to collect long-term, so we need other methods.)

In India, researchers are asking similar questions as they work to track medical graduates in the country. Why, for example, asked Aarushi Bhatnagar of Oxford Policy Management yesterday, do 75% of the doctors who graduate in Kerala, India, stay in Kerala—a state that produces a lot of health workers and already has high availability of health services—while only 53% of doctors who graduate in Bihar have stayed—despite the state's low availability of health workers?

There are a lot of reasons health workers move. Better pay, yes, but there's also availability of child care, good schools for their children, adequate housing, security and other factors. Of course, there's more to fixing the maldistribution of health workers than understanding motivations about where they want to live.

Countries also need data on how many health workers they already have, what they're qualified to do, and where they're stationed. Before Kenya decentralized its health system management from one national hub to 47 individual county governments in 2013, two big rooms within the Ministry of Health were packed with the cluttered paperwork that held these data. Over 50,000 personnel files were stacked high, creating a chaos in which it was difficult to find anything you needed, and impossible to aggregate the data there into a bigger picture of Kenya's health workforce. "But when you have a problem," Robert Nguni of IntraHealth International says, "walk to the other side of it—and turn it into a solution."

IntraHealth worked with the Kenyan government to organize and digitize their personnel files and enter them into IntraHealth's open source human resources information system, iHRIS. Now all the counties and national stakeholders have access to information on more than 57,000 health workers, including where they're stationed and what training they've had.

I can't help but imagine what would happen if we could somehow combine the power of iHRIS data with what we know about the most effective incentive frameworks for health workers—like the one that helped transform Turkana County, Kenya, from a place where health workers were sent as punishment into a highly sought-after assignment location. All those data could be a powerful combination—one that could put health care within reach for millions more people.

A health worker in Turkana, Kenya examines children for trachoma.

The Humanity behind Frontline Healthcare

By Margarite Nathe

The job is difficult, frustrating, risky—and immensely rewarding - Health Assistance to Central African Refugees .

© European Union/ECHO/ Aminata Diagne Barre

"Please don't rape me. Please don't rape me. Please don't rape me". This is what was going through Rushaana Gallow's mind in 2015 when one of the men who had climbed into her ambulance to rob it put his hand inside her shirt. She and another emergency medical technician had been prepping to take on a patient who was having chest pains in one of Cape Town, South Africa's "red zones"—areas so dangerous that health workers aren't permitted to enter without a police escort—when they were attacked.

"I've been shot at," Gallow told the audience during the first day of the Fourth Global Forum on Human Resources for Health. "I've been assaulted by patients' families and friends. I've ended up with multiple injuries." Sometimes her friends ask why she keeps going back to a job that's so difficult and dangerous, but her response is unwavering. "I have a passion for what I do," she tells them. "I love it."

Rushaana was one of six frontline health workers from around the world on stage for the Forum's storytelling session. Each one told us about the moments from their careers that most terrified, elated, or surprised them—and what keeps them going to work every day despite the challenges.

It was a surprisingly humanizing end to the first day of a conference that's drawn over 1,000 health workforce experts and global health specialists from around the world to Dublin, Ireland. Other topics throughout the day included health policy, financing, and data meta-analysis—all important, but unlikely to leave a lump in your throat.

I realized as the frontline health workers were speaking that the acronym "HRH" doesn't do them justice. They are the human resources for health, the living beings that make any level of expert care possible. But the terminology will never capture what it takes to help a mother deliver her baby on a Liberian roadside by the light of a mobile phone. Or to watch helplessly as a cardiac patient dies, despite everything you've done to try to help him. Or to hear a client say, "You've given me hope."

Not every day on the front lines of health care is an inspiration, of course. The job is gruelling and risky and frustrating. During the best moments, health workers like Gallow take comfort in knowing that they help the people of their communities—whose smiles, tears, and thanks make any other job unimaginable. Other times, though, they feel like they're struggling to keep the conveyor belt of endless patients moving along, with too few resources to do the job well. The job is made even more difficult by the worldwide shortage of health workers, which, according the World Health Organization, could reach 18 million by 2030 unless we manage to create 40 million new health sector jobs before then. This is a major barrier to reaching universal health coverage or any of the other aspirations we've set for ourselves through the global Sustainable Development Goals.

The hope of solving this challenge lay at the heart of the Forum, of not only filling the shortage of health workers, but to build the ideal workforce of the future. One that can care for our changing, growing global population. One that's ready for a rising tide of non-communicable diseases and unexpected epidemics. One that has the training and resources it needs to provide health care to all 7.6 billion of us.

Targeted

By Jennifer Trainor

"Welcome to my world". These were some of the first haunting words uttered by the WHO's Dr Rudi Coninx, as he pointed to a picture of a city in ruin. The room was silent.
"In my world, hospitals are under attack."

This was only one account of the current aggression and violence toward health personnel in the session Health Care in Danger: How to Better Prepare and Protect Health Care Personnel. Accounts were also presented by Dr Juan Garrote, General Council of Medical Colleges (Spain) and Dr Lubyanka Baig, Jinnah Sindh Medical University (Karrachi, Pakistan).

Each speaker presented different contexts on how health workers and the infrastructure were being targeted, and how health is ultimately impacted. There were examples of armed violence and attacks on health facilities in conflict zones, and the recent research on the violence and aggression against the health workforce in Spain and Karachi, Pakistan.

As a nursing professional, I was horrified at some of the accounts that I heard. Imagine going to work every day and risking your life to save the lives of others. And yet, this is the daily reality of countless health workers around the world. In 2016, there were 302 attacks in 20 countries on health staff, health centres and ambulances. 62% were reported to be deliberate attacks on health facilities and personnel, with 561 injuries and 418 deaths.

When health personnel and health centres are targeted, the entire health system suffers. A hospital is not rebuilt overnight when destroyed. A medical professional is not trained within a few weeks if they are injured, killed, or decide to leave the profession altogether due to constant harassment and risk of violence. Everybody feels the repercussions.

These attacks rob citizens of desperately needed care. Dr Tedros Adhanom Ghebreyesus, WHO Director-General, is clear in his stance: "Health workers must not be a target. Every attack on a health worker is a loss that ripples out to communities and through health systems. WHO stands ready to protect health workers so they can get on with their jobs and save lives."

This is a very frightening truth. However, the world will not be silenced. The health workers and the infrastructure need to be protected. This is everybody's business. The conversation has to continue. Research is central to further understand the phenomena, which inform policy and law makers on how to initiate change. In his closing statement, Dr Coninx issued a rallying call to all involved in international health to work together to address the issue of violence against health workers:

> This is a global issue. It is here to stay. We will have to work on it all together to make sure that the issue is being addressed. So, we count on the international community and also all the health professionals [and] all the health researchers to provide us with more evidence, so that we can make evidenced-based recommendations to the people who can make the difference.

Everyday Violence Takes a Toll on us All

By Margarite Nathe

Over September 2017, there were a total of 10 attacks on Syrian health care facilities in 10 days. Air-to-surface missiles sought out and destroyed ambulances and hospitals, killing the people inside them. I follow the news, I've read the devastating reports from organisations like Safeguarding Health in Conflict Coalition.

Catastrophic attacks like this have escalated and, in fact, 2016 was the worst year on record for such violence. War is a dangerous time for health workers and their clients, despite the Geneva Convention's ban on such crimes. But I didn't realize until this week at the Fourth Global Forum on Human Resources for Health the extent of everyday violence health workers face around the world. Slapping. Kicking. Pushing. Verbal abuse.

In some US states, nursing is more dangerous than being a police officer or a prison guard. In Spain, the problem is so widespread that the government has created a national observatory for violence against health workers to collect data about the attacks. Media advocacy campaigns have led to changes in the penal codes, so that attacks against health workers are now punished as severely as those against public servants. In fact, Spain has even created a national day against attacks on health care professionals (March 16) and a hashtag campaign (#stopagresiones). In Pakistan, Lubna Baig, pro-vice chancellor of Jinnah Sindh Medical University, describes the surprisingly high tolerance Pakistani health workers have for everyday abuse.

Baig was the principal investigator in a 2015 study in Karachi, Pakistan, to pinpoint evidence-based strategies that prevent violence. Pakistan has a big problem in this area, Baig said. Every day, health workers are being shot or kidnapped, vaccinators killed, ambulance drivers attacked. "That's just the tip of the iceberg," she added. When the researchers talked to health workers in Karachi, they found that 66% of those interviewed had experienced or witnessed violence. Many are just used to it. "They might say, 'Abusive language and a little bit of pushing are no big deal," Baig said, "'but if I get a broken tooth, that's not okay.'" Of course, none of it is okay.

What's the cost of this everyday violence against health workers? And how can we measure and manage it? Collecting credible, unbiased data on violence against health in times of war is incredibly difficult (though a real-time collection method in Syria highlighted in The Lancet last year is showing promising results). Everyday violence is even tougher to quantify. Baig estimates that over half of incidents go unreported.

But there are some methods that are proving effective in preventing it. In Pakistan, officials are seeing great results after developing training for physicians on how to deescalate violence, including how to sense when it's coming. The training, Baig said, has improved health workers' confidence and made them better able to deal with violence when it does happen. "Why not consider after-action reviews when there are incidents of violence, to determine what happened leading up to it and what could have been done to deescalate it?" Barbara Stilwell, senior director of health workforce solutions at IntraHealth International, suggested at the forum. "The military does this, but we don't tend to do it in the health sector. And what about mental health support for health workers who've been attacked?"

The uptick in complex global emergencies has resulted in prolonged stressful conditions for health workers around the world, and yet, Stilwell says, mental well-being for health workers is often overlooked. We know that, particularly in low-income countries where health worker shortages are most severe, the loss of even one health worker can leave thousands of people without health care. We lose too many health workers not only to catastrophic violence, but also to stress. Imagine being shoved by a stranger, spit on by a client, yelled at by the people you're responsible for helping—day after day. It would be upsetting for anyone. And the quality of care they could provide would likely decline.

"This is a global problem," says Rudi Coninx of the World Health Organization. "It's here to stay. So we all have to work together solve it."

Real Heroes Don't Wear Capes: The Role of Health Workers in Emergencies

By Moy Bracken

"We feel a responsibility towards the people of Southern Sudan, but we need support"
- A Sudanese health worker at the 4th Global Forum.
© EU/ECHO/Anouk Delafortrie

Three scenarios from different contexts, but the similarities are striking. The role of the health worker in emergency relief is vital. Infectious outbreaks, natural disasters and conflict all result in increased demands on health workers. Situations are further complicated when the health system is already in chaos. Speakers from Liberia, Nepal and Sudan documented the bravery of health workers in their countries at the 4th Global forum for Human Resources for Health. Their stories brought home the crux of the matter: health workers are people too. In times of emergencies they also suffer, but continue to help when they are needed most.

The ongoing conflict in Darfur, Sudan has placed a burden on the health system. 'Violence is a cause and consequence of massive planetary changes. Health workers are active participants in such violent social processes. Sometimes they are targeted' says Dr Enrico Pavignani, an expert on health emergencies. During times of insecurity and instability, much of the health work is done informally. This means the full

contributions by health workers are often not recognised or remunerated.

In 2015, the earthquake in Nepal affected health workers and their families. 'They still had to provide services, despite psychological stress and a challenging workload' says Dr Ramkrishna Lamiachane of the Nepalese Ministry of Health. Sometimes structural damage to health centres meant their place of work was not safe. People were forced take on tasks that exceeded their professional skills.

During the 2014 Ebola crisis in Liberia, health workers remained working at the frontline, despite the high risk of contracting the virus. They paid a high price. 378 were infected with the virus and 192 died. 'The system was not prepared enough to protect them,' acknowledges Dr Catherine Cooper (Assistant Minister for Curative Services Liberia). Without the selflessness of health workers, the casualties in these emergencies would be far greater.

Fail to prepare, prepare to fail was a mantra echoed by of all the speakers. However, these plans must be made with the country's resources in mind. Management and ownership of response strategies are also important. The human resources shortage is more complex than an imbalance in supply and demand. It is about the effective management and better utilization of existing health workers. But have we learned lessons from past experiences? We heard examples of how Liberia has set up a Public Health Institute to monitor and manage potential outbreaks post-Ebola. Nepal has formulated a new rapid response plan to deal with future emergencies. In Sudan, there is a drive to incorporate responses to emergencies into health worker training.

It is inspiring to hear about how resilient health workers are in times of crisis. However, they need more than just our gratitude and admiration. Learning from previous mistakes is an encouraging step in the right direction. It is unfortunate that it often takes a disaster for our health worker issues to be noticed.

A newborn baby is held by midwife Tania hours after he was born in Kutupalong Refugee Camp, Bangladesh.
© Anna Dubuis/DFID

Nursing and Midwifery Leaders - I am Listening

By Jennifer Trainor

Global Approaches to Nursing and Midwifery: Planning to Optimize Workforce Performance-An International Perspective brought together nursing leaders from Ireland, Northern Ireland, Wales, Scotland, Norway, and Canada. Representatives presented their research and policy strategies to improve staffing, retention, empowerment, and the global advancement of the nursing and midwifery role.

Nursing and midwifery account for a large proportion of the health care sector. The current 20.7 million nurses and midwives, out of a total 43.5 million health workers, are vital in providing important health services. Numerous countries have reported that nurses and midwives represent over 50% of their health workers.

While it may appear that the nursing and midwifery profession is strong and stable, this perception could not be further from reality. 27% of WHO member states have disclosed to having less than one nursing and midwifery staff member per 1000 people, and 48% reported to having less than three per 1000 people. These numbers reflect a potential shortage of 7.6 million qualified nurses and midwives by 2030. While this overall number will be a reduction from the current global shortage of nine million, the shortages in some countries will actually get worse. Countries in Africa and South-East Asia, who are already struggling with finding skilled health workers, will face the brunt of the shortage.

These forums are crucial to give nursing leaders a platform to present what has worked, and what has not, in the areas of research and policy development in nursing and midwifery. For my part, as a registered nurse, I want to know what is being done globally to strengthen and invest in the potential of the workforce. These policies affect my future as a nursing professional. I have witnessed and felt the effects of nursing shortages in both lower and higher income countries: Poor staffing, lower pay, high patient-to-nurse ratios, and constant budget cuts. All lead to nursing burnout, low morale, and poor retention. I have seen it. I have lived it. It is not only the nurse or midwife who suffers – ultimately, the patients themselves suffer.

The dialogue must continue. Global leaders in nursing and midwifery from all points on the globe need to continue with their efforts to come together and discuss their strategy successes and failures, especially with nurses and midwives who give direct patient care. In the end, we are all working towards a common goal. As Annette Kennedy, President of the International Council of Nurses, concluded the session, her message was clear:

> "We have to state very clearly to our governments and to our departments, no matter which country you're in, that they have to invest in the workforce. Otherwise, there will be no healthy people to actually work."

CROSS-CUTTING ISSUES

In a world where health workers and their patients are constantly on the move, how can we ensure healthcare gets to where it is needed the most?

Beyond Borders

By Jennifer Trainor

The migration or mobility of people is not a new concept. In the age of globalization, it has never been easier for individuals, particularly our global youth, to network and seek out new opportunities in other countries. The healthcare workers of today, having a desired and transferable skill set, are at an advantage. There is a health worker shortage and they are needed everywhere. Health workers are taking advantage of that demand.

The topic of health worker mobility was a highlighted issue at the Fourth Global Forum. *Maximizing Benefits from Health Worker Mobility* discussed the overall evidence in patterns, trends, and successful collaborative initiatives regarding mobility among health workers. The panel had representation from the World Health Organization (WHO), Australia, Ireland, Sudan, and South Africa. A key point presented was the importance of empirical data when discussing trends in health worker mobility.

For example, Ibadat Dhillon, from the WHO, showed the complex nature of health worker mobility. Beyond the movement of workers from lower income to higher income countries, Mr. Dhillon presented the current trend of global south workers migrating to other global south countries and the increase of movement of workers from the global north to the Global South.

Overall, the panel was unanimous on one major point: mobility among health workers is real and is not showing any signs of stopping.

The fundamental issue is how it is addressed. As Stacey Ann Pillay, of Africa Health Placement, noted:

> "[Health workers] are starting to be seen as people, and as people who are active agents who participate. We are not being sucked up by a country, but we actively participate in the process of where we work and where we live. [...] Whether we like it or not, health workers are on the move."

With this in mind, the World Health Organization established the Global Code of Practice on the International Recruitment of Heath Personnel in 2010. "The Code", as it is also known, encouraged countries to voluntarily follow principles on the ethical recruitment of health workers. Countries can also voluntarily complete national reports on current trends and patterns in health worker migration. The Code also served as a platform for continuous dialogue and cooperation between countries.

Dr Elsheikh Badr, from the Sudan Medical Specialization Board, presented WHO Code strategies to address health personnel migration. The Code guidelines encouraged Sudan to increase mobility evidence, promote bilateral migration agreements between countries and universities, and harness the knowledge acquired by Sudanese working abroad, all while focusing on national health worker retention strategies.

Dr Ayat Abu-Agla, Health Workforce Observatory (Sudan) & the Centre for Global Health, Trinity College Dublin observed:

"Migration is a serious issue. It's a reality that we have to deal with. It shapes the political, social, and cultural health systems that we live in."

Health worker mobility is a complex issue. It is evident that we cannot stop mobility, nor do I think we should. Health workers migrate for a variety of different reasons: perhaps it is the prospect of better working conditions, further training opportunities, a full-time contract offer, a salary increase, or simply the chance to travel. I believe in the exchange of information, technology, and skills, but we also need to support countries with fragile health systems. Evidence in trends and patterns of migration is key and countries must keep the dialogue going. Initiatives like the Code will hopefully maintain ethical mobility, but also encourage countries to keep working on their retention strategies.

Making the Invisible Visible

By Tsion Fikre

The social determinants of health encompass the ways in which people live, work, learn, and play, and highlight how these conditions may also affect health risks and outcomes. As always, a certain group fall through the cracks.

One in every seven persons in the world is a migrant. Slowly over time, women have begun to make the deliberate decision to migrate on their own. More women are entering the paid labour force, taking them away from traditional roles. This has allowed them some agency and provided the opportunity for improved opportunities for employment and their ability to support their families.

Upon entering the work force, many find themselves in the care field, where their work is often undervalued. The profession of caring is deemed to be a low-skilled job, when in fact many migrants in such roles already have credentials in their home country. Because the priority is in finding employment and maintaining livelihoods upon arrival, many resort to working for temporary agencies that do not employ strict regulations of in-home care. These women report fatigue, hunger, poor sexual and reproductive health outcomes, and poor mental health.

Ann Elizabeth has been living in Ireland for 15 years, with 11 years in the care work sphere. Speaking at a session entitled Women on the Move: Migration, Care Work and Health, she described how the contract from a typical hiring agency would state that caregivers will only work with patients. However, patients or family members would begin asking for favours like cooking lunch.

> The favour you did once will be expected every time. Interviews talk about annual leave, days off, bank holidays...

The caregivers themselves rarely profit from those benefits. Furthermore, many favours done once will soon become an unexpected daily task. Somehow, whether migrants are documented or not, they always take the backseat. The value they create, and the roles they play in every job sector are often overlooked.

It is crucial to recognize that migrant women care workers contribute to health and well-being through their support to health and social care systems. They deserve the support of resource centres and skills training to help promote their work and role in the health care field. Furthermore, we need to talk about the lives that migrant workers lead – and how their work conditions are indeed in violation of fundamental labour rights.

> Ignoring women, ignoring what they bring to the table is ignoring the needs of your country. It's important to recognize that women are the drivers of health care. We weren't allowed to vote in the 19th century. My voice was missing then, it's still missing now.
>
> **- Dr Kelly Thompson**, Gender Specialist at Women in Global Health.

We need to look at care as a global public good. Strong evidence, political will, robust strategies and the empowerment of women in health work force are all fundamental in addressing the needs of migrant workers.

It is time that we notice migrants and migrant women. And time that we address the issues that shackle them from the moment they enter their host country.

A Filipina nurse looks after children while waiting for her tiring day to end. The Philippines is the world's leading provider of quality nursing professionals.

© R. Borgonia/ILO 2011

Equip and Send: Fuelling the Rural Healthcare Workforce

By Tsion Fikre

From Australia to Nepal, the solutions to rural-urban health disparities are as diverse as their causes.
© U.S. Air Force/1st Lt. Christopher Diaz

The resolution to ensure healthy lives and promote wellbeing for all requires us to employ more health care workers in the field– and particularly fields where not enough attention is paid to rural communities. Throughout the Forum, delegates discussed the need for more. The need to hire. The need to train. The need to recruit. And the hardest of the four – the need to retain health care workers in rural and underserved areas.

70% of Uganda's 42 million people live in rural areas. In an effort to come up with a few solutions, an affirmative action programme was implemented to attract staff towards rural areas. The Ugandan Ministry of Health recruited 7,500 health care workers and increased staffing by 68%. But after two years, many of those workers had left. A hardship allowance for people living in the rural areas was allocated, and people from urban areas started moving because their base salary was not sufficient to sustain a living. This also did not last long. There were no schools for their kids, they struggled with the poor infrastructure, and ultimately, they left.

Incentivizing health professionals by writing off their debts in exchange for serving in rural areas is an approach Dr George Sigounas advocates for. But Dr Martinho Dgedge, General Inspector of Health in the Ministry of Health of Mozambique, can outline a more basic problem:

> You educate people, but you don't employ them. The public sector does not have enough resources.

While training and incentivizing community health workers may work for one country, this approach may not be the right move for another. Money is also the issue here. The demand exists, and the supply (of health care workers) is needed. They are trained but if there are not enough resources, there will be many who have to wait around to be employed.

The need for community engagement is thus a crucial factor - when individuals are recruited, their family members are also indirectly being recruited.

Shelley Nowlan, Chief Nursing and Midwifery Officer in the Department of Health of Queensland, Australia, proposes knowledge transfer tools to allow the learning to continue and training the healthcare workforce based on demand. If a tropical disease is the most prominent, make sure the workforce has the skillset for that. Rural Seeds proposed planting a seed: Expose young doctors in training to working in rural areas, and if they like it, they will hopefully stay and spread the word to others.

I turned to my neighbour briefly and asked, "what do you think is the issue here?" He had served as a community health worker in Nepal for the past eight years, and his response reflected that depth of experience:

> "The term 'rural' needs to be redefined. Do we mean rural in terms of accessibility or rural because of cultural norms, or what else?"

And then suddenly it was not so clear any more. Implementing social accountability of medical schools and residency programs by sending students for a section of their educational life is a very temporary solution. It is also a solution that may work in the rural parts of Canada, but not those of Nepal. He also highlighted that personal career goals are left on the back burner – as his were for the past eight years.

If we boil health care down to the person – the one caring and being cared for, and the unwritten agreement that health care professionals make when they're sworn into the job – then why do we still struggle to find enough community health workers to fill the gap in rural and under-served communities? For one, these people who are health care workers are also people – people with financial responsibilities, social ties and burdens like anyone else. So, let's start by addressing their needs. In practice, the effort should begin by establishing policy. The SDGs also apply to the rural areas. And that's where it is the hardest to achieve them.

Regardless of where they are in the world, rural areas have similar needs – but they do not have the same solutions. And so, the dialogue must continue.

"More than half (56%) of those living in rural areas worldwide do not have access to basic, essential healthcare" - Dr John Wynn-Jones, Rural WONCA

© AMREF Flying Doctors

Education and Training around the World

By Moy Bracken

Fixing the HRH crisis is not just about the number of health workers, but also the quality of care provided. Dr Ryan Tandjung, Head of the Healthcare Professions Division of Switzerland's Federal Office of Public Health, notes that, "investing in good education is the mainstay for system change".

Delegates from around the world pointed to similar issues in both high and low-income countries. Dr George Sigounas, of the U.S. Department of Health, identified three factors compounding the HRH problem:

- Health professional shortages,
- Maldistribution of skilled health workers, and
- Education and training.

Similar experiences can be heard from experts in Cambodia, Thailand, and Mozambique. The HRH crisis is thus a global issue, one that cuts across vastly different borders and contexts.

Increasing the number of skilled health workers seems like an obvious response to overcoming shortages. However, Dr Martinho Dgedge, of the Mozambican Ministry of Health, notes a disconnect between training and employment. Expanding training programmes in Mozambique increased the number of people trained, but not their subsequent employment opportunities. Increasing the number of health workers is pointless when a limited health budget prevents them from putting their skills to work, especially when there are no guarantees that they will bring coverage to underserved areas. But there are potential solutions.

One comes from the United States, where Washington has provided educational grants to keep doctors in rural areas. As part of the deal the doctors must practice for two years in a rural area, and in return their student loans are paid off. Following the program, 97% of doctors remained in their post after the two-year period ended.

Australia's National Rural Health Commissioner, Professor Paul Worley, offers an insight into rural health practice in Australia. There are many challenges in providing quality health care in remote Australian territories. Health outcomes for the populations in these areas can be similar to sub-Saharan Africa. Lifestyle factors and limited access to healthcare result in low life expectancy. Medical schools in Australia are generally located in cities where healthcare is already robust. This means the issues affecting the rural communities are often neglected. The Centre for Remote Health was set up to provide training in these areas, helping provide work experience in remote environments whilst improving the health of the rural population.

HRH faces similar challenges regardless of context. We can all learn from the successes and failures experienced in different countries – and appropriate education and training is key to solving the problem.

FILLING THE GAPS

To avoid a Human Resources for Health crisis by 2030, we will have to increase not only investment, but also partnerships and inclusion efforts.

Health is Wealth

By Moy Bracken

Health workers save lives and are the backbone of an effective, efficient health system, but they are in short supply. At the Forum, Minister for Health Simon Harris acknowledged that the Human Resources for Health crisis '*transcends geographical and political borders*' and reiterated Ireland's commitment to implementing the World Health Organisation code on HRH to build a sustainable resilient workforce.

An estimated shortfall of 18 million healthcare workers worldwide is projected by 2030, with population growth and migration of health workers to better labour markets cited as two of the major challenges to recruitment and retention. The critical shortage of health workers is often felt where they are required the most, including rural areas and low-income countries.

The Dublin Forum was uniquely placed, providing a space not just for analysis, but for the implementation of sustainable solutions. Political will and commitment are two of the most important factors required to stem the crisis. Dr Sarah Achieng Opendi, Minister of State for Health of Uganda notes that, "*Political will without leadership and commitment of resources is nothing*". Investment in health workers has the potential to yield both direct and indirect benefits, but development will not occur without investment.

Well-resourced, skilled health workers are motivated and equipped to maximise health gains and reduce inequities. Indirectly, a healthy population is a productive population, benefiting economic and social development.

The theme of youth empowerment in HRH was championed by Kevin McMahon, the Youth Forum representative. The Youth Forum had convened earlier to discuss the HRH youth action plan, where financing of health workers was dubbed as a '*smart investment*'. He advocated to "*looking at the future of healthcare workers in a proactive way and not as a reactive adjustment*". The eagerness of the youth movement to have a seat at the table in the decision-making process was encouraging, as they will be drive the change required to meet future targets and objectives.

The sentiments of the audience were perhaps best summarised by Miatta Gnaya, a delegate from Liberia, who noted that accountability is critical in ensuring that promising declarations are more than just rhetoric. Her point was met with applause from an audience no doubt au fait with working in a system that is both under resourced and overburdened. There was a sense that the speakers were 'preaching to the converted' – the delegates understand what is required to strengthen the global HRH sector. The challenge for building a sustainable health workforce therefore lies in convincing those in power that a long-term investment in human resources will yield a return far greater in terms of economic development.

Health Is A Productive Sector, Not A Consumptive One. Invest In It!

By Loice Epetiru

Dr Sylvester Onzivua is a senior pathologist at the national referral hospital in Uganda. As one of his day-to-day responsibilities, he examines biopsies for cancer and he is passionate about his job. In order for him to carry out his tasks well, he needs a microscope to examine the the biopsy samples. Dr Onzivua's passion for his work deteriorated when the microscope he uses broke down more than a year ago.

"*I wrote to the Ministry of health requesting for the microscope to be replaced more than a year ago, but the countless requests have not yielded any fruit.*" Dr Onzivua recounted in a televised interview during the Doctors strike in Uganda.

Facing a situation like that of Dr Onzivua, together with low pay, limited career advancement opportunities, and arrests by state operatives with no avenues for a meaningful mediation, the doctors have no option but to take to industrial action as the quickest remedy. While the doctors in Uganda are striking, trainee doctors in Malawi are quitting their profession for more rewarding careers since medical practice is not as glamorous as was hyped.

Dr Isabel Kazanga, a Lecturer at the College of Medicine in Malawi noted that eight intern doctors from the same ward quit in October 2017 when the economic challenges hit them. They realized that their love for saving lives alone could not keep them, but rather this passion coupled with support from leadership:

> "The intern doctors that are quitting the profession are mostly youth who are starting their career and need to be supported by the top leadership especially at a point when many have lost the impetus to work in the sector."

Whereas individuals in other skilled professions can take home big sums of money, doctors in Malawi are paid $500 per month with a risk allowance of 2 dollars. Meanwhile in Uganda, salaries can range from $950 for a senior consultant to just $267 for an intern doctor, with a lunch allowance of 17 dollars per month and no risk allowance. This amount is expected to cover the everyday costs rent, school fees for children, housing, food, clothes, etc. One thing that seems to be forgotten though is that the lives of the populace are at the mercy of the health workforce who put their lives on the edge to save lives of others at the expense of theirs. Losing one doctor can be tantamount to losing a thousand lives of health service users.

Dr Fredrick Oluga, the leader of Doctors Union in Kenya likens the topic of investment and leadership in the health system to that of a family setting. He notes that in a family, parents take responsibility over their children, and that feeling

of responsibility gives them the incentive to look for jobs to be able to provide for their families. Health systems are no different, where governments can often be compared to parents who neglect their children, or in this case, their citizenry.

Furthering this disconnect is the fact that top officials have the means to abandon the system entirely, and pay for treatment in other countries – at the expense of native health sectors. And much like uncles and aunties, development partners do not see anything wrong with such family set ups and continue to enable such irresponsible parents.

The State Minister for Finance of Uganda, Dr Gabriel Ajedra Aridru acknowledged that the political leadership has not prioritized training of the health workforce in Uganda, making it impossible to find specialized treatment in the country. The country therefore bears the burden of spending 250 million dollars annually in finding specialized treatment abroad for its citizenry, which is not sustainable.
But the political will is there, as Dr Aridru explains:

> The need for training health workforce … touched my heart when my wife needed a specialized operation that could not be done in Uganda and after this experience my attitude towards allocating finances for training of the health workforce changed. I pledged to be a crusader for the health care agenda at the Ministry of Finance.

Whether that will can be translated into action depends on development partners. At the UN level, at least, the Commission on Health Employment and Economic Growth has recognised that investment in health workers has a positive impact on economic growth.

But others have been slow to catch on. Professor Francis Omaswa, Executive Director of ACHEST, notes that development partners like the World Bank and the IMF have taught our leaders in Africa that health is a consumptive sector and a bottomless pit. Omaswa calls for a big effort to reverse and "un-teach" this out-dated message, which partly explains why investment in health in Africa is not yet at the desired level.

"For instance, in Uganda the health workers are on strike because there is no money to pay them, which places an urgent need for Africans to unlearn the prior teaching that health is just consumptive." Prof. Omaswa recounts,

> The biggest thing that could come out of this Forum is that all the thousands of us who are here will go back home as individuals who care for those who need health workers and do not even know that they can do something about it.

Effective Partnerships will make Workforce 2030 a Reality!

By Loice Epetiru

The Fourth Forum brought a thousand delegates together at the Royal Dublin Society to share experiences, best practices, and to forge ways to curb the global human resources for health crisis. They were drawn together by a common framework, developed by the Global Health Workforce Alliance, to consolidate evidence around the need for a comprehensive health labour market framework for universal health coverage. The framework subsequently became a strategy that now guides all the Global strategies on human resources for health: "Workforce 2030".

Some participants rated the oral session on Making Partnerships Work for Workforce 2030 as one of the most inspiring of the whole Forum. Prof. Francis Omaswa who spent many years of his career managing partnerships at the Global Health Workforce Alliance as the founding Director, and one of the Principal Investigators of the Medical Education Partnership Initiative (MEPI), shared his experience on effective partnerships. He recognized that partnerships work very well when all players have a strong vision, recounting the example of MEPI as a classic case of a successfully managed partnership where 13 medical schools in 12 sub-Saharan African countries collaborated to increase their own capacity to produce better-trained doctors. This model therefore gives the assurance that the Workforce 2030 implementation through partnerships, if managed well, will thrive.

Dr Elsie Kiguli-Mlwadde, the Deputy Secretary General of Network Towards Unity for Health acknowledged the great role played by partnerships in mentoring young educators.

> Partnerships provide an effective tool for mentorship, knowledge sharing and a platform for leadership, a key driver of success.

"I benefited from strong mentorship as a member of the aforementioned partnership cohort for 15 years before taking the leadership mantle, which would not have been possible without the South-to-South partnership initiatives." Dr Kiguli-Malwadde recollected while presenting at the oral session.

Whereas the dwindling funding opportunities for health programming remains a major stumbling block towards achieving Universal Health Coverage, experts at the session affirmed partnerships as the golden bullet that will surmount this challenge. Institutions taking the route of partnerships should tread on it cautiously, especially when collaborating with stronger institutions that sometimes exhibit selfish tendencies and dwarf their less powerful counterparts.

The feelings of the audience during this oral session was summarized by E. Oluwabunmi Olapade-Olaopa, a delegate from Nigeria who echoed that for partnerships to work well, relationship-building and trust built on sincerity should take centre stage. As we look for funding, there is a greater need to draw lessons from other global commitments such as the Millennium Development Goals, and now the Sustainable Development Goals, implemented in partnership to understand what worked and did not work at a country and global level.

The Health of All is Better when Sectors Work Together

By Jenny YC Lee

In a roundtable discussion, Dr Tana Wuliji from the WHO shared facts about the pressing issues in health workforce. She said, "If we add up all the shortfall of health workers around the world, the number would be 18 million. This is enormous." This is a gap that must be filled between now and 2030 in order to meet the SDG goals. Dr Wuliji also mentioned that such shortfalls are concentrated in the low- and middle-income countries.

Simply put, without health workers, we are not going to achieve the SDGs. Without them, we are not going to solve medical issues and foster healthier societies. For countries to thrive, health is fundamental. And improving health workforce should be a global effort.

In low- and middle-income countries especially, populations are getting younger. More and more young people come into society unemployed. There do not seem to be enough jobs for them. On one hand, we have youth unemployment. On the other hand, we have a shortage of health workers. So why not marry these two problems and find solutions? Although the health sector cannot have full control of the labour market, it can come closer to solving youth unemployment IF it works with the labour sector. This is why inter-sectoral actions are necessary.

The Forum showcased valuable experiences from Mozambique, Ethiopia and Myanmar about how inter-sectoral collaborations work in their health systems. Each of these countries has ensured that their ministry of health (MOH) has worked closely with the ministries of finance (MOF), the ministries of labour, and civil services. In Mozambique, the MOH has joint efforts with the MOF to develop an integrated human resource information system. In Ethiopia, inter-sectoral action centres on improving human resource management. In Myanmar, intra-ministry collaboration (between multiple departments in the health sector) is in place and the MOH works closely with non-governmental organizations to involve civil servants.

Inter-sectoral actions in all three countries are successful thus far. But what were some challenges and how did they overcome them? They all agreed that the initial stages of collaborations were difficult, because each sector has its own political agenda and needs to find common grounds with the health sector. These inter-sectoral relationships are a lot like marriage —which needs respect, high levels of commitment, and good partners. All sectors, like marriages, need patience. The key lessons to success are engaging in collaborations early and continuous communication. The health of all will be better when different sectors work together.

Gender Analysis: Making Research Transformative

By Jenny YC Lee

What does "gender" mean to you? Gender varies across social context and over time. Nowadays, many researchers around the globe incorporate "gender analysis" to ensure equity in health system research. If performed well, such analyses have the potential to revolutionize policy and practice.

Gender analysis research falls into a continuum. It ranges from gender unequal and gender blind, to gender sensitive and gender transformative. Gender unequal perpetuates gender inequality, while gender blind ignores gender norms, roles and relations. Gender sensitive considers inequality caused by unequal gender norms, but presents no remedial action to address it. Lastly, gender transformative addresses the causes of gender-based health inequities. It includes strategies to foster progressive changes in power relations between men and women. Thus, this kind of analysis transforms harmful gender norms.

During the Forum, Rosemary Morgan from Johns Hopkins Bloomberg School of Public Health invited participants to analyse example studies case by case, and place them on this continuum. One such case was a research study on the motivations of health workers in Vietnam. It showed that motivation is influenced by income, training and more, but noted no differences in motivational levels between men and women, and did not provide gender perspectives. It was placed firmly in the "gender blind" camp.

On the other hand, research from South Sudan offered a gender sensitive perspective. Focused on improving maternal health in South Sudan, this study described community dialogues for changing gender norms, and included women's views and perspectives.

Such discrete placements stirred up healthy debates amongst researchers in the room. The existence of this gender continuum itself implied that there was no discrete categorization of the research studies. Indeed, Rosemary and her colleagues intended for participants to carefully consider the different cases and motivate us to incorporate gender into our own research. This session highlighted the complexity of gender analysis and plurality of challenges faced in different cultural settings. More importantly, it addressed the need that research should attempt to move up the continuum towards a "gender transformative" approach.

Programmes like Somalia's *Healthy Mothers, Healthy Babies* seek to transform the lives of mothers and babies in Somalia through providing quality healthcare and trainings.

© European Union/ECHO/Thorsten Muench

LOOKING AHEAD

With the Dublin Declaration adopted and new connections built between health workers around the world, what are the next steps we must take?

Looking Forward

By Jennifer Trainor

For five days, delegates at the Fourth Global Forum on Human Resources for Health last November discussed a variety of topics on the theme of building and improving the capacity of future healthcare personnel. Specialists from different backgrounds presented on issues ranging from the protection and retention of healthcare workers, the delivery of quality health services in a context of migration and a deepening urban-rural divide, women's empowerment, and everything in between. Regardless of the topic, there was always one universal take-home message: looking ahead. At the end of the conference, there was a clear atmosphere of hope.

As a nurse, I was humbled to listen and interact with nurses from a variety of backgrounds. The sessions were always engaging and informative, but it was speaking to fellow nursing colleagues that truly touched me the most. When asking the traditional question of a person's profession to the person sitting beside me, the response would almost always be, "Me too! I'm also a nurse!" It's with that enthusiasm that also comes the "I understand" nod. That nod being a quiet understanding and reflection on past experiences.

During one of those sessions on protecting health workers, I happened to sit beside a particular woman. She listened intently, and would nod at some of the accounts of violence against health workers. Even before we spoke, one could tell that she had a story. She was listening carefully. Afterward, she asked me what I did for a living, and her response was not the enthusiastic response I am used to receiving. She did give me that "I understand" nod. She was quiet in her response "I too was a nurse. But I could not stay in it." She did not elaborate on why she left the profession, but it would turn out to be a major point of reflection throughout the conference. Somewhere in her career, a moment or perhaps many moments prompted her to leave the profession

Her words stayed with me, and I reflected on why these conferences are important. It is a way to show what is happening in global healthcare and how we are addressing these issues. The speakers are showing that they know what the reality is. Statistics, research, and personal accounts drive the healthcare field to do better. Conferences show that we can and that we are. If we can help nurses to not feel alone, to improve working conditions, and protect them, regardless of where they're working, then perhaps we can catch nurses before they leave and change the inner dialogue to "I couldn't stay" to "yes, I can do this".

I was proud to see my profession represented this week. I was proud to hear about nursing research, their inter-professional and international collaborations, and future policies being implemented to address and improve capacity, staffing and retention. Many nurses feel under-appreciated, a sentiment I have shared. Not this week. I have never been prouder. Let us look ahead to a hopefully bright future.

To Leap, To Soar: The Dublin Declaration

By Tsion Fikre

Facing the upcoming shortage of 18 million health workers by 2030, the Forum concluded with the unanimous adoption of The Dublin Declaration- a document that reaffirms the progress that has been made over the years, and an ambitious statement of intent by the international community on what lays ahead. It recognizes the health workforce as the backbone to the delivery of the 2030 agenda for Sustainable Development pertaining to health. The need to make investments towards fundamental health workforce education & training and mitigating the benefit for all are methods that would ensure that countries move with greater pace towards the goal of achieving universal health coverage.

The Forum also addressed the movement of health workers from where they are most needed to where they're least needed and working towards establishing a platform on mobilization of workers to mitigate the benefits.

When adopting the Declaration, country representatives from all over the world recognized that the shortage of health care workers, the issue of access, rural communities, and retaining health workers are not solely those of the disadvantaged. They are a global problem. They are the responsibility of a shared endeavour.

Addressing the Forum, Dr Godelieve van Heteren, Senior Health Systems Specialist, highlighted her most surprised moments as coming to terms with the idea that "in the end,

With a focus on sustainability in employment and education, the Dublin Declaration will ensure that people like Yerro Barry, Head Nurse at the Ould Mbonny Health Centre, will be able to continue to treat patients in places like Southern Mauritania for years to come.

© Sylvain Cherkaoui/DFID/ECHO/ACF

we need to take three steps back... we are here for a short time. Share the basic humanity- the sense of connectivity. It is a shared responsibility."

With the promises of the Dublin Declaration fresh in their minds, participants walked away to return to their home countries with the challenge to plant and reinforce distinctive change.

A Call to Action

By Ifunanya Ikhile

A simple yet powerful truth consistently emerged at the Forum: "Health is not a cost, but an investment". This is a call to action, one that must be embraced within countries, and not just at the global forum, for progress to be recorded. This includes investment in human resources for health. In fact, growing evidence from the World Bank group and International Monetary Fund shows that investments in human capital lead to faster economic growth.

The conference came to an end with the unanimous adoption of the Dublin Declaration: a document reiterating the responsibility of government and key stakeholders from across several sectors and nations towards building the health workforce of the future.

While acknowledging great progress that has been made since the 3rd Global Forum in 2013 towards advancing the global health workforce agenda on both the technical and political levels, there are still existent and arising issues to be handled. Hence, the declaration offered a seat on the table to every stakeholder towards the realization of the 2030 agenda.

A lot has been said, and many commitments made. As Jim Campbell, the director of the health workforce department at the World Health Organization, said at the Youth forum, "this is not just about having a seat at the table, this is a call to action".

These goals can only be accomplished with a keen focus on the ambition of the 2030 agenda for sustainable development, while working synergistically to ensure equitable access to quality healthcare, and ensuring systems-strengthening. The Sustainable Development Goals which include universal health coverage – working towards a shared vision of equitable access to health workers within strengthened health systems, and the right to enjoyment of the highest attainable standard of health and global health security – can all become reality when commitments translate into action.

Specific commitments within the Dublin Declaration include:

- Take co-ordinated, inter-sectoral and multi-stakeholder action in support of the implementation of the Global Strategy, the High-Level Commission Recommendations and the WHO Global Code of Practice.
- Track progress using milestones towards achieving the common goal of universal health coverage.
- Prioritize systems-strengthening and ensure the health workforce is highly skilled and well remunerated.
- Align social accountability, health workforce education, skills and employment to address priority population needs in conjunction with relevant stakeholders.
- Support evidence-based policies and planning for labour market transformation and employment for health emphasizing women and youth empowerment.
- Improve the safety and security of medical personnel and facilities in areas of conflict by upholding International Humanitarian Law, hence addressing challenges of delivering health services in fragile states and conflict-affected areas.
- Reaffirm the importance of establishing, measuring and reporting on commitments and milestones on human resources for health at the national and international levels as an important mechanism to advance a shared global health workforce agenda.

Seven Issues that will Shape the Health Workforce of the Future

By Margarite Nathe

What will it take to build the ideal health workforce? There are 7.6 billion of us on the planet today. That's 7.6 billion working adults, infants in nappies, nursing mothers, teens planning their futures, elderly people, and many, many more. We each have different hopes and needs. And our health care needs change dramatically over the course of our lives.

So how do we provide health care for everyone? To have a prayer of achieving universal health coverage, we must start with health workers. These are the pros on the front lines of health care, the lab techs and scientists behind the scenes, the advocates and funders and policy-makers guiding the big picture. Without all of them, health care simply doesn't happen. But we're facing some big challenges when it comes to our global health workforce. There's a shortage of health workers, for one thing—it could reach 18 million by 2030, according to the World Health Organization, unless we manage to create 40 million new health sector jobs before then. Fortunately, more countries are beginning to focus on their health workforces as a sustainable investment for their populations' future health and prosperity. So, what will it take to build the ideal health workforce of the future? Here are seven issues that are likely to shape the field.

Gender Equality

There is no #MeToo campaign for women health workers around the world—but there should be. There would be plenty to say. Despite the fact that women make up the vast majority of the world's health workforce, they occupy relatively few top spots. And they face rampant sexual harassment, discrimination, and even assault throughout their careers. An assessment of sexual harassment in Uganda's health sector, for example, found it to be rife with quid pro quo sexual harassment. "Supervisors may use performance appraisals to settle scores for refusing sex, or may favour those who submit to demands for sexual favours," writes Constance Newman of IntraHealth International. The consequences for a woman's career can be enormous—including punitive transfers, demotions, and much more.

Ugandan women aren't alone. Women health workers around the world experience similar barriers. But as we shed more light on these problems and more women rise to leadership roles in the health sector, health workplaces will demand greater equality, and more health workers will be able to focus their full professional time and energy on their patients.

© EU/ECHO/Peter Biro

Personal Safety

Slapping. Kicking. Pushing. Verbal abuse. These are just some of the types of everyday violence health workers face around the world. In some US states, nursing is considered to be more dangerous than being a police officer or a prison guard. Routine violence is enough to chip away at the quality of care anyone could provide, to say nothing of the emotional toll it takes on health workers. And then there are the more devastating attacks. The war crimes that see ambulances looted, hospitals bombed, and patients killed in their beds or sent fleeing into the streets. A 2017 report by the Safeguarding Health in Conflict Coalition found that the extent and intensity of violence against health workers globally remained alarmingly high in 2016, and that there is little to no accountability for those who commit them. This cannot continue. The health workforce needs protection, support, and safe, decent working conditions in order to offer effective care for all, whether it's during peacetime or in a warzone.

More Room for Young Workers

We often hear seasoned professionals tell students and youth organizations: "You have the power to change the future." But that's not the whole truth.

The fact is that today's massive generation of young people—half the world right now is under 30—will change the future, whether they want to or not. This is why we need to make more room for young workers, both in the frontline health workforce and in the field of global health. The millions of bright new candidates entering the workforce every year need roles they can sink their teeth into, mentoring without condescension, and the room and training to lead the way.

Affordable Education

In the minutes you spend reading this article, new study results, tools, ideas, and breakthroughs about human health and disease are pouring into the health care field. And health workers face the challenge of keeping up with the flood. But high-quality education is prohibitively expensive for many aspiring health workers. Even after graduating from nursing school, for example, there are the on-going costs and time involved in updating your training on a regular basis. Can you get away from work? Who will cover for you? Will you have to pay out-of-pocket and take time away from your family responsibilities? Is it worth the bother and expense? Of course it is—lives depend on a health worker's level of knowledge and expertise. But it's not easy.

Many experts are looking to eLearning as the magic solution to affordable, accessible education. It's relatively cheap to roll out, after all, and convenient for students who need flexibility. But quality often varies, and even the leading course-design companies are still grappling with how to balance the cost effectiveness of one-size-fits-all courses with the targeted, contextualized, and often hands-on training health workers need.

Another solution is to provide affordable financing for students who want to become health workers, but can't afford school. Kenya, for instance, has introduced the Afya Elimu Fund, which provides low-interest loans for health professional students in Kenya. So far, 2,478 fund recipients have graduated and 62% of those employed are already paying back their loans. More creative solutions like this could help prepare more aspiring and existing health workers with the training they need.

Data and Technology

More countries than ever are making decisions about their health workforces based on solid data. In 2013, for example, Namibia became the first country to assess its every public health facility to find out exactly how many and what types of health workers each facility needs to meet the health care demands of the communities they serve. As a result, the Ministry of Health and Social Services have changed various policies and procedures, and now uses those data to make decisions for planning and deploying its health workers. And every day, countries are digitizing more of their old paper-based personnel files, using software such as the open source iHRIS to help manage their health workforce information.

Data will only become more important in the years to come, as more countries rely less on international aid and take ownership of their health sectors. Solid evidence will help funds stretch further, and bring universal health coverage within reach. Other types of technologies will play a key role for the health workforce of the future, too. Apps that aid in frontline health care, communication systems that help health workers report potential outbreaks and stop them before they start. Whatever the technology, it doesn't have to be flashy—it just has to work within contexts of the people using them.

Creative Partnerships

If we want to make true, sustainable improvements to global health, we have to look beyond health care. As human beings, our experiences outside of the clinic—our education, personal finances, employment, gender roles, and so much more—all play their own parts in shaping our individual health and well-being.

"If you wake up in the morning and think 'How am I going to get through this day?' because you don't have $1.50 to feed yourself or your family, then you're not going to be thinking first about health care," says Pape Gaye, president and CEO of IntraHealth International. "If we want to transform health, we have to look at more than just health care." We're likely to see more smart, creative partnerships toward this end in the future, both among non-profits and private-sector organizations and among health workers who team up, for instance, with factory owners who want to offer their employees HIV services, or with motorcycle taxi drivers who can spread health-related messages to their clients.

Creative Partnerships

None of us knows what new disease, environmental disaster, or medical breakthrough will affect global health in the decades to come. We're making headway in investing in health workers, yes—but setbacks are frequent, and the future is uncertain.

The health workers of the future will face all this uncertainty and more—and so will we all. Investing in the systems that offer them training, support, and safe work environments is something we can do for them today.

Storytelling Night: Lives in their Hands

By Ifunanya Ikhile

Storytelling, an Irish tradition, was used as a powerful tool at the Forum to show how health workers around the world are everyday heroes. Health workers save lives, often at the risk of their own, they give hope to communities and the world at large. Six health workers from different countries, cultures, and contexts tell compelling stories of how, by simply 'doing their job', lives have been saved.

Miatta Gbanya, a Liberian who has worked in conflict zones in her own country and the Congo, found these experiences useful one night. While being driven in her work van on a dark, lonely road, a pregnant young lady by the side of the road desperately flagged the car. She was in labour. There was no health facility close by. Miatta, the driver, and a male colleague had to deliver the baby in the back of their van using only gloves from a first aid kit, light from a phone, and Miatta's shawl as a blanket. They were inevitably covered in blood thereafter, but were only concerned about the life and safety of mother and child. This was a week before the Ebola epidemic. Baby Miatta was born safely that day, and now as a three year-old attends school.

Hay Mar Khine, a city girl and fresh medical school graduate, told her story of performing surgery without electricity and equipment in a remote village on the Myanmar-Thai border. She was posted there as the only medical doctor serving a large population due to a shortage of health professionals. Hay Mar was more accustomed to well-equipped city hospitals, but here she was alone with a 35-year-old woman in labour, and a baby in distress with dropping heart rate. She tried to wait it out but knew the baby may die, so called in a few hands and a military doctor from the camp to help with the surgery, using head torchlights. After delivery, she was torn between an unresponsive baby and suturing the mother to avoid bleeding. But to Hay Mar's relief, the baby began crying a moment later, and was returned to the beaming mother.

Mariah Valenzuela, a Mexican immigrant foster child who was teased and isolated as a child, shared how she turned this experience around and now helps immigrant and foster children facing a similar situation to her own. Mariah migrated to a disadvantaged community in Phoenix, Arizona, mid-summer 1979, where other children mocked her for things like her accent and the fact that she had never tasted pizza. By the age of 14, she volunteered at the community centre and has since become a community health worker, helping the same community and giving hope to children and their families. Little Savannah was one of the kids inspired by Mariah. Today she is in college studying to be a social worker. Mariah's passion is evident, "I want to be able to give parents some hope - that one day their children will be successful."

Paul Nolan, an Irish cardiac physiologist, received comfort from the words of a fellow medical colleague when he lost a patient. Paul loved seeing patients who had come in gasping for air and in distress going home healthy and happy. He did his best for every patient and had so many success stories, but on this day, a patient came in and not long after passed out. Paul was confused; all his knowledge flew out of his head. The man died and Paul was convinced he had missed something. A senior doctor came in 20 minutes later and examined the patient. Afterwards, he said, "Paul, you didn't miss a thing, you did all you were supposed to do." Those words meant the world to Paul, and that night he learnt the importance of being kind to fellow health care workers; for Paul, "We need to be kinder to one another."

Marjorie Makukula, a senior Zambian nurse, was inspired to create a community of support for other nurses to improve their confidence in dealing with difficult situations. She shared her story of interviewing a male nurse in another facility. During the interview he seemed very fidgety. She then discovered he was dealing with a fairly common case of pre-birth bleeding, but didn't know what to do. Marjorie and her colleague intervened, stabilized the patient, called a gynaecologist, and eventually an ambulance arrived to move the patient to another facility. Marjorie realized that nurses panicked in certain situations, not realizing they could call for support from other medical professionals. This inspired a WhatsApp group for nurses' support, where they can ask questions and seek assistance concerning medical issues. Many nurses have become more confident as a result, and provide a better quality of care to their patients. For Marjorie, "Support for health care workers can mean the difference between life and death" for the patient.

Rushaana Gallow faces death everyday trying to save lives working in the red zones of Cape flats, South Africa. Rushaana has been shot at, groped, and assaulted by violent residents. She has been ill-treated by patients' families, and watched a 4 year-old girl die. But, she still goes to work every day in her ambulance to save lives. She is a paramedic, and that is what she will remain. During this presentation, she proudly wore her uniform as she described the horrors endured to save lives in the red zones.

We learn from these heroes that sacrifice and hard choices are a big part of being a health worker. They all have one thing in common: they love their job. Their reward is the smile on the faces of the patients, the fulfilment of helping others, giving hope, being part of something much bigger than themselves.

Storytelling used as education and psychosocial care in Tegucigalpa, Honduras.
© EU/ECHO/A. Aragón 2016

Dublin Declaration on Human Resources for Health: Building the Health Workforce of the Future

We, the representatives of governments and key stakeholders from across sectors and institutions, including representatives of academia, civil society, employers, foundations, health care professional associations and unions, and youth, having gathered at the *Fourth Global Forum on Human Resources for Health* in Dublin, Ireland:

1. Take inspiration from the ambition of the 2030 Agenda for Sustainable Development, with its vision to leave no one behind, its seventeen indivisible goals and its 169 targets;

2. Note the opportunity presented by the integrated nature of the 2030 SDG Agenda to address longstanding and growing health workforce challenges, including important synergy, as appropriate, with the *UN Secretary-General's High Level Panels on Women's Economic Empowerment and Humanitarian Financing, the International Commission on Financing Global Education Opportunity, the Global Commission on Business and Sustainable Development, the UN Global Initiative on Decent Jobs for Youth and the development of a Global Compact for Safe, Orderly and Regular Migration;*

3. Acknowledge the growing evidence from the World Bank Group and the International Monetary Fund that investments in human capital lead to faster economic growth, and that all countries stand to benefit from having a healthy and well-educated workforce with the knowledge and skills needed for productive and fulfilling work. Strategic investments in the health and social workforce, in particular, are imperative to our shared prosperity. We recognize the importance of substantially increasing health financing and the recruitment, development, training and retention of health workforce in developing countries, especially in least developed countries and small island developing States;

4. Affirm our commitment to accelerate progress toward strengthened health systems, each country's path towards achieving the Sustainable Development Goals including universal health coverage, and working towards a shared vision of equitable access to health workers within strengthened health systems, the right to enjoyment of the highest attainable standard of health and global health security;

5. Emphasize the fundamental importance of a competent, enabled and optimally organized and distributed health and social workforce, especially in rural and under-served areas, for the strengthening of health system performance and resilience;

6. Call attention to the urgent need for robust, coordinated and transformative investments to address the escalating mismatch between the supply of , economic demand for, and population need for health workers, , with projections pointing to an additional 40 million heath worker jobs to be generated by 2030, largely residing in upper-middle and high-income countries, while a needs-based shortfall of 18 million health workers is anticipated for the same period, with gaps prominent in low- and lower-middle income countries;

7. Recognizing that robust and transformative actions build on the foundations of the previous three global forums on human resources for health and key WHO normative instruments and guidelines, reaffirm the continuing importance of the *Kampala Declaration and Agenda for Global Action, the Bangkok Outcome Statement, the Recife Political Declaration on Human Resources for Health, the WHO Global Code of Practice on the International Recruitment of Health Personnel (WHA Res 63.16) and the WHO Guidelines on Transforming and Scaling Up Health Professionals' Education and Training (WHA Res 66.23);*

8. Acknowledge that twenty-first century health challenges related to demographic, epidemiological and technological changes will require a health workforce geared towards health promotion, disease prevention, and people-centred community-based health services and personalized long-term care, according to nationally set priorities;

9. Welcome with appreciation the substantial progress made since the 3rd Global Forum in Recife, Brazil in advancing the global health workforce agenda on both the technical and political levels, including a more comprehensive understanding of the health labour market, as evidenced by:

a) the adoption of the "*Follow-up of the Recife Political Declaration on Human Resources for Health*" by the 67th World Health Assembly (WHA Res 67.24);

b) the adoption of *United Nations General Assembly resolution A/Res/69/132* which strongly condemns all attacks on medical and health personnel and urges States to develop effective measures in promoting the safety and protection of such personnel;

c) the adoption of the *United Nations Security Council Resolution 2286* that demands that all parties to armed conflict fully comply with their obligations under international law and urges States and all parties to armed conflict to develop effective measures to prevent and address acts of violence, attacks and threats against medical and humanitarian personnel;

d) the conclusions from the five year review of the *WHO Global Code of Practice* pointing to the relevance, effectiveness, value and legitimacy of the Code, as further evidenced by the improvement in quantity, quality and geographic diversity of second round of national reporting on the *WHO Global Code* (WHA A68/32 and A69/37);

e) the adoption of the World Health Assembly resolution to implement the Sustainable Development Goals (WHA Res 69.11);

f) the development and adoption of the *Global Strategy on Human Resources for Health: Workforce 2030* (WHA Resolution 69.19), its vision, four objectives, elaboration of policy options, and the establishment of global milestones for 2020 and 2030, including the call for progressive implementation of National Health Workforce Accounts to support national policy and planning and noting the emerging political consensus on the contribution of healthcare workers to improved health outcomes, to economic growth, to implementation of the International Health Regulations (2005) and to global health security;

g) the report of the UN Secretary-General's *High-level Commission on Health Employment and Economic Growth* highlighting benefits across the SDGs from increased and transformed investments in the health and social workforce (including SDG 1: poverty elimination, SDG 3: good health and well-being, SDG 4: quality education, SDG 5: gender equality, and SDG 8: decent work and economic growth), with the identification of ten recommendations and five immediate actions; as well as the subsequent resolution of the United Nations General Assembly urging its Member States to consider the recommendations of the Commission including development of inter-sectoral plans and enhanced investment in education and decent job creation (UNGA Resolution A/Res/71/159);

h) support in the *Berlin Declaration of the G20 Health Ministers* for adoption of the WHO, ILO, OECD Five Year Action Plan to give effect to the Commission recommendations and for investments in building and maintaining a skilled and motivated health workforce as an integral part of a functioning and resilient health system, as well as the *G20 Leaders'*

Declaration: Shaping an Interconnected World that calls for cooperative action to strengthen health systems worldwide, including specific focus on developing the health workforce as a means to contribute to broader prosperity and well-being;

i) the adoption of the ILO, OECD, WHO *Five Year Action Plan* by the 70th World Health Assembly (WHA Res 70.6) in order to coordinate and advance the intersectoral implementation of the *Global Strategy and High-level Commission* recommendations and actions, with the WHA resolution urging WHO Member States to take action in this regard, emphasizing that investing in the health and social workforce has multiplier effects that enhance inclusive economic growth and generate benefits across the SDG Agenda;

j) the establishment in May 2016 of the Global Health Workforce Network, hosted within WHO, as a means of leveraging multi-sectoral and multi-stakeholder engagement to advance coordination and alignment in support of the *Global Strategy and High-level Commission* recommendations and immediate actions, especially through facilitating information exchange and dialogue;

10. Note the invitation by the 69th and 70th World Health Assembly to stakeholders across sectors, regions, and nations to join in supporting implementation of the *Global Strategy* and the *High-level Commission* recommendations and immediate actions;

11. Recognizing the substantial socio-economic benefits arising from expanded and transformed investments in the health workforce, and reaffirming the *Global Strategy*, its vision, objectives and milestones, commit to taking co-ordinated, inter-sectoral and multi-stakeholder action in support of the implementation of the *Global Strategy*, the *High-level Commission* recommendations and the *WHO Global Code of Practice,* including where appropriate enhanced investments towards transformative health workforce education and the creation of decent jobs in the sector, especially for women and youth;

12. Welcome with appreciation the launch of the WHO, ILO, OECD *Working for Health Programme,* take note of the establishment of the associated UNDP Multi-Partner Trust Fund, and express support for coordinated and catalytic financing to country-driven priorities and implementation of the *Global Strategy* and *High-level Commission* recommendations;

13. Welcome also the launch of the *International Platform on Health Worker Mobility* to maximize mutual benefits and mitigate adverse effects from the increasing rate and complexity of health labour mobility, through strengthened evidence, analysis, knowledge exchange and policy action, including strengthening the *WHO Global Code of Practice* and its implementation;

14. As also reflected in the ILO, OECD, WHO *Five Year Action Plan*, reaffirm the importance of establishing, measuring and reporting on commitments and milestones on human resources for health at the national and international levels as an important mechanism to advance a shared global health workforce agenda;

15. Affirming that progress towards implementing the Global Strategy on Human Resources for Health requires countries to disaggregate data on the quantity and distribution of all health occupations to help to make projections with regard to health workers in demand;

16. Recognize the particular challenges faced by humanitarian personnel exclusively engaged in clinical duties and by health personnel in irregular contexts such as complex humanitarian emergencies and protracted crises, and further recognize the need to develop tailored strategies for planning, education, deployment, retention, and staff performance management in these contexts;

17. Call upon all relevant stakeholders to align social accountability, health workforce education, skills and employment to address priority population needs, including through continued support for the implementation of the *WHO Guidelines on Transforming and Scaling Up Health Professionals' Education and Training,* the *Global Strategy on Human Resources for health* and the *Working for Health* programme;

18. Call upon all relevant stakeholders to support the progressive implementation of National Health Workforce Accounts to support evidence-based policies and planning for labour market transformation and employment for health;

19. We acknowledge the particular challenges of delivering health services in fragile states and conflict-affected areas, where health systems are often compromised and ill-equipped to respond. Moreover, medical personnel and facilities in areas of conflict are increasingly under attack. Highlighting UN Security Council Resolution 2286 (2016) and UN General Assembly Resolution A RES/69/132 and UNGA 71/129, we strongly condemn violence, attacks, and threats directed against medical personnel and facilities in violation of International Humanitarian Law, which have long term consequences for the civilian population and the healthcare systems of the countries concerned, as well as for the neighbouring regions. We therefore commit to improving their safety and security by upholding International Humanitarian Law.

20. Call upon the *Global Health Workforce Network* to engage with academic institutions and civil society to track progress, as appropriate, on the implementation of the *Global Strategy* and its milestones, *High-level Commission* recommendations and immediate actions, *Working for Health* programme and deliverables, and the *WHO Global Code,* with progress to be shared at the *Fifth Global Forum on Human Resources for Health* in addition to being reported via respective governance processes;

21. Urge WHO to strengthen the governance and leadership of human resources for health through the development of normative guidance, the provision of technical cooperation, and the fostering of effective trans-national coordination, alignment and accountability in order to accelerate the inter-sectoral implementation of the *Global Strategy* towards achieving its overall goal;

22. Urge national governments and all relevant stakeholders to prioritize health system strengthening, including ensuring an adequately skilled and compensated health workforce;

23. Call upon all relevant stakeholders to strengthen their collaboration to expand and transform investments in the health and social workforce, with particular emphasis on empowering women and advancing youth employment;

24. Express our gratitude to Ireland's Department of Health, Department of Foreign Affairs and Trade, the Health Service Executive of Ireland, the Global Health Workforce Network, Trinity College Dublin and the World Health Organization for co-organizing this landmark event.