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## EDITORIAL

# Human Resources: An Impersonal Term for the People Providing Health Care

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**T**HE subject of this journal issue is a crucial one, and the papers speak eloquently of the importance of health care providers to well-functioning health services, measured through their training and skills level, the extent of managerial support they are given, the pay and benefits they receive, their career advancement opportunities, the conditions they are expected to work in and the resources available to them for their work. The papers reveal how starved public health services are of support for well-trained, well-paid, highly motivated health care providers, in practically every country examined.

This journal issue includes papers about the women and men who collectively form the human resource base of public sexual and reproductive health services in Bangladesh, Guatemala, Indonesia, Kenya, Lithuania, Mongolia, Morocco and Zambia and in AIDS treatment programmes in Malawi and South Africa. In each case, many elements of the story are the same. Given the increasingly high expectations placed on health systems and health workers – e.g. to reduce maternal deaths, to prevent HIV infection – more health workers, better training and greater skills are needed and working conditions and salaries must be greatly improved.

### **More staff, more training, more skills and strengthened health systems**

The extent of the human resources problem is rapidly being quantified and the Round Up on human resources in this issue provides some data and a more general picture of the problem.

Much of the existing data do not focus in on specific services, but on the workforce in health

systems as a whole. This journal brings together papers specifically on human resources issues in sexual and reproductive health care, with papers that focus primarily on family planning, maternity care, unsafe abortion and AIDS treatment programmes. The paper by Gerein, Green and Pearson shows, using national and regional data, the implications for sub-Saharan Africa of shortages of midwives, nurses and doctors in maternal health care and the inequitable distribution of maternal health professionals between geographic areas and health facilities. This situation is illustrated most poignantly in this issue by the letter to the editor, which describes how a young doctor, just out of medical school in Europe, visited a maternity ward in a sub-Saharan African country and failed to find not only the doctors he went to see, but any other staff either. Having assisted two women to deliver their babies, he was asked to carry out an emergency caesarean section, all within an hour of his arrival. The use of “shortage of health professionals” to describe such a situation is totally inadequate.

Recruiting more people to medical and nursing schools, and upgrading training and skills are the most obvious places to start to address the lack of essential services such as emergency obstetric care (EmOC), but this is no easy task. Islam, Haque, Waxman and Bhuiyan describe a four-year national programme in Bangladesh in which medical officers, nurses, facility managers and laboratory technicians received training in the country's eight medical college hospitals. The aim was to get EmOC facilities fully functioning in the country's sub-district and district hospitals. In 2004, 105 of the 120 sub-district hospitals had

become functional for EmOC, while 53 of 59 of the district hospitals were providing comprehensive EmOC compared to 35 in 1999. Sustaining and retaining these people in their jobs, continuing the involvement of key stakeholders (especially trainers), bringing in new trainees, introducing evidence-based protocols to standardise practice and improve quality of care, upgrading more of the remaining facilities and ensuring 24-hour coverage as well are very tall orders.

However, even the best training is not enough, on its own. In a paper about scaling-up of post-abortion care services in 22 of the 33 public sector district hospitals in Guatemala, Kestler, Valencia del Valle and Silva describe an 18-month programme of interventions, including strengthening the knowledge and technical capacity of staff, expanding post-abortion care, enhancing related infrastructure, distributing informational materials and instituting an abortion surveillance system. But despite achieving a better quality of care in these hospitals for many more women, the level of deaths and severe complications remained unchanged during the study period. This is because the abortions women had had before they reached the hospitals for care were as unsafe as they had been before the intervention began. All the health care providers could do, and it is a crucial public health task under the circumstances, was to make the best possible job of treating the complications women presented with. If they could gain permission of the government to inform women these services were available, women might present more immediately, before complications became severe. In the long run, however, only by making abortions safe to begin with will these problems be resolved.

Indeed, it is not just in relation to induced abortion that women's needs are still so incredibly neglected. In most of the poorest countries in the world, the mix of nurses and other mid-level providers to whom maternity care is entrusted can only be labelled "skilled attendants" because so few of them are fully trained midwives. Yet, while these not-quite midwives are increasingly being called upon to provide skilled care for pregnant women and newborns, they are greatly undervalued. In Morocco, there is a persistent lack of professional recognition of midwifery, which Temmar, Vissandjée, Hatem, Apale and Kobluk argue is consistent with a system of widespread gender inequality associated

with women's low status more generally. Their paper in this journal issue describes the history of midwifery training in Morocco, starting in the 1950s with a programme requiring only a primary school certificate, while most women were being attended by auxiliaries, nurses or traditional birth attendants, trained or untrained. Only in the 1990s did the country institute an undergraduate programme to train midwives in the essential competencies. The authors emphasise the importance of recognition and treatment of midwives as competent, skilled and valued partners alongside nurses and obstetrician-gynaecologists. It is only on this basis, they argue, that midwifery practice in countries such as Morocco can progressively evolve into women-centred maternity care.

A paper by Schneider, Blaauw, Gilson, Chabikuli and Goudge starts from the premise that significant access to antiretroviral therapy in many developing countries is unlikely to be achieved without strengthened health systems and an adequate supply of skilled and motivated health care workers, who are now regarded as the key to scaling up of HIV treatment. This, in sub-Saharan Africa, means tackling problems of supply, migration, distribution, skills mix, remuneration, productivity and management, as well as attention to a range of stewardship tasks. Macro-economic constraints on employment of health care providers also need addressing, and evaluation is needed of the performance of cadres such as mid-level and community health workers and their potential role in HIV treatment scale-up.

Van Damme and Kegels provide a valuable commentary to this paper on the fact that health systems, which were mainly set up to deliver mother and child health services and care for acute episodes of disease, suddenly have to cater for large numbers of people living with AIDS, in need of lifelong chronic disease care. They provide data on the availability of medical doctors and nurses against the number of people living with AIDS in 13 countries, and argue that countries with over 2,000 people living with AIDS per doctor may have to develop different antiretroviral delivery models from those in southern Africa, and certainly from Brazil, where there is a doctor for every two people living with AIDS.

Palmer provides a country case study of human resource needs in the health system in Malawi, where health sector staffing is particularly low, even by regional standards. Donors have helped

the government develop and finance an Emergency Human Resources Programme to address the factors that are making staff leave the public health service. This paper also discusses the fact that donors have been reluctant to undertake the significant investments required to tackle a problem of this scale and complexity, given the social and political sensitivities involved, and because of concerns about the sustainability of interventions and risks of rising donor dependency.

### **The human face of human resources in sexual and reproductive health care is usually a woman's**

Several of the theme papers in this journal issue focus on qualitative issues – the human face of human resources in sexual and reproductive health care – and the points of view are of primarily women patients and primarily women providers. Wood and Jewkes examine the effects of family planning nurses' attempts to stigmatise teenage sexuality because they disapprove of adolescents having sex. This leads to harsh treatment of adolescent girls and unwillingness to acknowledge the girls' experiences as contraceptive users, thus undermining their effective use of contraception. In addition to scolding, however, are issues such as respect for confidentiality on the part of health workers, which adolescents often lack confidence will be guaranteed to them in primary health care settings. A study in Lithuania by Jaruseviciene, Levasseur and Liljestrand, that assessed general practitioners' decisions whether or not to respect confidentiality for under-18s, found that their decisions were influenced by external forces. These included the legislative framework, societal attitudes towards adolescent sexuality; institutional features in clinical facilities such as the presence of a nurse during consultations and the openness of the medical record filing system. Individual factors included GPs' relationships with adolescents' families and their personal attitudes towards sexual and reproductive health issues. Thus, a complex of factors, not easily untangled, finds providers replicating the societal norms of the world around them.

Health workers are not always cast in a negative light, however. In a paper from Indonesia in this issue, for example, health care providers are described as near to the angels. Utomo, Arsyad and Hasmi illustrate the central role played at

the village level by family planning volunteers in Indonesia, who not only promote and provide family planning, but also organise meetings, provide information, organise income-generation activities, give savings and credit assistance, collect and report data and deliver other family welfare services. Their work, which has had a profound influence on the uptake of family planning in the country, is taken so for granted that they remain unpaid today – primarily, it seems, because they are women and working the furthest away from the centres of power.

Sometimes, the positive influence health care providers seek to have on women's health outcomes may be foiled by the communities they serve. Despite five decades of work in a community health and development programme in India with a clear bias in favour of women, described in a paper by Jacob, Surya, Minz, Singh, Abraham, Prasad, George, Kuruvilla and Jacob, improvements in health and the empowerment of women have lagged behind those achieved by men. The authors believe this has happened because the community, with its strong male bias, utilises the health facilities, and education and employment programmes, more for the benefit of men and boys than for women and girls.

Another example of a situation where the preferences of the community and those of health workers may conflict is to do with place and type of care provided, as shown in a paper from Bangladesh by Blum, Sharman and Ronsmans. This study examined the feasibility of home- vs. facility-based delivery from the perspective of skilled birth attendants. The findings reveal major constraints encountered by the attendants during home deliveries, including poor transportation, inappropriate environment for delivery, insufficient supplies and equipment, lack of security, and inadequate training and medical supervision, all of which sometimes prevented the provision of skilled care. Most difficult was the pressure by families to adhere to traditional child-birth norms and convincing families to accept the need for referral in the face of complications. Yet the families preferred women to deliver at home.

Finally, national efforts to build health workers' skills and quality services may be undermined by a change of government that leads to a change in policy. It can also be adversely affected by a lack of consensus between government and donor



SEAN SPRAGUE / PANOS PICTURES

Birth attendants with new equipment from UNICEF, Delta region, Egypt, 2002

communities, competing health priorities and the politicisation of debates on issues such as fertility and abortion. Hill, Dodd and Dashdorj show this happening very recently in Mongolia, a country that was making significant advances in contraceptive use, women's education and reductions in maternal mortality, and has set up innovative adolescent-friendly health services and developed family group practices that are reaching out to marginalised populations. Thus, politics can threaten to trump public health goals and initiatives, often disempowering health care providers.

### Other features

RHM has begun to publish regularly on adolescent sexual and reproductive health issues, and in this issue there are several contributions to the literature. One is a paper by Warenius, Faxelid, Chishimba, Musandu, Ong'any and Nissen on nurse-midwives' disapproving attitudes towards adolescent sexual and reproductive health needs in Kenya and Zambia. Those with more education and those who had received continuing education

tended to have more youth-friendly attitudes. Hence, the authors suggest that critical thinking around the cultural and moral dimensions of adolescent sexuality should be emphasised in undergraduate training and continuing education, to help nurse-midwives to deal more empathetically with the reality of adolescent sexuality.

Another is a paper by Rashid on married adolescent girls living in an urban slum environment in Bangladesh, who are an extremely vulnerable group. Cultural and social expectations meant that 128 of the 153 girls interviewed had borne children before they were emotionally or physically ready. Twenty-seven had terminated a pregnancy, of whom 11 reported they were forced to do so by family members who depended on their earnings and wanted them to stay in work. Poverty, economic conditions, marital insecurity, politics in the household, absence of dowry and rivalry among family, co-wives and in-laws made these young women acquiesce to decisions made by others about whether they had children in order to survive. However, because economic productivity had begun to take priority over their

reproductive role in some of their families, the effects on reproductive decision-making may be considerable in future.

In Japan, in contrast, young women are mostly not having children and in 2004 the fertility rate had dropped to 1.29. International population policy since the 1960s has encouraged a reduction in world population growth, but the success of family planning policies in achieving that goal suddenly seems to be causing a return to pronatalism among some demographers and policy-makers. A paper by Goto, Yasumura, Yabe and Reich discusses why Japan is currently facing a conflict between wanting to reduce unintended pregnancies and at the same time to increase the national fertility rate. They find psychosocial problems in the families in which unintended pregnancies have been taken to term. At the same time, they find that young couples consider childrearing a burden they are often unwilling to assume, which is a growing issue in more countries than Japan. They believe the government needs to address the social challenges affecting people's family lives, which underpin current low fertility, rather than focus on trying to reverse fertility decline per se.

The right of women to decide whether or not to continue a pregnancy is a right that RHM has been committed to promoting in its pages from the beginning. We are pleased to be able to publish a paper by Henry David in this issue, which highlights the consequences for children born to women who are refused an abortion. His paper brings together the findings from a 35-year-long study following children born in 1961-63 in Prague to women twice denied abortion for the same unwanted pregnancy. The findings suggest that, in the aggregate, denial of abortion for unwanted pregnancy entails an increased risk for negative psychosocial development and mental well-being of the child of that pregnancy until adulthood, including the need for psychiatric treatment, especially if the child was an only child.

Nidadavolu and Bracken have a paper about the content of information materials on abortion and sex determination in a district in Rajasthan, India, and people's perceptions of them. Most of the informational material about abortion in the district was produced by one abortion service provider. The public sector had produced materials on the illegality of sex determination, some of

which failed to distinguish between sex selection and other reasons for abortion. In the absence of knowledge of the legal status of abortion, the negative messages and strong language of the anti-sex selection materials may have contributed to the perception that abortion is illegal in India. Based on what they learned from the research, they produced an excellent pictorial booklet designed for low-literate women and an educator's manual, covering both abortion and sex determination, the law on abortion in India, the risks of unsafe abortion and the need to seek a safe abortion from a trained provider.

Finally, a study by Wu, Viisainen and Hemminki analyses the relative contributions of under-reporting of female births, abortion of female fetuses and excess early female neonatal mortality to the high sex ratio among newborns in a rural county in Anhui province, China, based on a cohort of 3,697 pregnancies. This is not the first paper published by RHM on sex preference in parts of Asia, and it is unlikely to be the last. This study finds that selective abortions of female fetuses probably contributed most to the extremely high sex ratio among newborns. The under-reporting of female live births and neglect or poorer care of female newborn infants seemed to play a secondary role. New technology, specifically ultrasound used for antenatal screening, has helped the one-child policy to become, in practice, an "at-least-one-son" practice. This paper also describes how mandatory pregnancy testing was carried out by township family planning staff every 2-3 months on all married women under the age of 50, and how the township family planning office was informed of the outcome of each pregnancy, whether miscarriage, abortion, stillbirth, live birth or neonatal death. This level of regimentation and control of pregnancy itself deserves more attention.

Lastly, it seemed fitting to reproduce FIGO's recently published Ethical Guidelines on Conscientious Objection in this journal issue, because of the extent to which conscientious objection has an impact on the practice of obstetricians, gynaecologists and other providers of sexual and reproductive health care. These guidelines elucidate the responsibility of providers as "at all times to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible. Any conscientious objection to treating a patient is secondary to this primary duty".

## **A gender perspective**

One of the almost invisible aspects of the human resources issue, however, which emerges in the papers published here, is in relation to gender. Especially in countries where the status of women is much lower than men's, not only are women patients more likely to be neglected and treated poorly, but women health workers are also likely to have a lower status and lower (if any) pay than male health professionals and workers. They are also more likely to have fewer skills than they require to be able to give their patients optimum care. It is neither an accident nor bad luck that maternal mortality, including from the complications of unsafe abortion, continues to be a major public health problem in so many countries. It is because it is primarily women who are involved and affected.

## **Conclusions**

It is frustrating that the production of knowledge so often does not lead to tangible action. It is also worrying that the best minds and efforts seem to go into describing the causes and parameters of problems, while the people and institutions on the ground that are responsible for implementing the solutions are constantly understaffed, under-funded and under-supported. The conclusions that can be drawn from the papers in this journal issue are obvious. Countries must work together to address the global need for skilled health care providers on a global scale. To meet the growing health care needs of more demanding and often still growing populations, in which human resources play a central role, health must be allotted a greater proportion of national budgets. That includes in the developed world, which has the money to train all the health workers it needs without poaching them from health systems with far fewer resources. Lastly, health care providers need to come together in professional associations and trade unions to fight for better training and working conditions, and for strong public health systems, because their interests are also their patients' interests.

## **Future submissions to RHM**

RHM, now in its 14th year, is increasingly becoming a "known" journal, including in academia. This is resulting in more articles reporting on

research being submitted, in which findings are shown primarily through data and in tables and figures. Such articles also tend to be longer than the 5,000+ words that RHM asks for. Many such articles contain important findings, and have highly relevant implications for policy, service delivery and advocacy, and we are pleased to publish them. However, others are sometimes short on the action component that RHM is looking for in this genre. Moreover, their appearance may discourage the submission of non-academic papers, a consequence we wish to avoid.

The kind of papers RHM is eager to publish also include discussion and commentary papers, in which critical thinking on current issues is presented and the multifaceted nature of problems and their solution are explored. We are interested in papers that describe the content and activities of educational programmes, health and safer sex promotion activities and advocacy campaigns, and papers that analyse law and policy on a specific topic. And we continue to seek a range of in-depth, qualitative research on the perspectives of women and men, service providers and policy makers. We urge potential authors to read our editorial policy and to take it seriously.\*

The November 2006 issue on condoms is a good place for such papers, as is the May 2007 issue on strategies for taking on the opposition to sexual and reproductive health and rights. We urge authors who want to write "non-academic" papers to submit more often. And we urge academic authors to consider whether papers full of tables, numbers, percentages to the tenth decimal and confidence intervals are always the best way to present what is really important in their findings. From the point of view of many in the RHM audience, who take one look at complicated tables, go cross-eyed and turn to the next page, we urge authors to find other ways to present their data where possible, especially qualitative data. While accurate data are crucial for supporting policy and programmatic proposals and interventions, presenting them ways that those without statistical skills can understand and absorb is more likely to convince others working in the field to act on what they learn from such studies and use it to change the world.

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\*Thanks to the 2005 RHM editorial advisory board meeting for raising these issues.