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W4H
WOMEN FOR HEALTH

Addressing the shortage of female health workers

Contributing to WHO's 'Global Strategy on Human Resources for Health'

The Women for Health Programme 2012-2020

Contents

Abbreviations and Acronyms

DFID	Department for International Development (now Foreign Commonwealth and Development Office, FCDO)
FYP	Foundation Year Programme
HTIs	Health Training Institutions
ID	Infectious Diseases
MDGs	Millennium Development Goals
NCD	Non-Communicable Diseases
NMCN	Nursing and Midwifery Council of Nigeria
PRRINN-MNCH	Partnership for Reviving Routine Immunisation in Northern Nigeria - Maternal Newborn and Child Health
RMNCH	Reproductive, Maternal Newborn and Child Health
SBA	Skilled Birth Attendant
SCL	Student Centered Learning
SDGs	Sustainable Development Goals
SHWs	Skilled Health Workers
SMoHs	State Ministries of Health
UHC	Universal Health Coverage
UK	United Kingdom
WHO	World Health Organization
W4H	Women for Health

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Contributing to WHO's 'Global Strategy on Human Resources for Health'

1. Background

A critical shortage of health workers exists globally[1,2,3]. Producing more health care professionals in the right number and with the right competencies is therefore critical to meeting the health needs of the population. If competent appropriately skilled health professionals are not available in adequate numbers and distributed proportionately to the population, many citizens will not receive the services corresponding to their health (and cultural) needs.

The shortage of health workers in Nigeria is due to a myriad of factors including: inadequate production of graduates from the health training institutions due to a lack of institutional and practical training sites; poor absorption into the workforce (e.g. health worker recruitment embargo in some states); challenges with the management of available human resources for health including ineffective deployment, poor monitoring, supervision and regulation; and poor remuneration and work environment, among others[4,5].

The available health workforce is inequitably distributed between the rural and urban areas and also between the Southern and Northern parts of Nigeria. Although there was a national average of 12 doctors per 100,000 population, it was as low as four in the North Western and North Eastern zones of the country[6]. In many predominantly Muslim communities of Northern Nigeria, and consistent with their social and cultural norms, there are strong same gender preferences when it comes to being treated by a health worker. Husbands prefer a female health worker to attend to their spouses and disapprove of other males touching or talking to their spouses. However, females from these same Northern communities are grossly under-represented in the health sector workforce[4,5].

In response to the global health workforce crises, the World Health Organization (WHO) developed the ***Global Strategy on Human Resources for Health: Workforce 2030***[7]. The global strategy aims to accelerate progress towards Universal Health Coverage (UHC) and the United Nations Sustainable Development Goals (SDGs) by ensuring equitable access to health workers within a strengthened health system.

This document is a learning note, it describes how one country can contribute to the ***Global Strategy on Human Resources for Health: Workforce 2030***. It also describes how learning from a country programme can contribute to the development of global strategies. Using the Women for Health (W4H) programme in Northern Nigeria as a case study, it situates W4H interventions and achievements against the ***Global Strategy on Human Resources for Health: Workforce 2030*** and demonstrates how the UK aid funded W4H programme has contributed to its ambitions between 2012 and 2019. This document is aimed at health planners, programmers, international organisations, bilateral and multilateral development partners, policy makers and other relevant stakeholders in the health workforce area including professional regulatory bodies, education and training institutions, professional associations and civil society.

1. Chen L, Evans T, Anand S et al. Human resources for health: overcoming the crisis. Lancet. 2004 Nov 27-Dec 3;364(9449):1984-90. Available from <https://doi.org/10.1016/S0140-6736(04)17482-5>

2. Narasimhan V, Brown H, Pablos-Mendez A, et al. Responding to the global human resources crisis. Lancet. 2004 May 1;363(9419):1469-72. Available from <https://doi.org/10.1016/S0140-6736(04)16108-4>

3. World Health Organization (WHO). The World Health Report 2006: working together for health. Geneva: WHO, 2006. Available at: http://www.who.int/whr/2006/en/.

4. Afenyadu G, Adegoke A, Findley S. Improving Human Resources for Health means Retaining Health-Workers: Application of the WHO-Recommendations for the Retention of Health-Workers in Rural Northern-Nigeria. J Health Care Poor Underserved. 2017;28(3):1066-1086. doi: 10.1353/hpu.2017.0098.

5. Adegoke AA. Retention of Skilled Birth Attendants in Nigeria: Experiences and Challenges. Partnership for Routine Immunisation in Northern Nigeria-Maternal Newborn and Child Health (PRRINN-MNCH) Knowledge Summary. 2013.

6. Federal Republic of Nigeria. National Human Resources for Health Strategic Plan: 2008 to 2012. 2008. Abuja, Nigeria.

7. World Health Organization. 2016. Global strategy on human resources for health: Workforce 2030. Available from <https://www.who.int/hrh/resources/pub_globstrathrh-2030/en/>

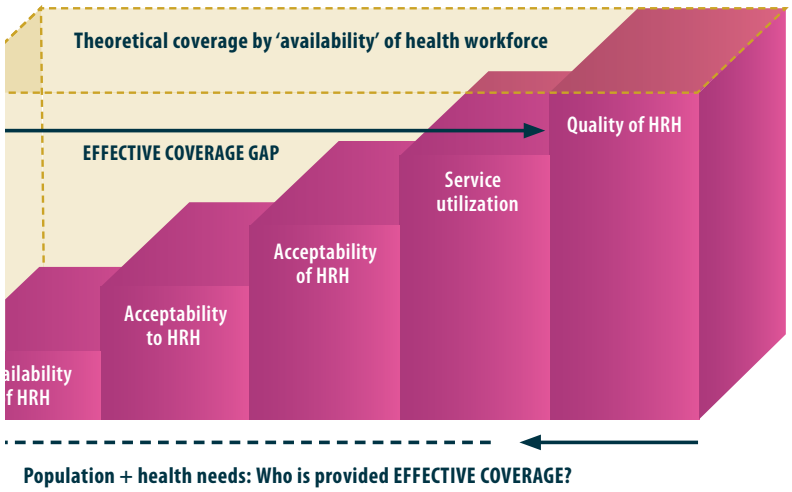
2. Overview of the Global Strategy on HRH: Workforce 2030

The development of the *Global Strategy on HRH: Workforce 2030* was informed by a process launched in 2014 following the Sixty-seventh World Health Assembly adopted resolution WHA67.24. This resolution, is a follow-up of the Recife Political Declaration on Human Resources for Health: renewed commitments towards UHC. The development of the *Global Strategy on HRH: Workforce 2030* involves a series of consultations and consolidations of evidence around a comprehensive health labour market framework for UHC.

The overall goal of the Global Strategy is to improve health, social and economic development outcomes

The Global Strategy is based on the premise that ***"there is no health system without health workers"***, that health systems can only function with health workers and that improving health service coverage and achieving the highest attainable standard of health is dependent on their availability, accessibility, acceptability and quality[8]. The strategy stressed that mere availability of health workers is not sufficient and that it is only when they are equitably distributed, accessible and acceptable by the population and deliver quality care can theoretical coverage translate into effective service coverage (Figure 1). This framework summarises the core principles suggested by the WHO for countries to improve their HRH.

Figure 1: Human resources for health: availability, accessibility, acceptability, quality and effective coverage



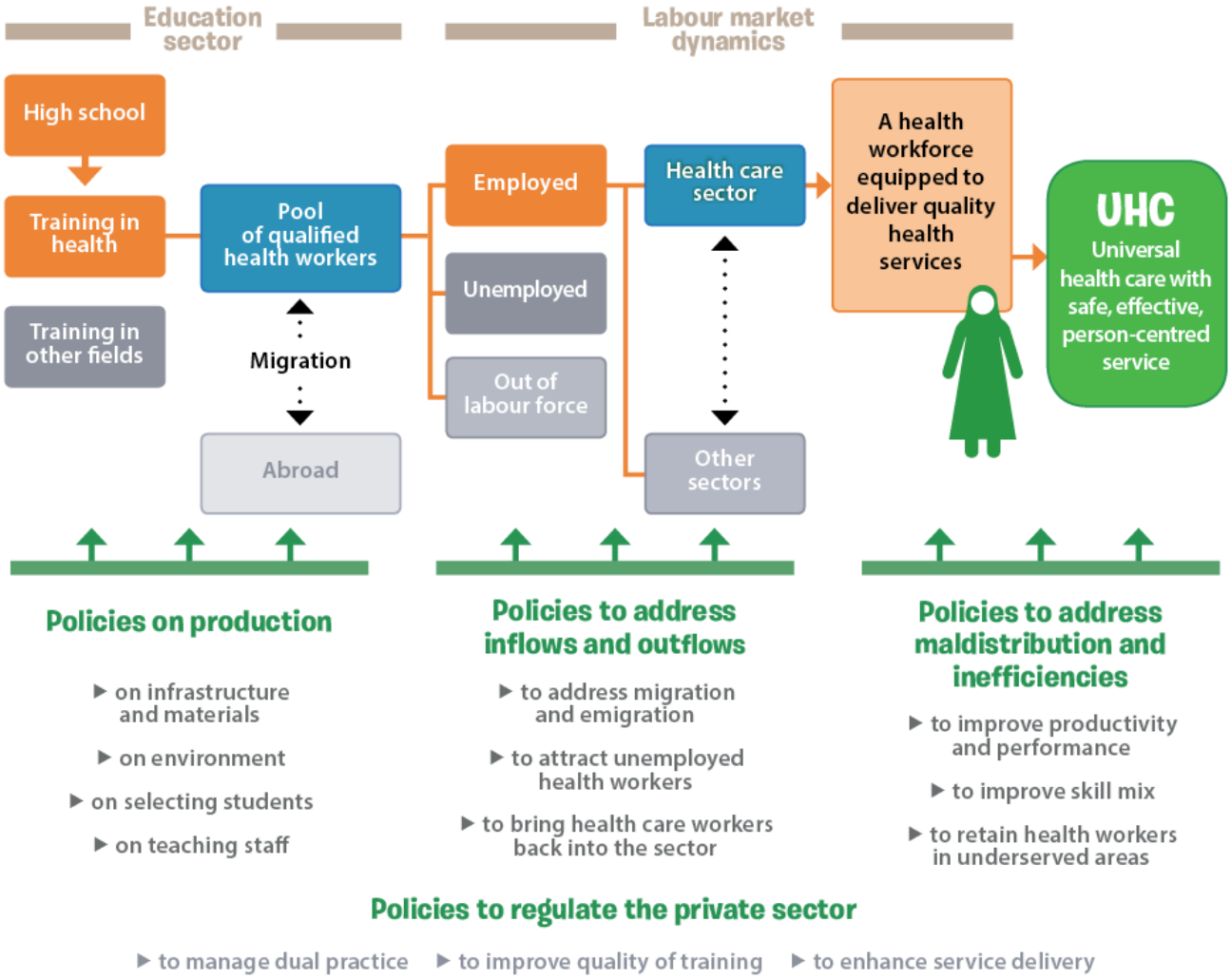
Source: Campbell et al. 2013 *Global Strategy on HRH: Workforce 2030*

The Global Strategy also stresses the importance of effective policy and funding decisions on both the education and health labour market aligning with the evolving needs of the population (Figure 2).

The overall goal of the Global Strategy is: to improve health, social and economic development outcomes by ensuring universal availability, accessibility, acceptability, coverage and quality of the health workforce through adequate investments to strengthen health systems, and the implementation of effective policies at national, regional and global levels.

8. WHO. Global Health Workforce Alliance. A universal truth: no health without a workforce. Report of Third Global Forum on Human Resources for Health, Recife, Brazil. Geneva: World Health Organization; 2014. Available from <http://www.who.int/workforcealliance/knowledge/resources/hrhreport2013/en/>

Figure 2: Policy levers to shape health labour markets



It is only when health workers are equitably distributed, accessible and acceptable by the population that theoretical coverage translates into effective service coverage

The Global Strategy has been developed having the SDG health targets and the global ambition towards UHC in mind. It has four objectives:

Objective 1: To optimise performance, quality and impact of the health workforce through evidence informed policies on HRH, contributing to healthy lives and well-being, effective UHC, resilience and strengthened health systems at all levels.

Objective 2: To align investment in HRH with the current and future needs of the population and of health systems, taking account of labour market dynamics and education policies, to address shortages and improve distribution of health workers, so as to enable maximum improvements in health outcomes, social welfare, employment creation and economic growth.

Objective 3: To build the capacity of institutions at sub-national, national, regional and global levels for effective public policy stewardship, leadership and governance of actions on human resources for health.

Objective 4: To strengthen data on HRH, for monitoring and ensuring accountability for the implementation of national and regional strategies, and the global strategy.

These four global objectives are aiming to deliver thirteen milestones – seven by 2020 and the remaining six by 2030.

Global milestones by 2020

1. All countries have inclusive institutional mechanisms in place to coordinate an inter-sectoral health workforce agenda.
2. All countries have an HRH unit with responsibility for development and monitoring of policies and plans.
3. All countries have regulatory mechanisms to promote patient safety and adequate oversight of the private sector.
4. All countries have established accreditation mechanisms for health training institutions.
5. All countries are making progress on health workforce registries to track health workforce stock, education, distribution, flows, demand, capacity and remuneration.
6. All countries are making progress on sharing data on human resources for health through national health workforce accounts and submit core indicators to the WHO Secretariat annually.
7. All bilateral and multilateral agencies are strengthening health workforce assessment and information exchange.

Success of The Global Strategy requires implementation of effective policies at national, regional and global levels

Global milestones by 2030

1. All countries are making progress towards halving inequalities in access to a health worker.
2. All countries are making progress towards improving the course completion rates in medical, nursing and allied health professionals training institutions.
3. All countries are making progress towards halving their dependency on foreign-trained health professionals, implementing the WHO Global Code of Practice.
4. All bilateral and multilateral agencies are increasing synergies in official development assistance for education, employment, gender and health, in support of national health employment and economic growth priorities.
5. As partners in the United Nations SDGs, to reduce barriers in access to health services by working to create, fill and sustain at least 10 million additional full-time jobs in health and social care sectors to address the needs of underserved populations.
6. As partners in the United Nations SDGs, to make progress on Goal 3c to increase health financing and the recruitment, development, training and retention of the health workforce.

The distribution of these milestones across the four objectives is shown in Table 1 below

Table 1: Global HRH milestones 2020 and 2030

Milestones to be delivered		
	by 2020	**by 2030**
Objective 1 – Optimise workforce performance	1	2
Objective 2 – Align investment with need	0	4
Objective 3 – Build institutional capacity	3	0
Objective 4 – Strengthen data for monitoring	3	0
Total	**7**	**6**

3. The Women for Health Programme

Before the inception of W4H Northern Nigeria had fewer nurses and midwives per capita than the rest of Nigeria. In fact, the health worker ratios were well below neighbouring countries, even those with lower per capita incomes

The UK aid-funded Women for Health (W4H) programme supported the government of Nigeria to improve the number and capacity of female health workers in six states in Northern Nigeria (Kano, Katsina, Jigawa, Zamfara, Yobe and Borno). At the same time it contributed to women's empowerment and gender equality in communities and institutions in the North. It implemented various interventions to respond to a severe shortage of female health workers in the Northern region where there are social and cultural barriers to women being seen by male health workers. It is expected that the increase in female health workers led by W4H will lead to an increase in women's access to and utilisation of health services in Northern Nigeria and support progress towards delivery of UHC.

During the first five years of implementation, from 2012 – 2017, W4H worked in five states (Kano, Katsina, Jigawa, Zamfara and Yobe). In the extension phase between April 2018 and September 2020, W4H evolved to adapt to the emerging context and new challenges in Northern Nigeria. This included expansion to conflict-affected Borno state and conflict-affected parts of Yobe state, and sustaining the progress achieved over the first five years in the remaining four states (Katsina, Kano, Jigawa and Zamfara).

Before the inception of W4H, a root cause analysis[9] of the health workforce situation in Northern Nigeria (Jigawa, Kano, Katsina, Yobe and Zamfara) carried out by the Partnership for Reviving Routine Immunisation in Northern Nigeria-Maternal Newborn and Child Health (PRRINN-MNCH) programme in 2012, showed that Northern Nigeria has fewer nurses and midwives per capita than the rest of Nigeria. In fact, the health worker ratios are well below neighbouring countries, even those with lower per capita incomes than Nigeria. The root cause analysis model presented in the report compared current trends to two measures of needs for the health workforce: the WHO minimum ratio[10] of 1.73 nurses and midwives per 1,000 of the population, and targets set by State Ministries of Health (SMoHs). Various policy interventions, including changes in nurse and midwife training, recruitment, and retention were modelled. Transformational investments in HRH were required in Northern Nigeria, the analysis concluded. To meet the WHO minimum ratio for nurses and midwives by 2030, the states must greatly increase their nurse and midwife production: by a factor of 20.6 for Jigawa, 19.4x for Kano, 26.5x for Katsina, 14.7x for Yobe, and 17.6x for Zamfara. Without these massive investments, millions of Nigerians will not have access to basic health services.

Key interventions implemented by W4H to support the government of Nigeria included the following:

- Supporting health training institutions (HTIs) to achieve full accreditation status
- Ensuring the availability of an adequate number of tutors
- Improving the quality of teaching
- Improving the responsiveness of the institutions to the needs of female students
- Increasing, appropriate and better-quality training for nurses and midwives in conflict-affected areas in Yobe and Borno
- Disseminating the W4H approach to facilitate learning for sustainability and scale up
- Strengthening federal capacity, policy and systems for better and more gender equal HRH planning, production, recruitment, deployment and retention
- Strengthening the capacity, policy and systems for sustainability of state governments and HTIs

9. Root Cause Analysis of Northern Nigeria's Health Worker Crisis; 2013; PRRINN-MNCH

10. World Health Organisation. 2006. The World Health Report: Working together for health. WHO. Geneva Available from <https://www.who.int/whr/2006/whr06_en.pdf>

W4H has achieved a wide range of successes including:

- Increasing the physical, management and teaching capacity of 21 HTIs
- Improving the quality of teaching and supporting a transition to a Student-Centered Learning (SCL) approach
- Introducing a Foundation Year Programme (FYP) for rural women to improve their academic credentials, study skills and confidence to enter health worker training
- Engaging with 912 underserved communities to promote positive attitudes towards, and community sponsorship of women attending tertiary education to become health workers
- Engaging with government to ensure commitment, legislation and budgeted funding to sustain HTI and FYP activities into the future
- Collaborating with Nursing and Midwifery Council of Nigeria (NMCN) to strengthen its capacity to carry out its mandate

4. Contributing to the Global Strategy's policy levers and HRH framework

W4H has contributed to nine of the milestones—four among the 2020 milestones and five among the 2030 milestones (Table 2).

Table 2: Numerical analysis of W4H contribution to global HRH milestones 2020 and 2030

Milestones to be delivered			Contributed to by W4H	
	by 2020	by 2030	2020	2030
Objective 1	1	2	1	2
Objective 2	0	4	0	3
Objective 3	3	0	1	0
Objective 4	3	0	2	0
Total	**7**	**6**	**4**	**5**

In terms of how W4H fits into global framework to increase the number of health workers, W4H has contributed extensively to all the policy levers to shape the health workforce as described above in Figure 2. This includes all the key elements of the **education sector** (high school, education in health, and education in other fields); resulting in a **pool of qualified health workers**; and **labour market dynamics** including employed, unemployed, out of labour force, health sector, other sectors resulting in a **competent health workforce** equipped to deliver quality health services which ultimately will result in achieving UHC.

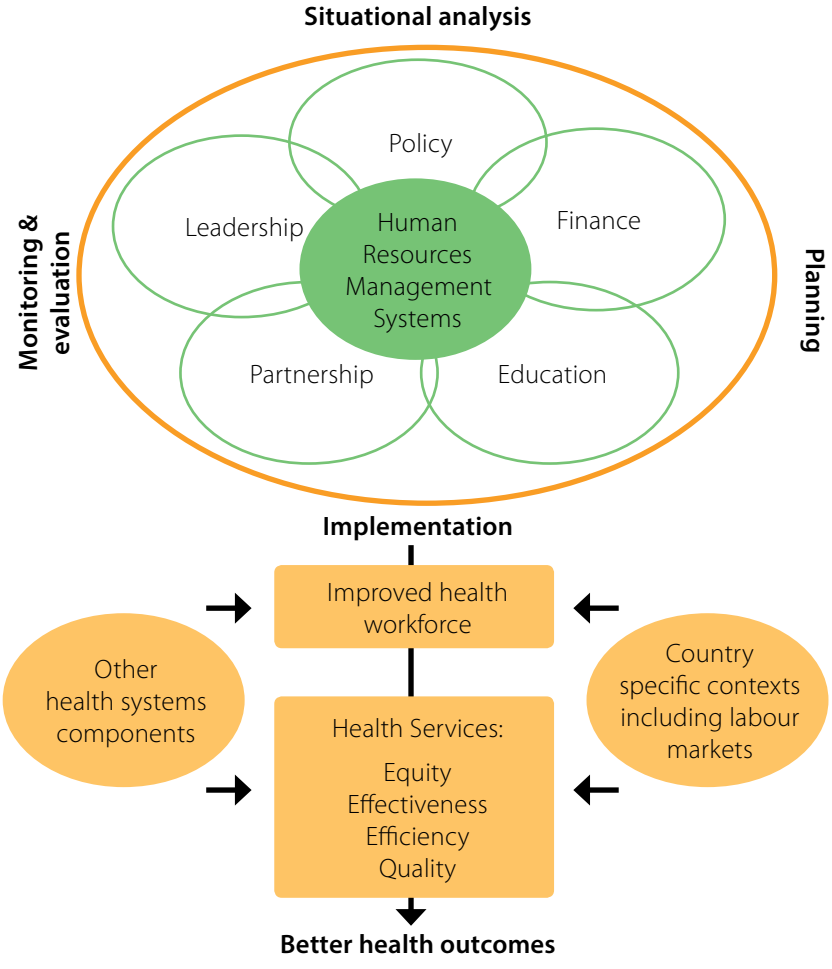
W4H has responded very positively to the situation on the ground regarding young women from rural areas who could not complete high school or who did not pass the required subjects. These women were carefully selected and supported through the W4H FYP to be able to meet the HTI entry requirements and to undertake education in health or education in other fields (if they failed to meet criteria for Education in Health). At the time the W4H programme ended in 2020, some **2,801 young rural women had benefitted from the FYP**. Of these, 556 had graduated as health workers (the others had not yet graduated). Overall, **a total of 9,601 female students were supported to enroll in health training institution during the programme**. Over the eight years of the programme since 2012, W4H steadily contributed to a pool of qualified health workers in the rural areas of the supported states. **A large proportion have been employed (79.8%), with 97% of those employed deployed to rural areas**. The contribution of W4H has steadily improved service delivery in the health care sector because of improvement in a health workforce equipped to deliver quality health service and further leading to UHC with safe, effective, person-centered health service.

5. Contributing to the Global Strategy's Objectives

Contributing to Objective one

To optimise performance, quality and impact of the health workforce through evidence-informed policies on HRH, contributing to healthy lives and well-being, effective UHC, resilience and strengthened health systems at all levels, Objective 1 of the Global HRH Strategy speaks to two pillars of the WHO HRH systems framework – Policy and Leadership (see Figure 3).

Figure 3 HRH Action framework



Milestones

There are three milestones under this objective and W4H has been contributing to all three – one of them to be achieved by 2020 and the other two by 2030. W4H's contributions are as follows:

> *a) By 2020, all countries will have established accreditation mechanisms for health training institutions*

Before the W4H intervention started in Jigawa, Kano, Katsina, Yobe and Zamfara states of Nigeria in 2012, the environment in most of the HTIs was unsuitable for single and married female students. Given the community's attitude and desire to have female health workers attend to women (particularly pregnant ones), it was urgent to ensure that a significant change happened. Such change would ensure an environment that is appropriate for women, especially from rural areas, so they could enroll in HTIs and boost the supply of female health workers to the rural areas.

W4H was the catalyst for this change. One hundred and sixty-seven (167) infrastructure projects were carried out by W4H and the accommodation and security of female students in the five states was vastly improved. **Before W4H, only one school in the five states had full accreditation status. As at September 2020, 21 schools, out of 22, had secured full accreditation** because of the effective collaboration between W4H and the governments of the six states while one (a newly-established school) had secured provisional accreditation. **The number of indexed places has risen from 1,198 in 2012 to 3,090 in 2020 – an increase of 257%**. This increase in indexed places was achieved through improving accreditation status – which allows for higher student enrolment – and through the opening of new HTIs and new programmes of study. All the HTIs were well below the required tutor-to-student ratio in 2012 – and by 2020 there were many more qualified tutors in the HTIs. W4H support to state governments to develop, implement and monitor their Tutor Training Plans, so that by 2020 all the HTIs met the required tutor-to-student ratio, which is a key accreditation requirement set by the regulatory bodies.

One other issue that stood in the way of full accreditation was the poor governance in the schools prior. Poor governance and lack of accountability contributed to systemic failings and inability to secure accreditation. W4H changed all that. There are strong management systems in place in all the HTIs, and W4H supported a transition to computer-based information management systems. **The success of W4H and its contribution via this global milestone is demonstrated by the fact that 9,601 female students had enrolled in the 22 HTIs by September 2020**.

> *b) By 2030, all countries will have made progress towards halving inequalities in access to a health worker*

One of the major inequalities in Nigeria's health service delivery is in the distribution of health workers.

The rural population in Nigeria is very poorly served with the Northern part of Nigeria being the most affected. Very few female health workers get deployed to rural areas and retention rates are low. To begin to address this inequality, W4H's response was to strategically select young women secondary school graduates from the rural areas, supporting them to qualify for HTI admission and getting them admitted to study to be study to be midwives, nurses, Community Health Extension Workers or Junior Community Health Extension Workers (CHEW/JCHEW) in the 22 HTIs in the six states supported by the programme. This intervention, the

FYP, aims to help the young women to get deployed to the rural areas where they are from after completion of their training. **By September 2020, 2,801 female students from rural areas had been admitted into FYP, of whom 556 had completed professional training** (others are still in training).

To sustain the intervention and ensure ownership by the rural communities, the FYP students are being empowered to act as leaders and role models in their communities. W4H's state teams mounted concerted advocacy to get state governments support the recruitment and deployment of health workers to rural areas. Another major challenge addressed effectively by W4H was the issue of incentives for rural female health workers to improve retention. **W4H worked to address the social and cultural barriers in the rural areas and constructed 35 houses to accommodate midwives in selected rural areas as part of a pilot study on strategies for improving retention in rural areas**. This fed into other supports and interventions provided by the programme to state government to improve rural retention policies and incentive schemes.

> *c) By 2030 all countries will have made progress towards improving the course completion rates in medical, nursing and allied health professional training institutions.*

With the transformation of the 22 HTIs, course completion by students has markedly improved in the five Northern states supported by W4H. **Increasing numbers of students are now graduating from the schools which have become more attractive and helpful to students**. Before W4H, lectures were exclusively didactic with passive note taking by students. There was also no provision for supporting underperforming students, resulting in high academic drop-out rates. Student centered Learning (SCL) was introduced by W4H, and the capacity of all tutors and lecturers in HTIs was strengthened using modern teaching methodologies as well as specialist subject refresher courses. In an assessment carried out **in 2018, 88% of students agreed that teachers had started using methods that encourage students to be active in class**. The same study showed that 77% of the students agreed that tutors now provide learners with academic counselling and learning support. This was a great departure from the situation in 2012, where the pass rates were as low as 20% in some HTIs. **Thanks to support from W4H, the pass rate in 2020 was typically between 94% – 100% across the 22 HTIs**. As part of the improving quality of training in the HTI, W4H contributed a lot in other areas including having more appropriately trained/qualified tutors, better teaching and learning materials, increased opening times of the libraries and e-learning. All these have contributed to increased pass rates across the HTIs.

Contributing to Objective two

Objective 2 is about aligning investment in HRH with the current and future needs of the population and of health systems, taking account of labour market dynamics and education policies, addressing shortages and improving distribution of health workers, so as to enable maximum improvements in health outcomes, social welfare, employment creation and economic growth. Figure 5 shows that Objective of the Global HRH strategy sits within three functions of the WHO HRH management framework – particularly finance, coordination and partnership.

Milestones

> *a) By 2030, all countries will have made progress towards halving their dependency on foreign-trained health professionals, implementing the WHO Global Code of Practice on the international Recruitment of Health Personnel.*

W4H has not contributed to the attainment of this milestone.

> *b) By 2030, all bilateral and multilateral agencies will have increased synergies in official development assistance for education, employment, gender and health, in support of national health employment and economic growth priorities.*

W4H was funded by UK aid funding from the UK government and shows an effective and robust contribution to this milestone. The profile of female health workers has been raised by this contribution. The communities that were negatively disposed to young women studying to become nurses and midwives now have great pride in the achievements of young women health workers from their communities. FYP students and graduates now get involved in community decision-making especially in matters relating to health. The intervention supported by UK aid has contributed to great community awareness about the need to address the female health worker crisis. The intervention started to contribute to employment of female health workers.

W4H was able help young women in the six Northern states take up required science subjects so that they can qualify for admission into nursing and midwifery training schools. They are given encouragement and intensive coaching so that they can pass the required qualifying examinations. Not all of them qualify and those who are unable to continue on professional courses are encouraged to enroll for vocational studies which help them to become useful to themselves and the community (as proposed in the WHO model in Figure 2).

> *c) By 2030, partners in the SDGs will have made progress to reduce barriers in access to health services by working to create, fill and sustain at least 10 million additional full-time jobs in health and social care sectors to address the needs of underserved populations*

Before W4H, there was a low level of gender awareness in the HTIs. There were few female tutors and women in management or decision-making positions. As could be expected, this alone discourages young women from going into the profession and reinforced community stereotypes of professional health workers. Supplying health workers was urgent but even more so was the supply of female health workers. W4H worked to address these barriers and positively contributed to this milestone. The programme has transformed many aspects of the HTIs, including making them more female-friendly institutions.

A survey in 2018 found that 60% of students felt that HTIs had become more responsive to their needs. **By 2020, the institutions had recruited more female tutors and there were more females in senior management positions**. The low status of young women in rural communities is now being progressively addressed and with some success. Advocacy is being conducted, with vigor, to ensure that female graduates from nursing and midwifery schools are employed by the government and posted to rural communities, where they can help improve access to health services.

Providing incentives to health workers in rural areas is a great challenge. Rural allowances have been introduced to ensure that they stay and perform effectively. **W4H's pilot of purpose-built accommodation for rural health workers has been taken on by state governments**. W4H advocacy ensured that state governments build on and continue to provide rural incentives in the future.

d) By 2030, partners in the UN SDGs will have made progress on Goal 3c to increase health financing and the recruitment, development, training and retention of health workforce

Nigeria has faced challenges in all sectors in recent decades. Health and education have not been spared. The HTIs were starved of funds and many of them entered a spiral of deterioration as a result. As stated before, only one of the training institutions had full accreditation before W4H, meaning that they could not produce the maximum number of nurses and midwives. **Funding has significantly improved in the W4H states and legislation has been passed to ensure the FYP is sustained**. Policy makers are now aware that funds need to be made available to the HTIs. Budgets have improved for the HTIs and they now have predictable imprest and are involved in the budget setting process. The Training Institutions have also been trained in financial management and have computer-based Student Information Management Systems.

Many states had placed an embargo on employment (and the health sector was not spared) due to lack of funding. Strong advocacy has helped to change this situation. W4H worked to ensure that many of the health workers produced through the programme were employed by government, and this has happened fully or partially in all the states. Retention of female health workers is still an issue and W4H worked to ensure that governments continued to take action to address this after the programme ended.

Contributing to Objective three

Objective 3 aims to build the capacity of institutions at sub-national, national, regional and global levels for effective public policy stewardship, leadership and governance of actions on HRH. The third objective of Global HRH plan sits within the education function of the WHO framework as shown in Figure 3.

Milestones

a) By 2020, all countries will have inclusive institutional mechanisms in place to coordinate an intersectoral health workforce agenda

W4H was a member of the HRH forum at National level and supported the HRH unit in its bid to be effectively positioned to coordinate the state level HRH units.

b) By 2020, all countries will have an HRH unit with responsibility to develop and monitor policies and plans

In the sense of bottom-up approach, W4H worked with selected states in Nigeria to strengthen their HRH units to be able to deliver on their mandates. A series of capacity building meetings were conducted specially to integrate HRH monitoring into efforts to strengthen states' HRH monitoring systems. Ten States (Jigawa, Kano, Katsina, Yobe, Zamfara, Borno, Kaduna, Kwara, Nasarawa and Kebbi) were supported to assess their HRH situation and to enable them identify gaps and distribution challenges. W4H was a member of the HRH forum at National level and supported the HRH unit in its bid to be effectively positioned to coordinate the state level HRH units. W4H supported the development and implementation of the national task shifting and task sharing policies, the tutor training plan and the collection of HRH data and implementation of a national HRH registry.

c) By 2020, all countries will have regulatory mechanisms to promote patient safety and adequate oversight of the private sector

W4H did not work on this milestone.

Contributing to Objective four

Objective 4 is to strengthen data on HRH, for monitoring and ensuring accountability for the implementation of national and regional strategies, and the global strategy. Finally, Objective 4 of the Global HRH plan sits with the cross-cutting functions of the WHO HRH framework as shown in Figure 3. This includes Monitoring and Evaluation, Situational Analysis and Planning.

Milestones

> *a) By 2020, all countries will have made progress to establish registries to track health workforce stock, education, distribution, flows, demand, capacity and remuneration.*

To ensure that Nigeria Government is not left behind, W4H worked with Federal Ministry of Health to develop a national health workforce registry. The registry is designed to collect data from health facilities, states and collate it at a national level. The approach allows room for both the state and national government to use the registry for decisions in relation to HRH in Nigeria. Ten States were supported by W4H to collect data to feed into the national registry. W4H collaborated with the WHO and other development partners to support the development of the HRH registry.

> *b) By 2020, all countries will have made progress on sharing HRH data through national health workforce accounts and submitting core indicators to the WHO Secretariat annually*

W4H did not work in this area

> *c) By 2020, all bilateral and multilateral agencies will have strengthened health workforce assessment and information exchange*

UK aid funded W4H to support Nigeria in improving the HRH situation in six programme states and four additional states on workforce assessment as part of a regional learning approach. W4H worked with government agencies and other projects like Solina (funded by the Gates foundation) in Kano and MNCH2 (another UK aid supported programme). The collaboration itself was instructive because it promotes sustainability and scale up for HRH development in Nigeria. Since these interventions were donor-supported, the three partners worked together to ensure that all states receiving their support carried out this activity and that the supported state governments can sustain the efforts after closure of the programmes.

6. Recommendations which W4H contributed to

The Global strategy on HRH contains 88 policy options, responsibilities and 14 recommendations. A critical review of these, revealed that W4H contributed to at least ten of the recommendations (see Table 3).

Table 3: Global HRH strategy Recommendations that W4H is responding to

Number	Recommendations to stakeholders	Related W4H actions
24	Adopt transformative strategies in the scale-up of health worker education	FYP, SCL
25	Optimise health worker motivation, satisfaction, retention, equitable distribution and performance	Midwifery Recruitment and Retention Scheme (MRRS) activities
26	Harness – where feasible – information and communication technology (ICT) opportunities	Student Information Management Systems and e-learning
27	Build greater resilience and self-reliance in communities	Main focus of efforts in Yobe and Borno states
28	Strengthen capacities of the domestic health workforce in emergency and disaster risk management for greater resilience	
30	Strengthen the capacity and quality of educational institutions and their faculty through accreditation of training schools and certification of diplomas awarded to health workers	Accreditation efforts in all HTIs in W4H states
33	Governments to collaborate with professional councils and other regulatory authorities to adopt regulation	Support to NMCN
34	Develop normative guidance, support operations research to identify evidence-based policy options, and facilitate technical cooperation	Midwife Recruitment and Retention Schemes
35	Education institutions to adapt their institutional set-up and modalities of instruction to respond to transformative educational needs	SCL; Twinning
36	Professional councils to collaborate with Government to implement effective regulations for improved workforce competency, quality and efficiency	Support to NMCN; Implementation of 5-yr strategic plan

7. Conclusion

W4H has contributed to WHO's Global HRH ambition 2030 which supports the health-related SDGs and in particular the drive for UHC. An analysis of W4H successes shows that the programme contributed to the achievement of all four objectives of the global strategy; contributed to nine of the thirteen global milestones as well as at least ten of the 14 recommendations.

Of importance also is the fact that the Global HRH framework and its policy levers did not recognize the exclusion that rural women face and the barriers to accessing tertiary education – and how that would influence production of female health workers in particular. However, throughout the Global Strategy the need to ensure that the framework is adapted to suit each country is given priority, which is in line with the approach taken by W4H in Nigeria: prioritising the elimination of education, social and financial barriers that young women face while accessing tertiary education; supporting them in training and ensuring their deployment back to the health facilities in their communities not only ensures the accessibility of health workers, it has increased acceptability, utilisation of services and the quality of services provided. Ensuring these young women are from the rural communities, have ties in the communities and were trained for the rural communities, enhances their retention in the communities.

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