WEBINAR SERIES

HEALTH THROUGH THE LIFE COURSE

Promoting health throughout the life-course during the COVID-19 pandemic

World Health Organization
REGIONAL OFFICE FOR South-East Asia

INDIAN INSTITUTE OF PUBLIC HEALTH GANDHINAGAR

WEBINAR-5:
TASK-SHARING TO MAINTAIN SEXUAL AND REPRODUCTIVE HEALTH SERVICES DURING COVID-19

Availability of health work force: Sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH)

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Outline

1. **Background**
   - Changing health needs
2. **How to change the health workforce to improve SRHR?**
   - Numbers
   - Distribution
   - Skill-mix
   - Performance/quality
3. **Conclusions**

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Health needs Globally and in SEAR are changing

Health needs Globally and in SEAR are changing

In South-East Asia Region:

1- Population is aging: Pop > 60 years (110 mill in 2000 → 310 mill in 20

2- ↑ NCDs: Overall burden of disease (40% in 2000 → 60% in 2015)

3- Urbanization: 32% in 2000 → 41% in 2018

4- Unfinished MDG agenda: Communicable & MNCH

5- COVID-19: public health workers, PHC, diagnostic, treatment + essentia

Health services to be reorganized to adapt to changing needs

MCH, infectious diseases

- **Awareness**: People know they have a problem
- **Care**: short duration
- **Problem**: often single condition

Noncommunicable Diseases

- People may be asymptomatic and feel healthy
- long-term, possibly life-long
- commonly multiple morbidities in the same person

Transitions needed for UHC

Past	*Future*
Provide interventions targeting diseases (**disease-centric**)	Provide interventions targeting needs for the individual (**person-centric**)
Episodic focus– prevention and promotion, MCH, CD	**Continuum of care focus** – promotive, preventive, curative, rehabilitative and palliative at all ages
Equity focus: **poor rural** populations	Equity focus: Identification of all **persons left behind** - urban poor, rural poor, gender gaps, cultural barriers
Focus on **access**	Focus on both **access and quality**
Service delivery approach: **primary care** facilities coordinated by a primary hospital	Service delivery approach: **Role for all levels**, through public-private mix
Plan results based on **budget**, with resource mobilization externalized	Plan results based on **need**, with resource mobilization internalized (domestic resource mobilization)

Health workforce also has to adapt to changing needs and services…

Health services to be adapted

Changing needs

Existing Workforce

Future Workforce

Health workforce implications

-Additional numbers
-Distribution of HWF
-Competencies needed
-New roles (task shifting)
-Skill-Mix (teams)
-Deployment

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1. Background
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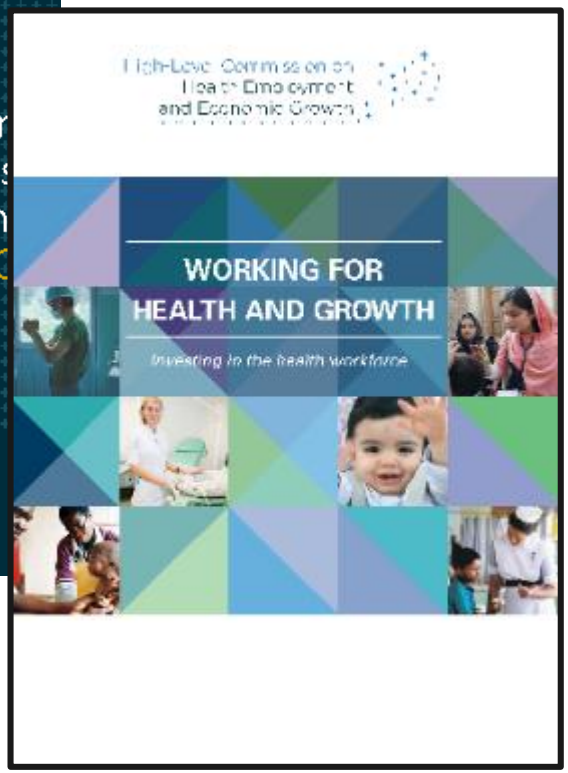
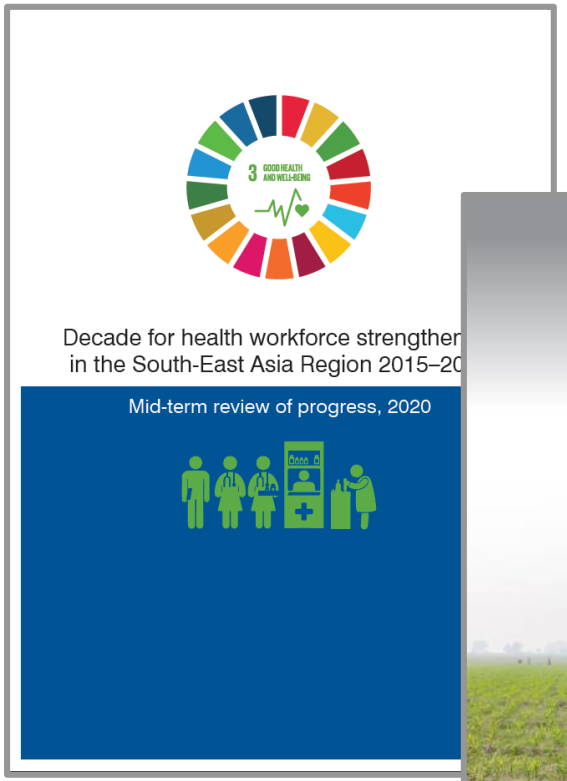
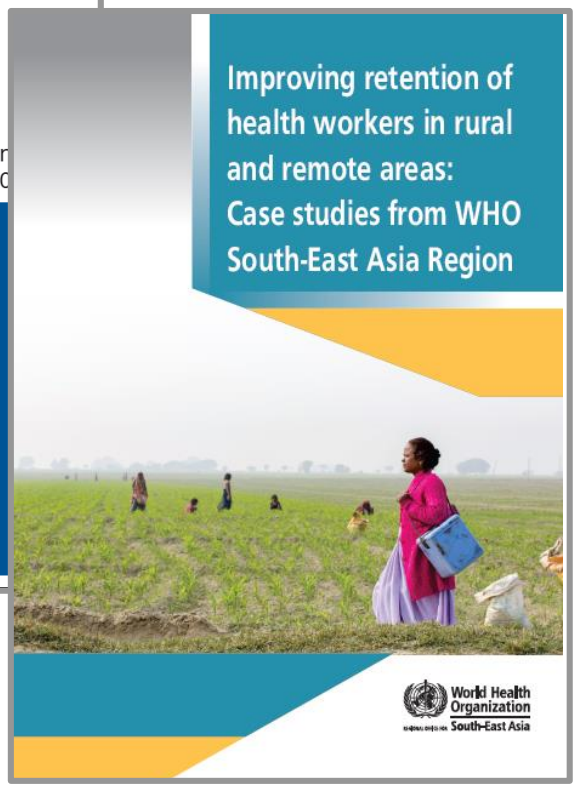
2. **How to change the health workforce to improve SRHR?**
   - Numbers (availability)
   - Distribution
   - Skill-mix
   - Performance/quality
3. Conclusions

Regional and Global Developments







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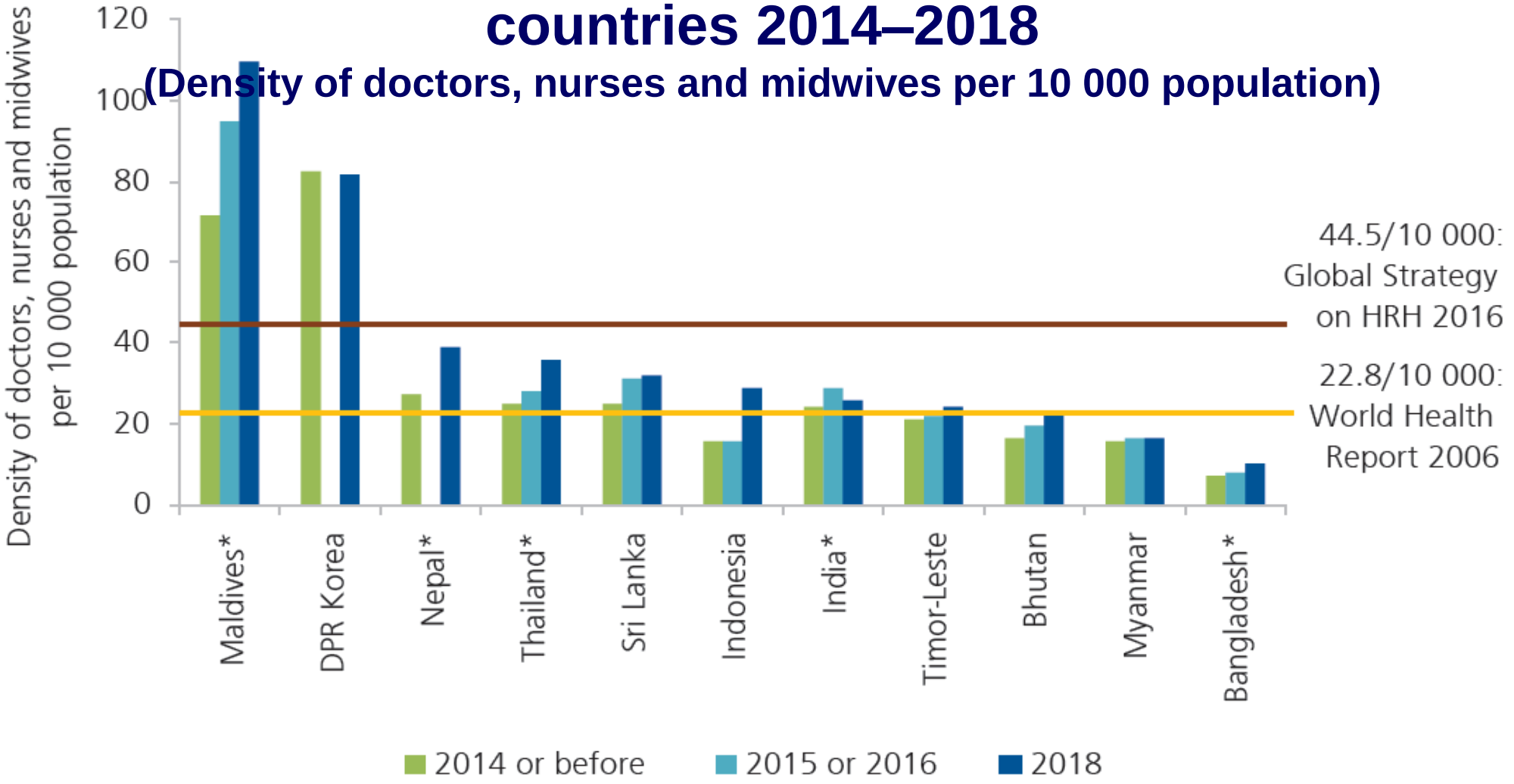
SEAR National Health Workforce Strategies

Country	Name of the document	Period
Bangladesh	"Bangladesh health workforce strategy 2015"	2016-2021
Bhutan	“Health human resource master plan”	2011-2023
DPRK	“Strategic plan for development of human resource for health”	2019-2023 (draft)
India	No HRH strategy. Contained in "National Health Policy 2017"	2017-2025
Indonesia	"Action plan for the development of HRH"	2020-2024 (draft)
Maldives	"National health workforce stratetic plan"	2014-2018
Myanmar	"Myanmar human resources for health strategy"	2018-2021
Nepal	"Human resources for health: strategic roadmap 2030"	2018-2030 (draft)
Sri Lanka	"Human resources for health strategic plan"	2009-2018 (revision initiated)
Thailand	"Health workforce plan"	2017-2026
Timor Leste	"Timor Leste human resources for health master plan"	2020-2024

Trends in availability of health workers in SEAR countries 2014–2018

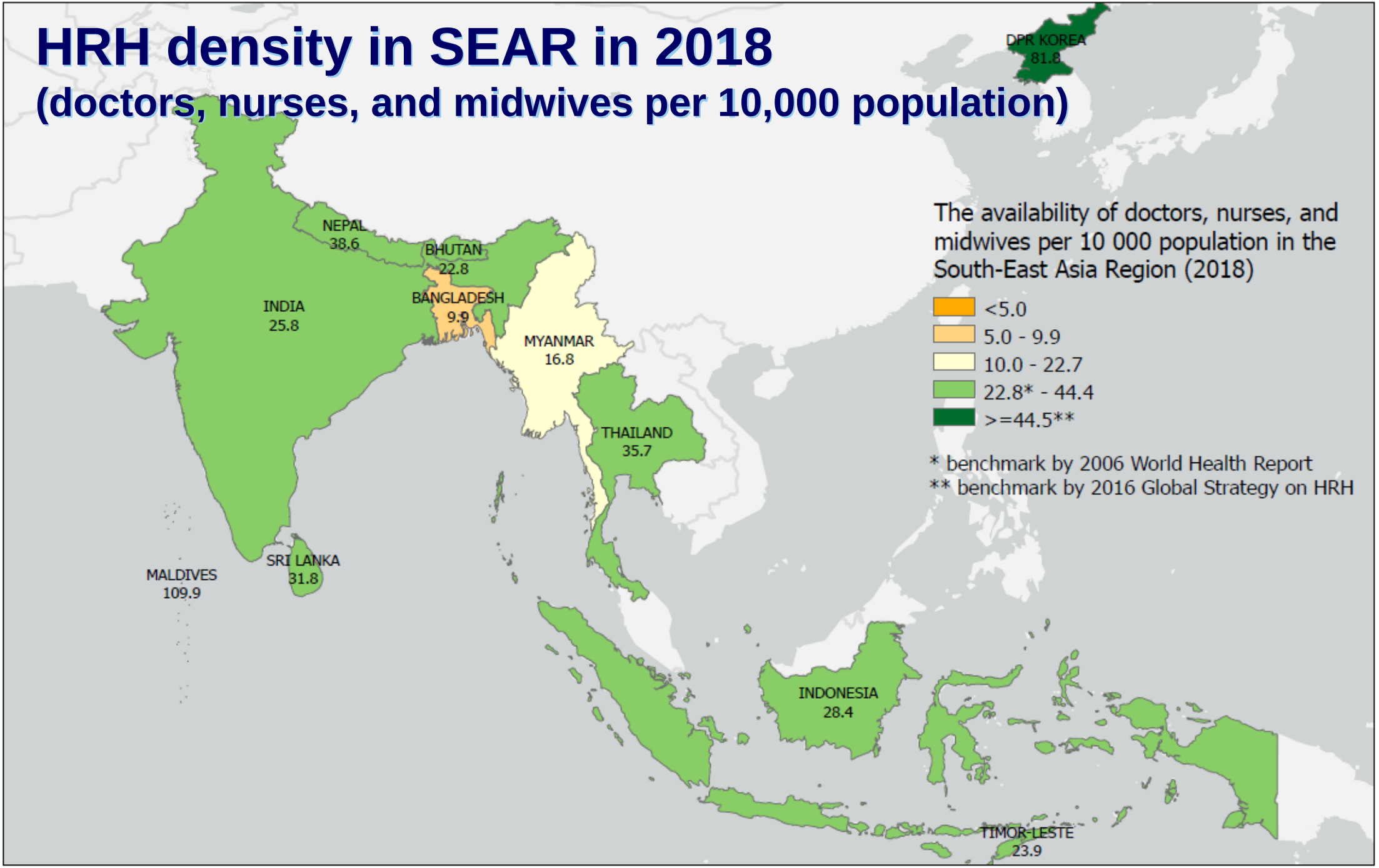
(Density of doctors, nurses and midwives per 10 000 population)



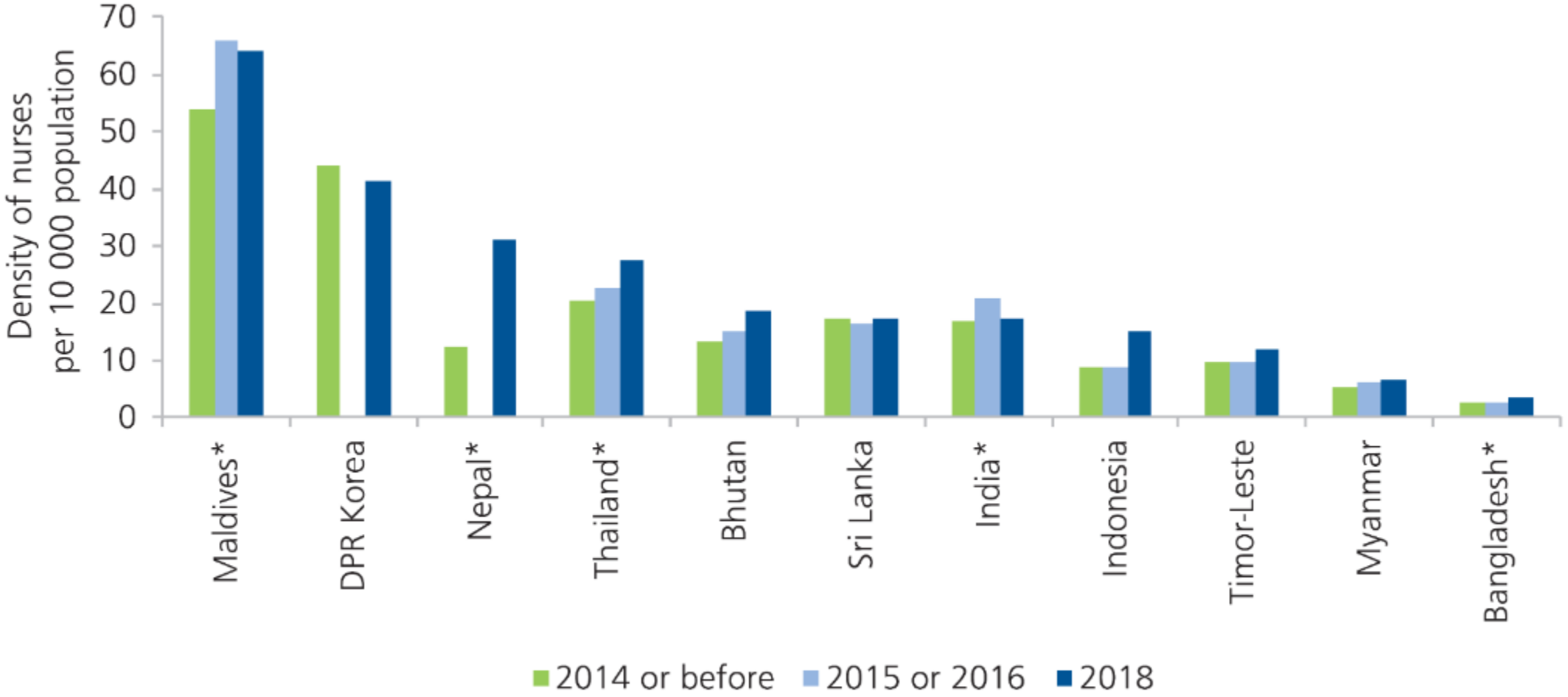
Source: Country data reported to WHO through NHWA online platform (MoH & *professional councils) as of 15 December 2019.

HRH density in SEAR in 2018

(doctors, nurses, and midwives per 10,000 population)



Trends in availability of nurses per 10 000 population in SEAR



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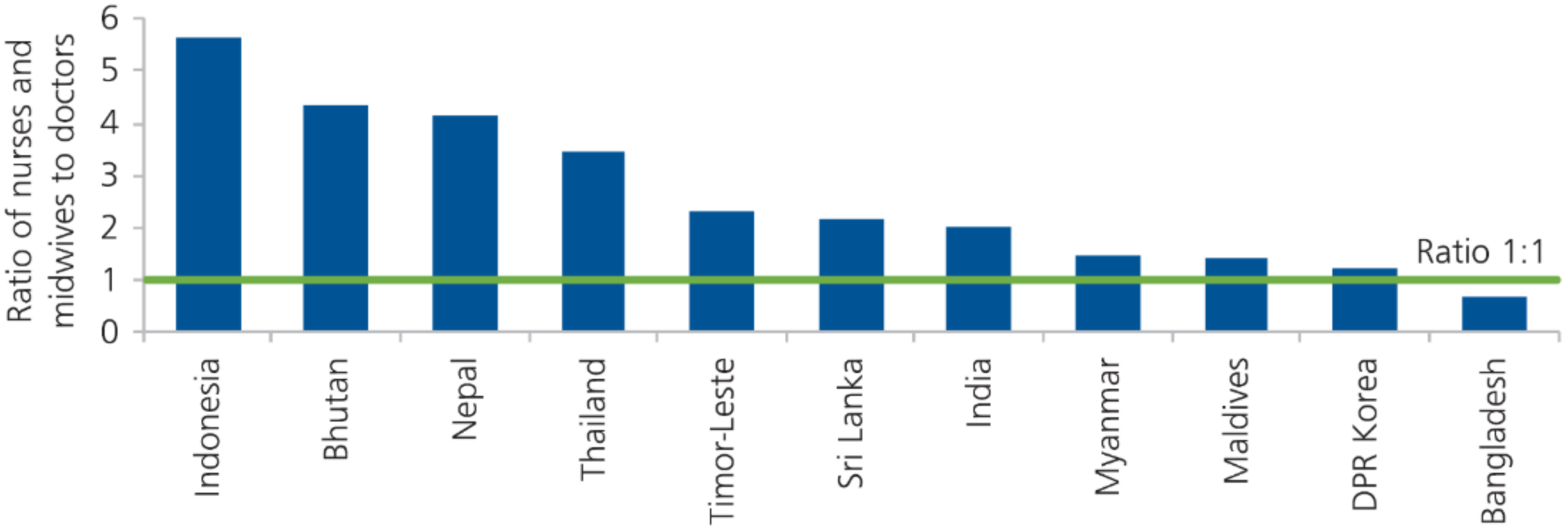
Ratio of nurses and midwives to doctors in SEAR (2018)



Country data reported to WHO (main sources MoH & *professional councils)

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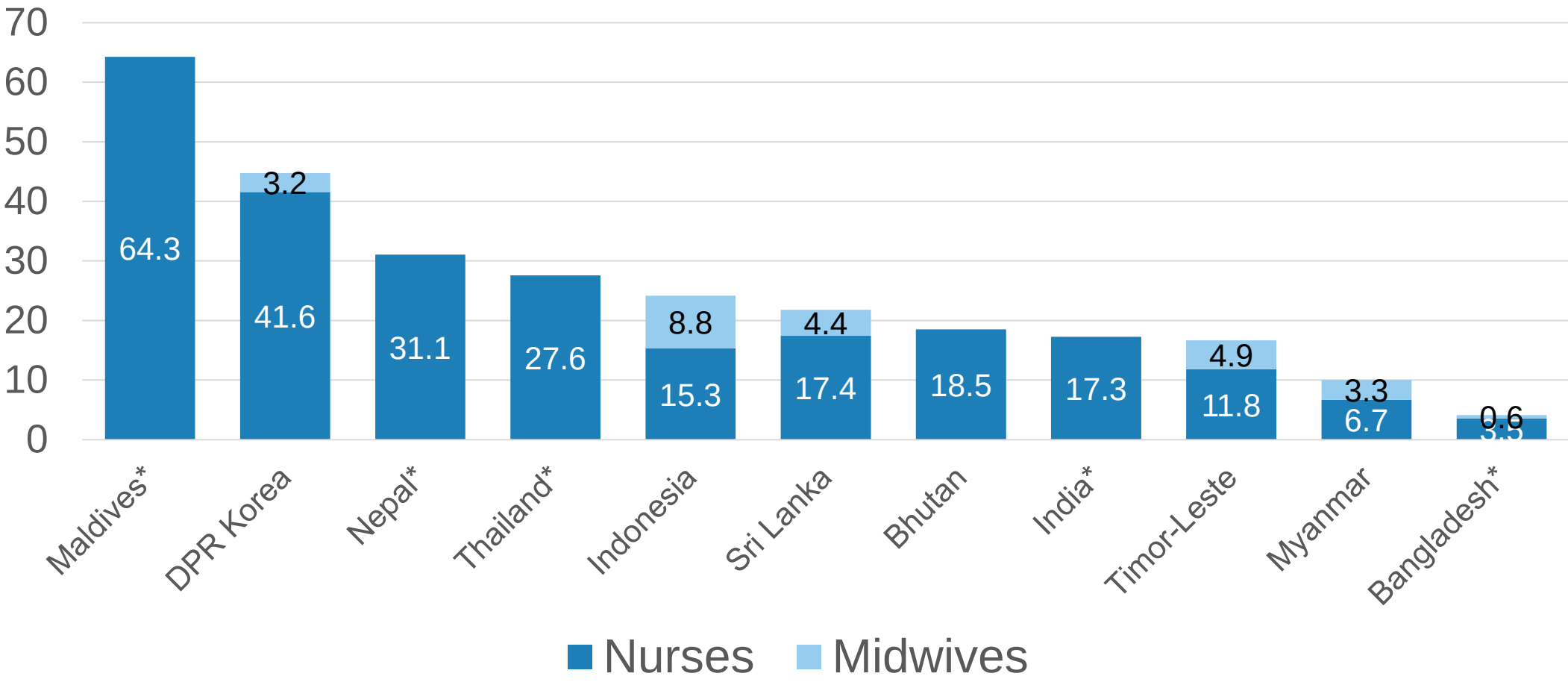
Density of Nurses and Midwives per 10 000 population (2018)



Country data reported to WHO (main sources MoH & *professional councils)

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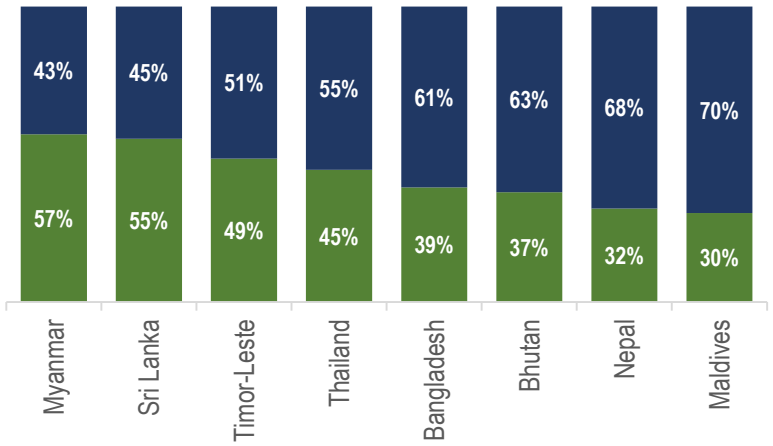
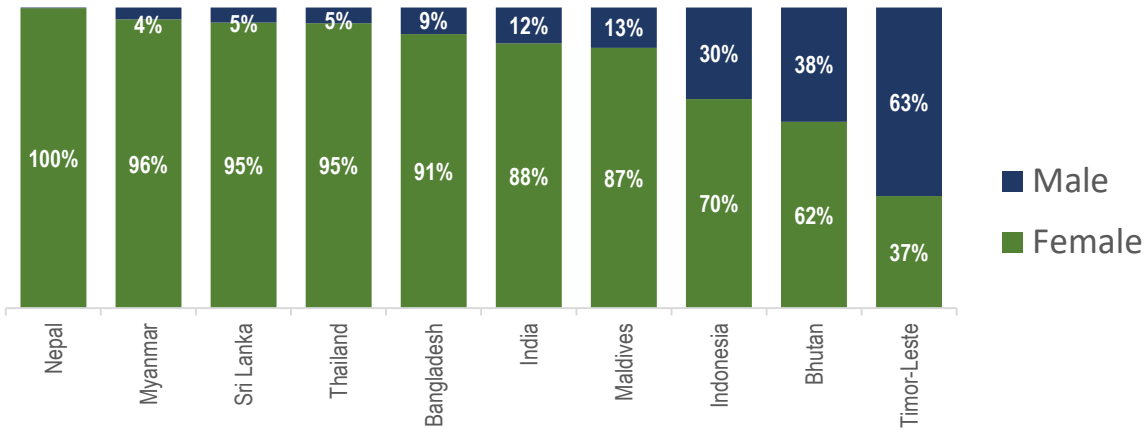
Sex distribution in SEAR (2018)

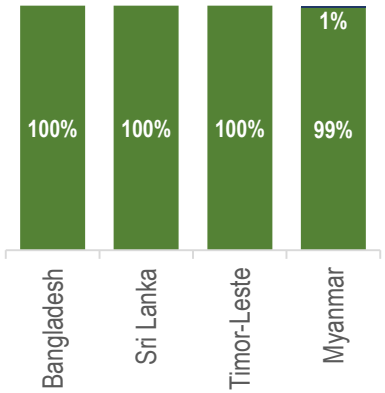
Doctors



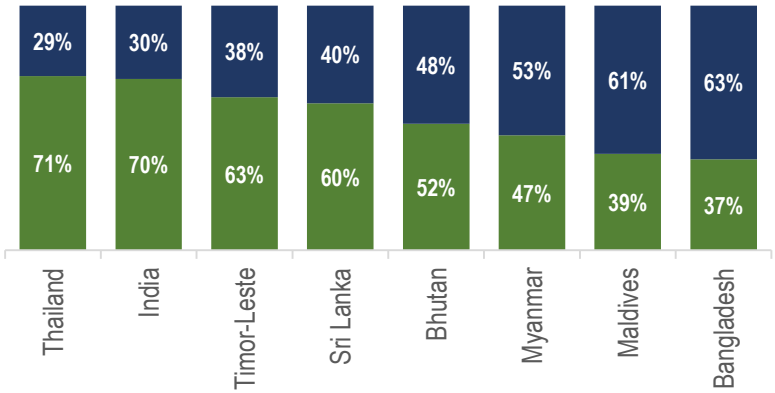
Nurse



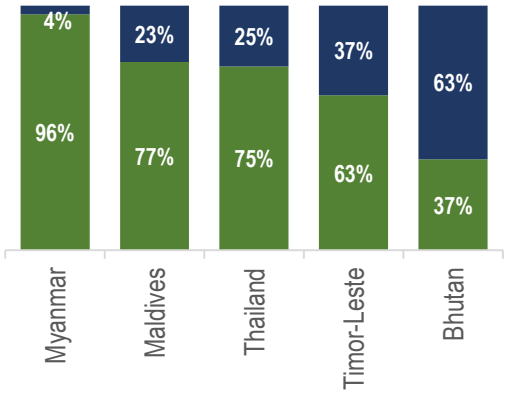
Midwife



Dentist



Pharmacist



Country data reported to WHO through NHWA online platform as of 15 December 2019.

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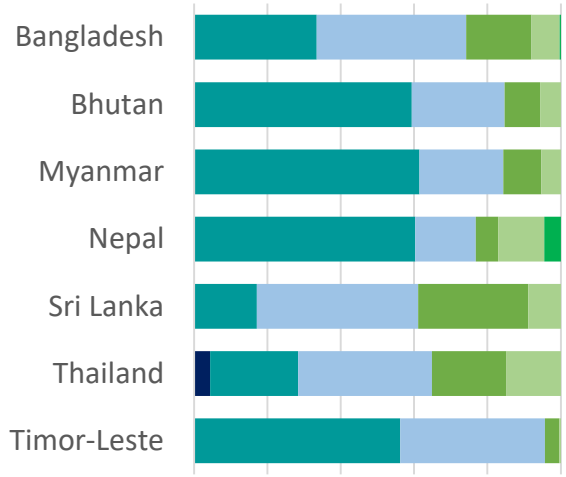
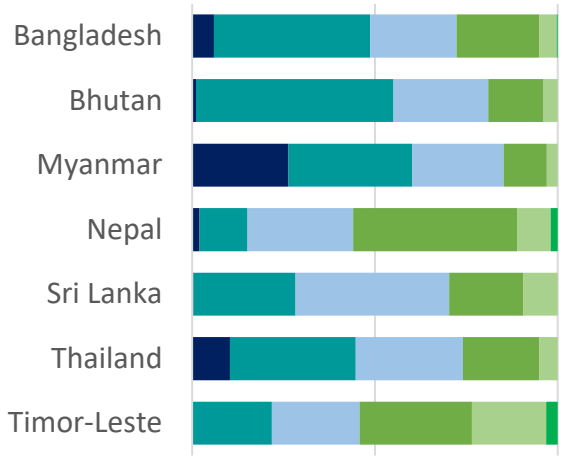
Age distribution in SEAR (2018)

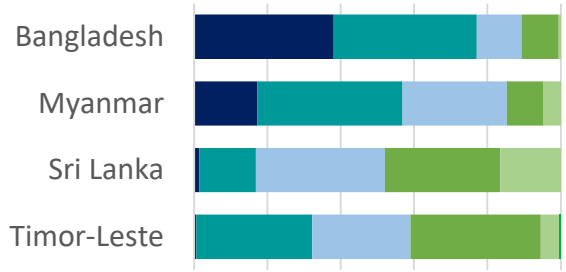
Doctors



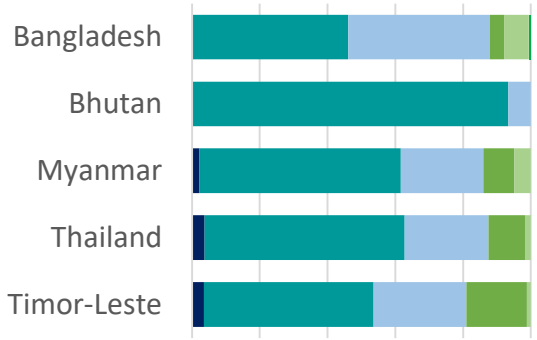
Nurse



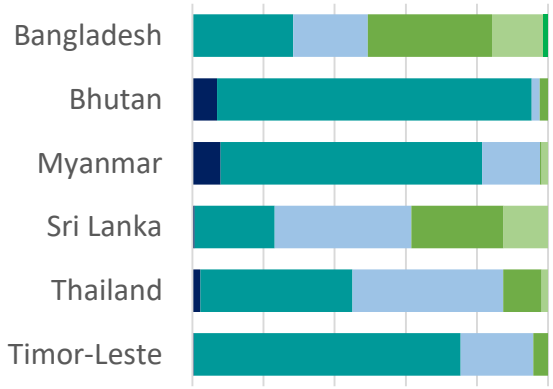
Midwife



Dentist



Pharmacist



Country data reported to WHO through NHWA online platform as of 15 December 2019.

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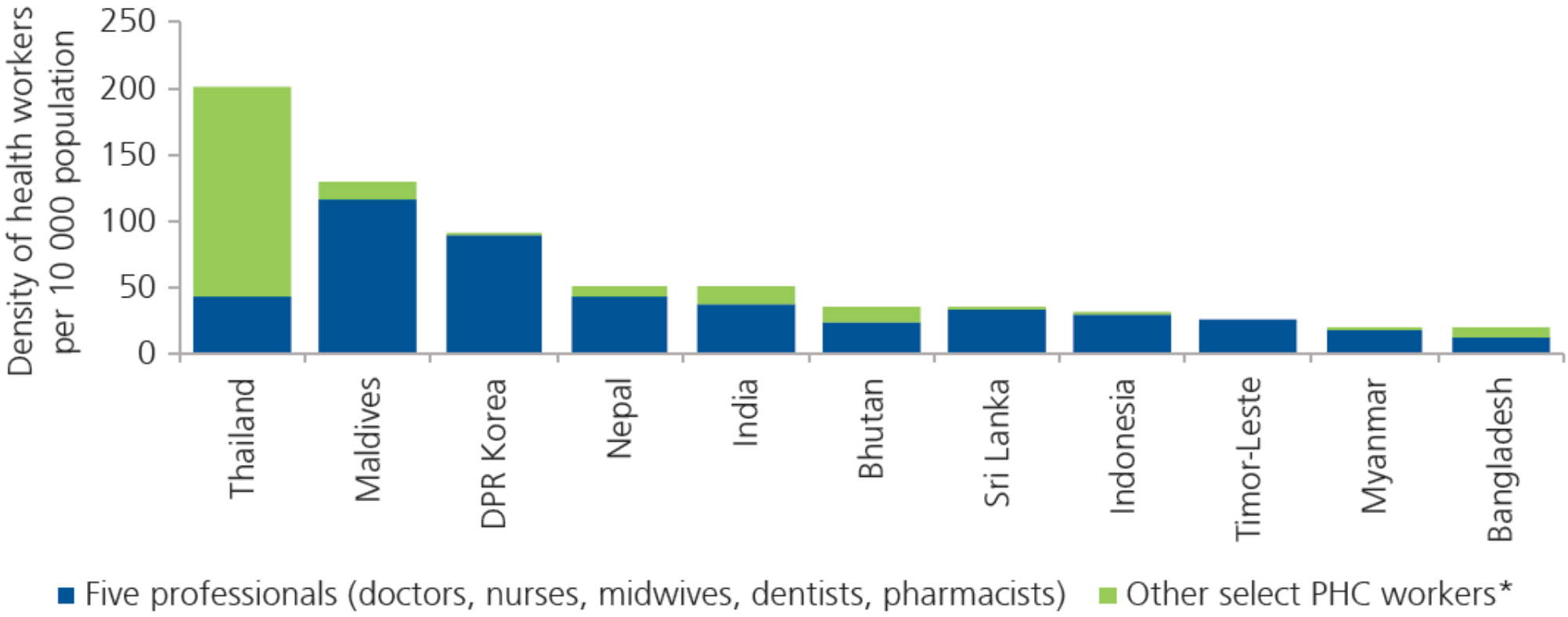
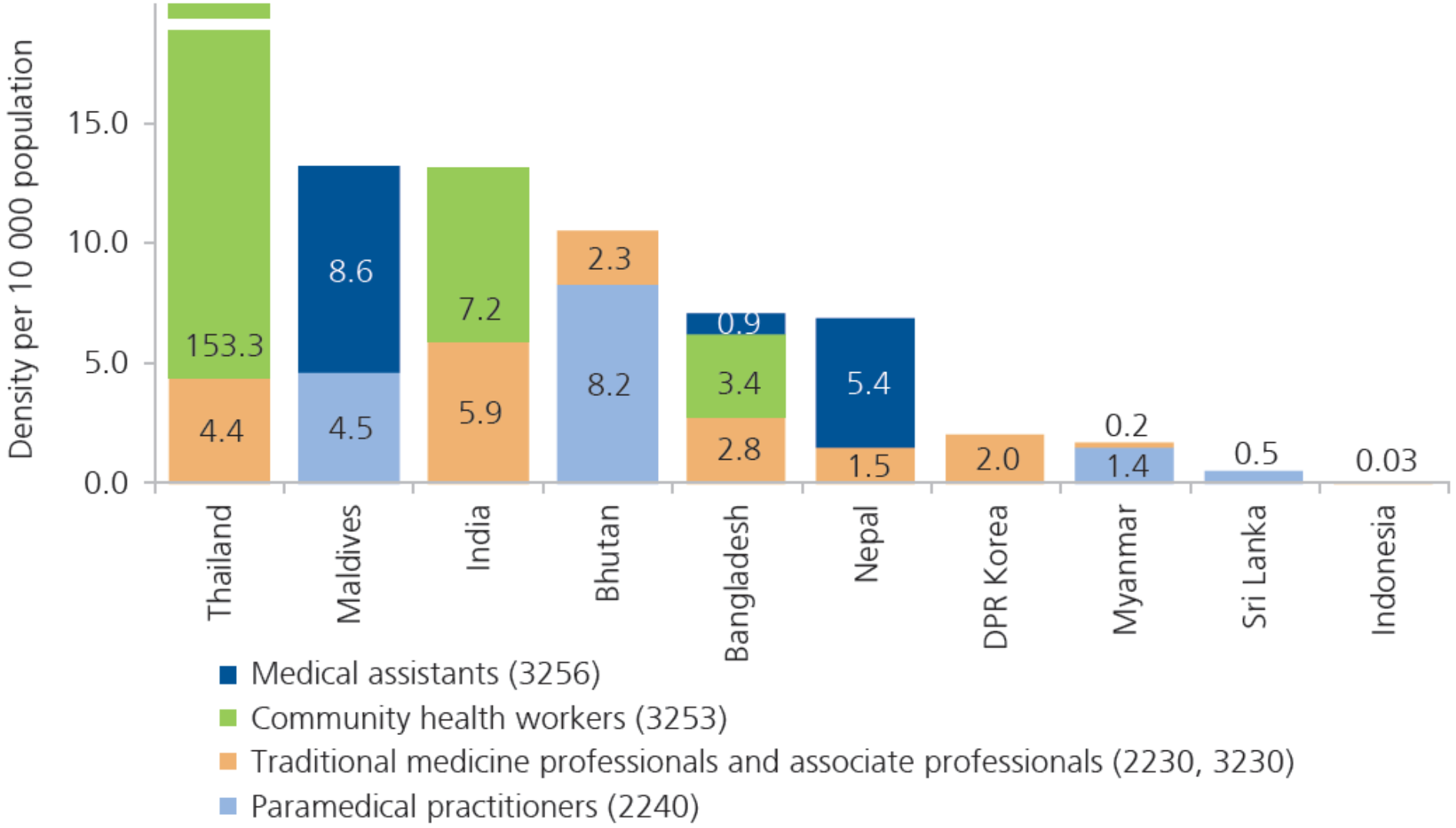
Availability health workers, including PHC workers, in SEAR (2018)



*Note: Same as Fig. 4

Source: Country data reported to WHO through NHWA online platform as of 15 December 2019.

Availability of PHC workers in SEAR (2018)



Note: Numbers in parentheses are International Standard Classification of Occupations (ISCO-08) codes.
Source: Country data reported to WHO through NHWA online platform as of 15 December 2019.

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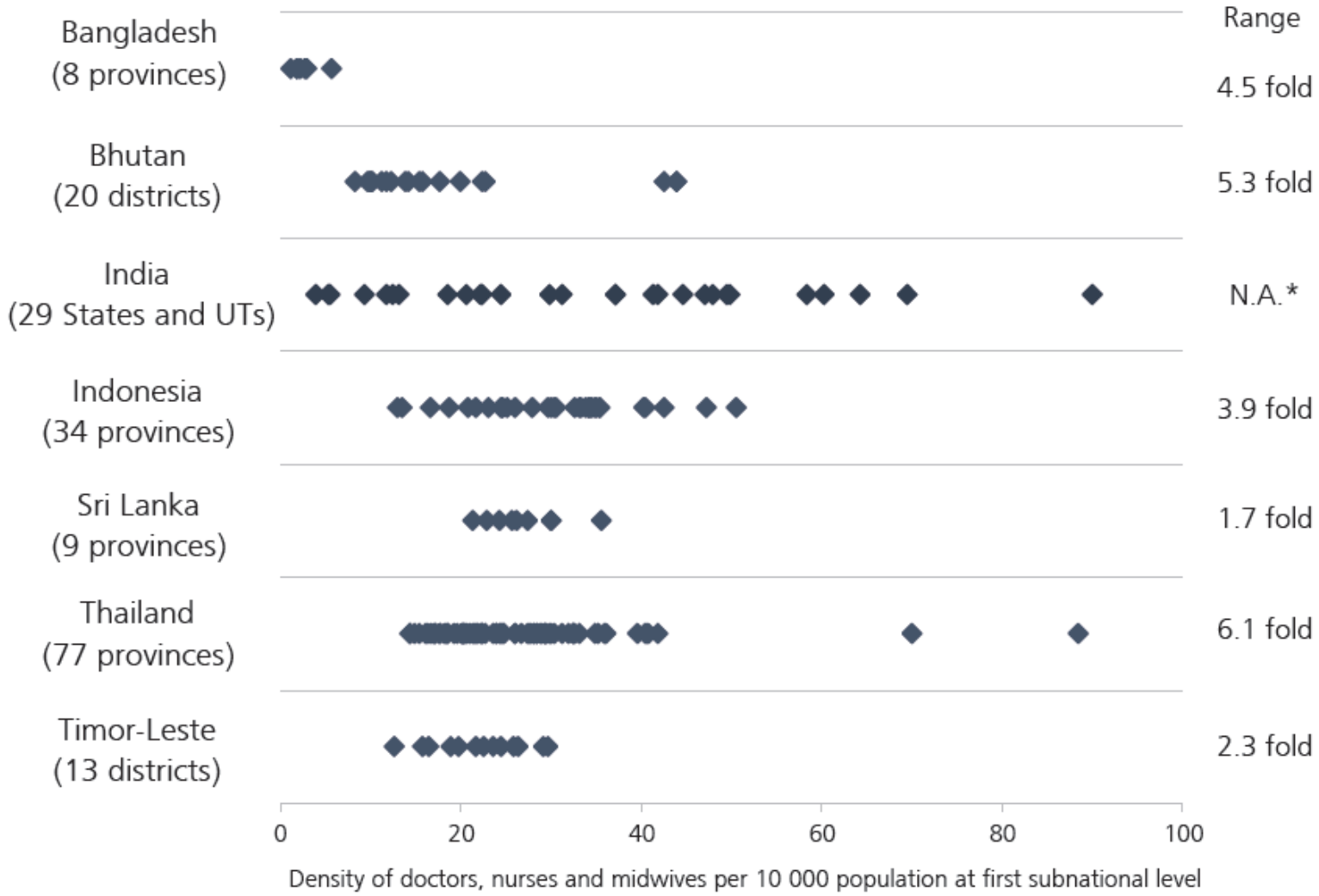
Health worker distribution by geographical area (2018 or latest available year)



Source: Country data reported to WHO through NHWA as of 15 December 2019

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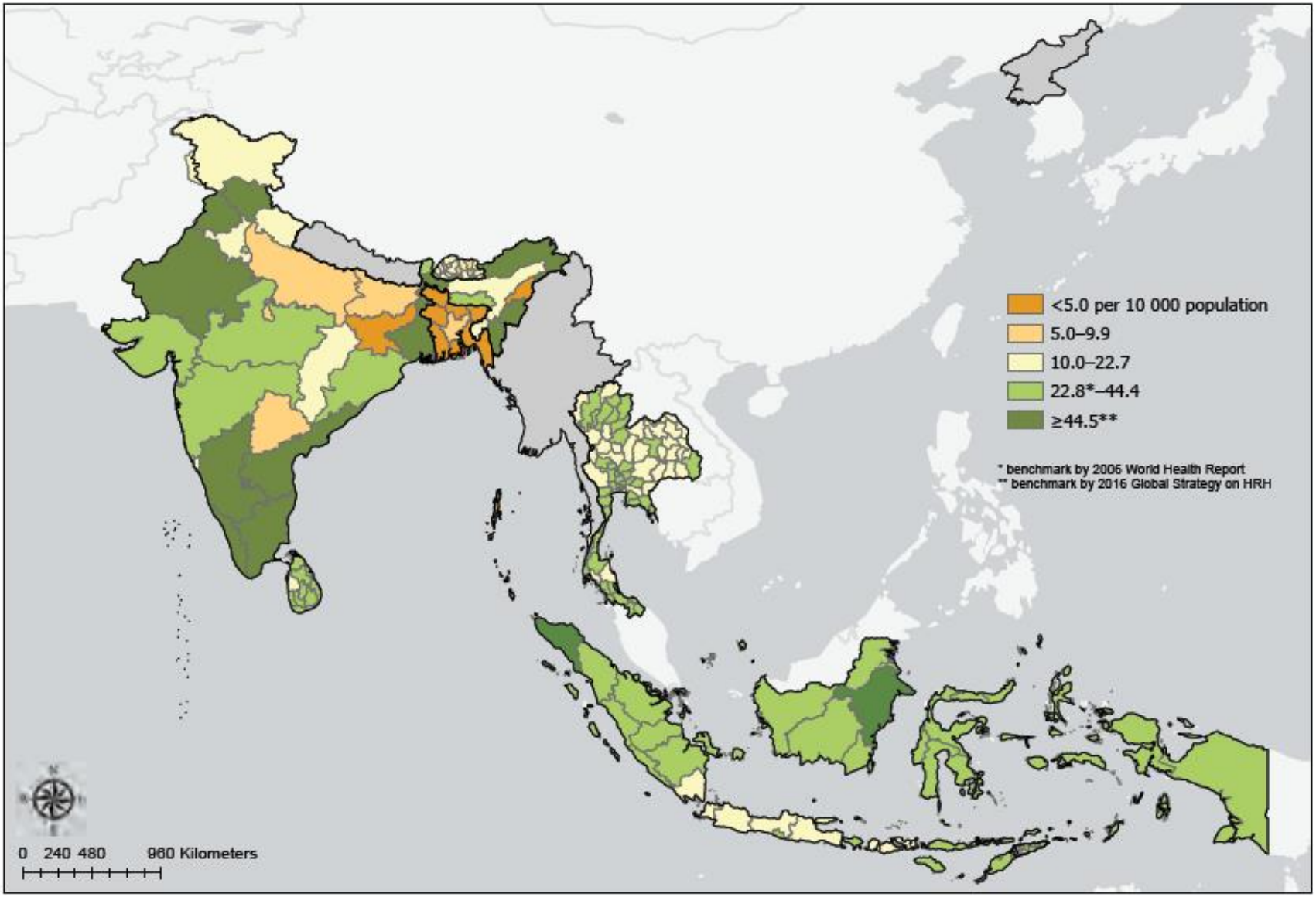
Health worker distribution by geographical area (2018 or latest available year)



DISTRIBUTION

- Geographical
  - Subnational level
  - Urban-rural
- Urban poor
- Gender gaps
- Cultural barriers

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What skill mix?

- How many different types of primary health care workers should a country have?
  - Country context (burden of disease, available budget, power of different professions, history of the health system…)
  - Focus on person centered care (critical interpersonal continuity of care), avoid excessive fragmentation
  - Patient workload:
    - Quality: Few patients in many PHC facilities (lack of trust, **poor quality***…)
    - Access:
      - Bangladesh: only 33% of Upazila Health Complex perform c-sections
      - Chhattisgarh: only 9% of CHCs performed c-sections on a monthly basis in 2018 (96% vacancy rate of specialists). Task shifting to MOs?
  - Prioritization: Bangladesh-midwives in Union sub-center or in UHC?

*Source: Rethinking assumptions about delivery of healthcare: implications for UHC. J.Das BMJ 2018

What skill mix?

- How many types of nurses should a country have?
  - ANM, GNM, BSc…
  - Some countries have discontinued ANMs…(bridge course). Depends on the stage where the country is…
- Should a country have an specific cadre on midwives?

*Source: Rethinking assumptions about delivery of healthcare: implications for UHC. J.Das BMJ 2018

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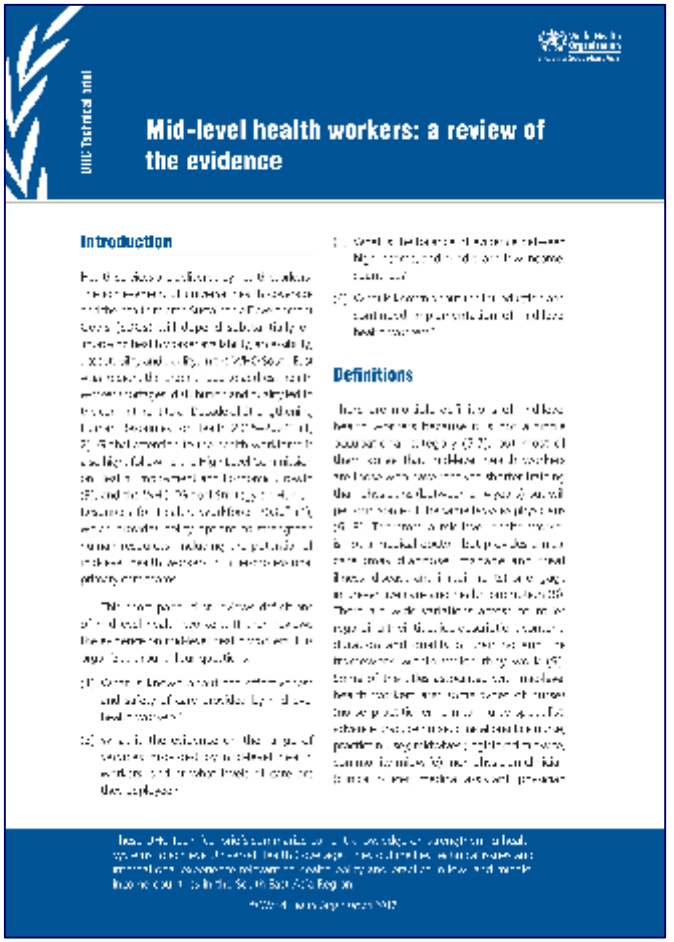
Task shifting…
Mid-level Health Workers

- Those who have received shorter training (2-4 years) than medical doctors but will perform some of the same tasks as medical doctors. Normally these workers follow certified training courses and receive accreditation for their work*.
- Clinical care or preventive care and health promotion.
- Community, in a primary care facility or in a hospital.
- Wide variations across countries



Source: UHC Technical brief: Mid-level health workers a review of the evidence, WHO-SEARO 2017
https://apps.who.int/iris/bitstream/handle/10665/259878/UHC-health_workers.pdf?sequence=1&isAllowed=y

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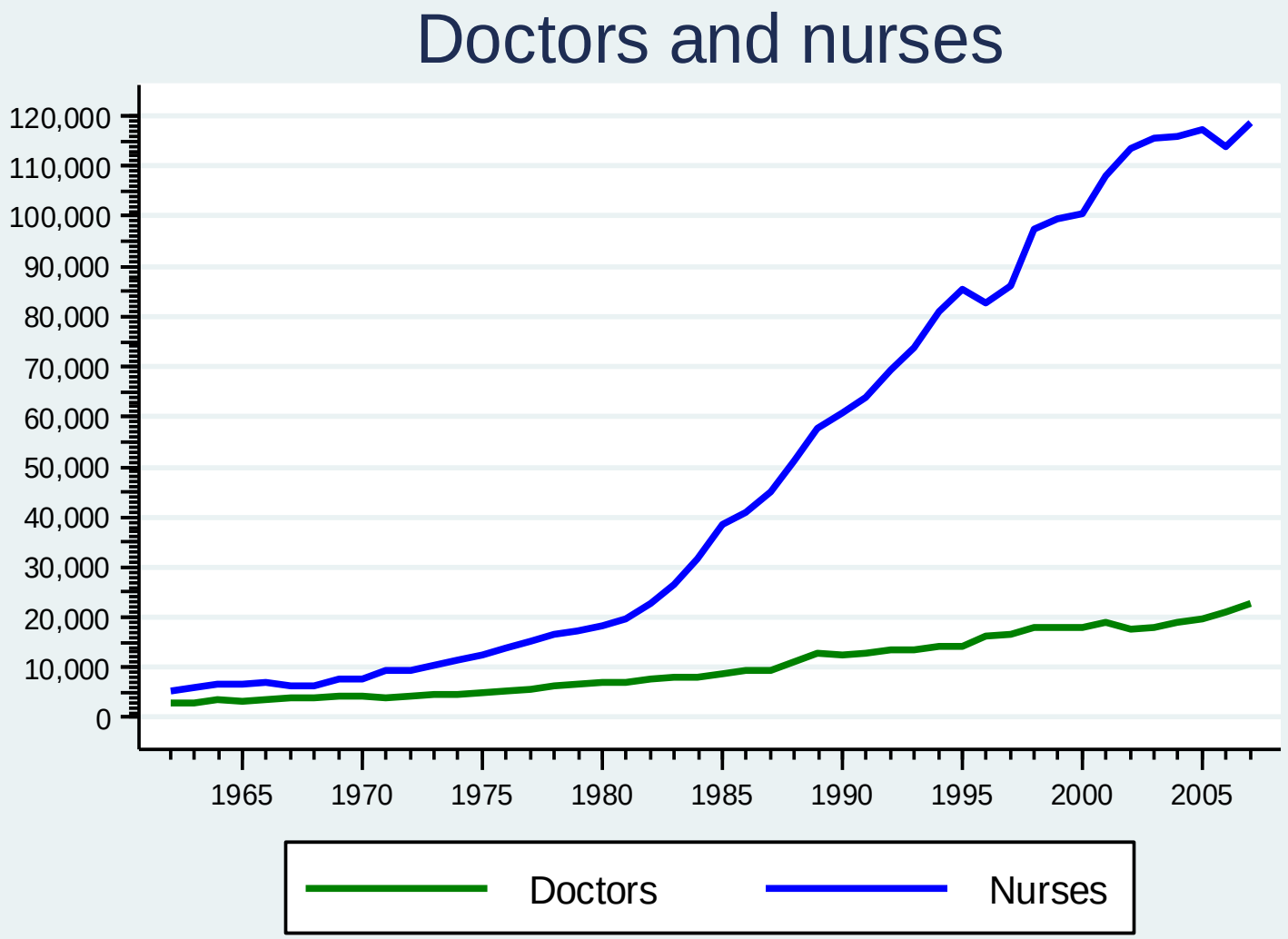
Mid-level health care workers

- Health care provided by MLHW is **as effective as** care provided by physicians for specific interventions
- Lower training costs, reduced training duration, and potential for success in rural placements
- Expanding coverage and access, shortage of human resources, retention of health workers in rural areas, international migration of health workers
- MLHW need to be well-embedded in the system, receive adequate training, support, recognition and pay.
- The mid-level occupation should also be well regulated by competent regulatory bodies

Long term policy to increase levels and change mix of health workforce



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International Journal of Integrated Care

Zapata, T et al 2017 How to Integrate HIV and Sexual and Reproductive Health Services in Namibia, the Epako Clinic Case Study. *International Journal of Integrated Care*, 17(4): 1, pp. 1–12, DOI: https://doi.org/10.5334/ijic.2488

INTEGRATED CARE CASE

How to Integrate HIV and Sexual and Reproductive Health Services in Namibia, the Epako Clinic Case Study

Tomas Zapata*, Norbert Forster†, Pedro Campuzano‡, Rejoice Kambapani‡, Heena Brahmbhatt†, Grace Hidinua†, Mohamed Turay§, Simon Kimathi Ikandi†, Leonard Kabongo‖ and Farai Zariro‖

Introduction: During the past two decades, HIV and Sexual and Reproductive Health services in Namibia have been provided in silos, with high fragmentation. As a consequence of this, quality and efficiency of services in Primary Health Care has been compromised.

Methods: We conducted an operational research (observational pre-post study) in a public health facility in Namibia. A health facility assessment was conducted before and after the integration of health

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5624130/pdf/ijic-17-4-2488.pdf

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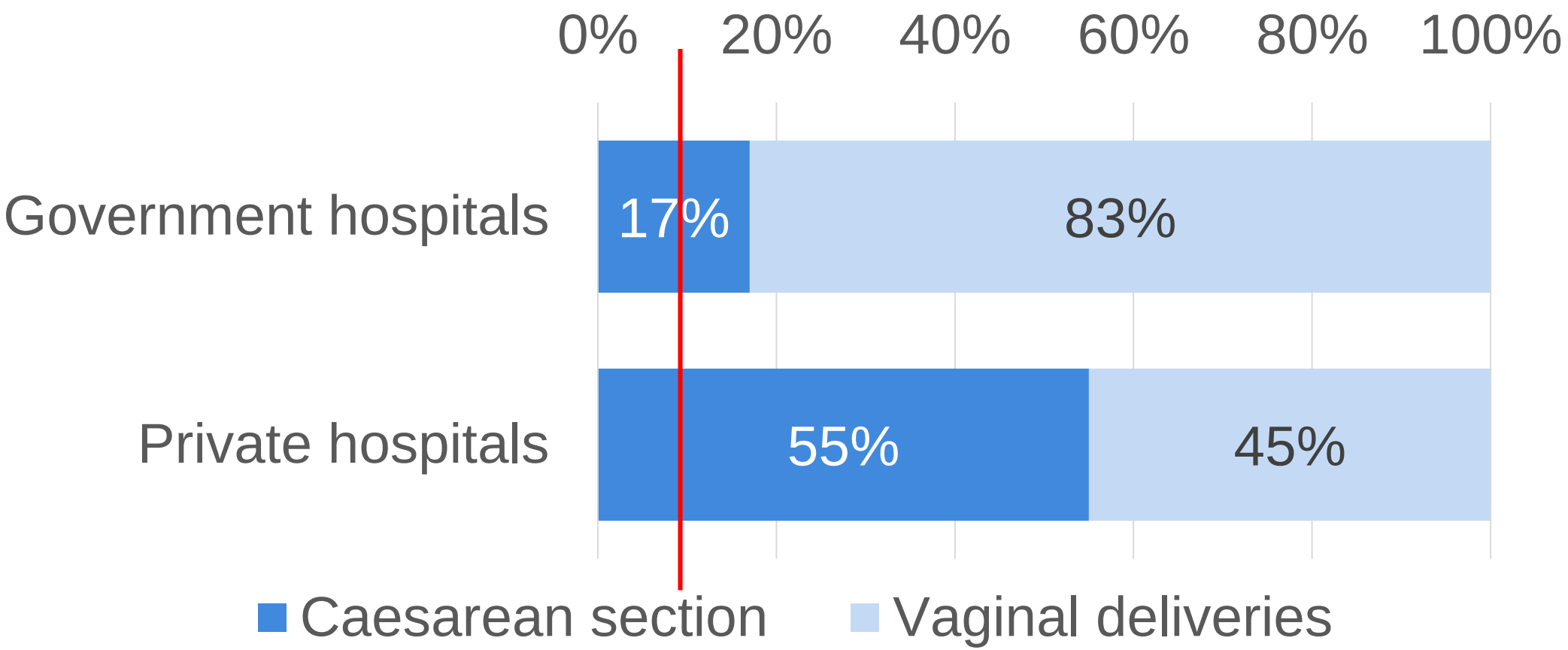
- **Qualifications-clinical knowledge gap**
- **Competency gap**
- **KNOW-DO GAP** In many countries large gaps exist between what doctors and other health workers know and what they actually do.
  - How to improve effort and motivation?

Proportion of Caesarean section delivery by hospital type (India)



Source: Household social consumption in India: Health NSS 75th round (July, 2017 – June, 2018)

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Conclusions

- Health workforce has to **adapt** to changing health needs and changing health services
  - Numbers: Increase the density of health workers in SEAR, including nurses & midwives
  - Distribution:
    - Improve rural recruitment & retention
    - Improve HWF density in poor urban areas, considering gender and cultural inequities
  - Skill mix:
    - Consider task shifting in PHC. Mid-levels health workers can provide effective care if adequately trained, paid and supervised.
    - Avoid fragmentation and provide quality continuum services. Person-centred services
    - Focus on quality of PHC services and PHC providers
  - Performance:
    - Improve quality of pre-service education to address the qualification-knowledge gap.
    - Develop competencies to provide quality care.
    - Improve motivation and effort of health workers to address the know-do gap.

THANK YOU

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