VSO and Continuing Professional Development for Health Workers

1. EXECUTIVE SUMMARY

This Policy Briefing Paper aims to set out VSO's position on Continuing Professional Development (CPD) and highlights VSO's unique contribution in this area. Fragile health systems exist in many countries where VSO works and development of a skilled motivated workforce is key to raising standards of patient care and addressing challenges such as health worker shortage. "At the heart of each and every health system, the workforce is central to advancing health. There is ample evidence that worker numbers and quality are positively associated with immunization coverage, outreach of primary care, and infant, child and maternal survival." [1]

VSO has been placing international health volunteers in developing countries for over 50 years. Building the capacity of fellow health professionals through the provision of on the job training and mentoring has been the key focus of the work for many of them. VSO has gathered evidence of the benefits of providing effective CPD and is therefore ideally placed to advocate for policy change in this area. The paper draws together existing VSO statements and experience in the field, with particular input from a recent survey of VSO programmes carrying out CPD (see country references in the text), as well as research evidence from WHO and other global partner agencies. Two key health system pressures are health worker shortages and lack of financial resources. The paper takes the position that CPD for existing staff is equally as important as training new health workers, but is underinvested in at present. It increases health worker productivity, is quicker, more cost effective, improves retention and builds for the future in strengthening the health system and developing professional approaches. On value for money the paper supports strengthening CPD through increased on-the-job training and moving away from over-reliance on centralized workshop training, as the most cost effective way to increase and maintain skills.

The paper identifies good practice and innovation, as well as gaps in practice and training delivery. It asserts that CPD must be strongly tied to the health needs of the surrounding population and that much more emphasis should be given to primary care, as the place where most patients first present for treatment. "Reforms in education must be informed by community health needs." [2] This is essential to address the health MDGs (Millennium Development Goals) and to support efforts to ensure Universal Health Care covering the whole population.

The paper looks at the important role of licensing and accreditation, and the key part to be played by government in supporting standards and setting up frameworks and legislation. It notes the importance of CPD as a key part of the Health Strategy, the need for collaboration between the education, health and finance ministries and the role of donors in supporting an integrated response to developing the health workforce. In addition, it highlights that health is a global profession and that the "international community has an important role to play by partnering to support country-led efforts" [3] and sharing best practice through care pathways, evidence based medicine and use of participatory learning methodologies.

The key position put forward by the paper is the importance of life-long learning for all staff cadres and volunteers. "In order for health workers to provide quality care and meet their communities' changing health care needs, they must

[1] WHO, 'World Health Report: Working Together for Health', 2006

[2] WHO, 'Transforming and Scaling up Health Professional Education and Training', 2012, Global Group

[3] WHO, 'Transforming and Scaling up Health Professional Education and Training', 2012, Global Group

become life-long learners dedicated to updating their professional knowledge, skills, values and practice."(Zambia) VSO support for CPD ranges from providing technical support to government on developing frameworks for CPD to on-the-job training for staff and students in subjects as diverse as emergency procedures, use of the ECG (electrocardiogram) machine, and neo-natal care (Malawi). VSO is also supporting research projects that aim to evaluate compliance with the CPD programme and the ensuing challenges (Malawi) and to identify the most effective ways of delivery CPD (Sierra Leone).

2. PURPOSE

The purpose of the document is to set out VSO's position on Continuing Professional Development (CPD) for health workers in Africa and Asia. It aims to guide future policy development around health training and capacity building of health workers and to draw specifically on significant learning over the past few years from VSO's health and HIV and AIDS programmes. The paper is entirely devoted to in-service training, for employed staff: it is not about pre-service training. The paper aims to set out the full scope of CPD, for instance its role in maintaining quality and safety of practice, but also how it can support initiatives to address shortages of health workers such as task shifting and community health volunteers. The paper will identify best practice, innovation and value for money. It will also provide the rationale for management and government to invest in CPD as an essential part of the health system.

"There is enormous scope to make far better use of the potential and talents of all the people working in healthcare – and we need to do so at a time of health worker shortages and financial constraints." [4]

3. BACKGROUND

Health systems cannot function effectively without sufficient numbers of skilled, motivated and supported health workers [5] who display a good work ethic at all times. Continuing Professional Development is an important part of this.

3.1 Definition

"Continuing Professional Development for health workers is defined as the process by which individual healthcare professionals maintain and improve standards of healthcare practice, through development of knowledge, skills, attitudes and behaviour." [6] It may be called refresher training, continuing education, in-service training or Continuing Medical Education (CME) but it will always be about developing professional practice and ethos, through life-long learning. Modes of delivery may vary from formal classroom teaching to on-the-job training and remote use of technology.

The purpose and principles of CPD are the same for all cadres of staff, but the paper focuses on doctors, nurses, midwives, community health workers and health managers to address the main issues. The paper focuses on the public sector but the lessons drawn are equally applicable to the private sector.

3.2 Current Situation

CPD in many of the countries where VSO works is generally small in scope but with inspiring examples of good practice and innovation, including planning of CPD at national level to accredited standards. Several countries said that most staff received no CPD (eg Ethiopia and Zambia). "One of the reasons that medical care in Ethiopia suffers is that people receive no training or education beyond their basic training and this makes improvement or development near-impossible' (International volunteer). "Most health workers that attend pre-service training have no opportunity to participate in any CPD programmes especially in rural Zambia." (Zambia)

A global report into health education sees "educational institutions as crucial to transform health systems". [7] However, in many countries there is a lack of capacity in training institutions, budget support and infrastructure (eg Papua New Guinea and Tanzania). There are gaps between the training offered and the challenges being faced in the workplace.

[4] UK APPG on Global Health and Africa APPG, All the Talents: how new roles and better teamwork can release potential and improve health services, 2012
[5] WHO, Working Together for Health: the World Health Report, 2006
[6] Laura Golding and Ian Gray, 'Continuing Professional Development – a Brief Guide, 2006
[7] The Lancet, 'Health Professionals for a new century: transforming education to strengthen health systems in an interdependent world', 2010

Courses tend to be very theoretical, while there is a lack of basic clinical skills and management training (the latter often required by doctors posted to rural areas). Many courses are only held centrally (Mongolia and Tanzania) and involve travel and accommodation, thus increasing costs. Courses are often longer than needed and there is little sharing of knowledge or skills on return to the workplace.

The most advanced countries have a national Human Resources Plan with moves being made towards standardisation of skills, regulation and accreditation (eg Malawi) but in others there may be no plan or CPD has a low priority. "Another challenge is the lack of a National Training Plan that focuses on structured post-graduate training to meet emerging needs for specialists. Within this context efforts should be taken to ensure complementary improvement in the continuous development of other health cadres." (Tanzania).

Countries vary in their response to health worker shortages. Some countries focus exclusively on increasing the numbers of health workers through pre-service training (eg South Sudan). While this is part of the response, it is important to recognise that improving the skills of existing staff would more quickly boost productivity and quality of care. (eg Kenya) In others CPD has been enthusiastically taken on as a way of substantially raising the skills of large numbers of staff in a cost effective manner, as in the Virtual Nursing School project adopted by Kenya, Uganda and Tanzania. [8]

3.3 Delivery of CPD

Modes of Delivery

Formal workshops have been the traditional way of supporting capacity building amongst health workers. The drawbacks are the inability to monitor whether classroom learning is being applied consistently in the field, as well as the length of time staff are away from the workplace adding to the problems of the staff who remain behind.

On the job training, *coaching and mentoring* has been the most frequently used model by VSO volunteers in Hospitals for some years now, in contrast to traditional centralised workshop training. "In most VSO supported institutions VSO volunteers run weekly clinical meetings at which health workers discuss and learn critical clinical subjects to increase their skills" (Zambia). Sri Lanka reports that "a VSO volunteer, an Occupational Therapist started 1:1 supervision group meetings; this was found to be a very important initiative to develop the skills of the Occupational Therapists and to change their attitudes towards patient centred care." (Sri Lanka).

Competency Based Training addresses the area of skills in the workplace, and is key to registration and accreditation for safe practice. Competencies are skills, and there should be a list of required competencies for each job role. Several VSO countries are developing this important aspect of CPD. "We have an approach for senior health managers in planning and budgeting, starting with a task analysis by unpacking the tasks that needed to be carried out." (Mongolia)

Clinical Pathways for particular conditions eg diabetes, gynaecology have become the norm in the UK and elsewhere. They incorporate the best of what is known about a particular condition. A clinical pathway is like a route map giving options for diagnosis and treatment, for all the staff cadres involved. Clinical pathways are professionally recognised and are accessible electronically, often through the professional association. Pathways are generally new to VSO countries, although the Zambia Public Health site, for example, includes some pathways.

Distance learning using paper materials is a method that supports student learning at home, with sessions at the training institution. A system was set up by Tanzania to alleviate health worker shortages, and the utility and potential of this initiative was later evaluated.[9] It found a distinct role for distance paper based learning, but that it must be properly supported ie the distance learning materials must be fully available and teaching staff must be accessible to students.

E-learning is an innovation of great promise for widening access, improving cost effectiveness and maintaining staff in the workplace whilst they undergo training. AMREF (African Medical and Research Foundation) has set up a Virtual Nursing School, which has been supported by the governments of Tanzania, Kenya and Uganda. Its main aim is to encourage enrolled nurses to upgrade to registered diploma level. In Kenya, "with the capacity of 100 students per year

[8] AMREF, Annual Report 2011, Strategic Direction Six: Developing a strong research and innovation base to contribute to health improvement in Africa

[9] ITECH, 'Tanzania Distance Learning Assessment: Assessing the use of distance learning to train health care workers in Tanzania, 2009

in the traditional classroom system, it would have taken over 200 years to train the country's 22,000 nurses." [10] However, Internet access is not always available to all or is intermittent. "E-learning is non-existent due to very poor internet access, so all CPD is done by inviting nurses into the centre." (Papua New Guinea).

Professional Associations

Ideally all health workers will belong to their national professional association, part of whose role is to initiate, provide and promote CPD. In some countries where VSO operates, professional associations play a substantial role in CPD, in others their role is less developed. This can be for historical reasons eg Mongolia (where the post-soviet Ministry of Health still has a leading role) or as a result of weak health systems or conflict.

There is a general movement towards strengthening of professional associations. "The NMC (Nursing and Midwifery Council) of Malawi are involved in CPD and also have a responsibility to regulate the training, education and practice of nurses and midwives in Malawi, which includes registration processes and the licensure examinations for Malawi trained nurses and midwives. Their work in future will include the setting of standards. (Malawi)

In several countries professional associations need support in building capacity in clinical skills, financing and infrastructure. (Mongolia and Ethiopia).

There is good potential for partnering with UK or other professional associations, especially in the light of new technology. "They would benefit from high-level partnerships with equivalent UK institutions to help them set up and maintain structures for continued training and revalidation. " (International Volunteer Ethiopia) As an example the UK Royal College of Midwives has secured British Government support for a major three year Global Midwifery Twinning Project to strengthen midwifery associations and to improve midwifery services in Nepal, Cambodia and Uganda.

Training Institutions

In general only a minority of training institutions offer CPD. For example, in Zambia there is "a two year conversion training programme for enrolled nurses, and a medical licentiates programme for Clinical Officers to enable them to carry out caesarean sections." (Zambia) In Sri Lanka the "training department of the National Institute of Mental Health also conducts CPD for Medical Officers, Nursing Officers and Community Psychiatric nurses." (Sri Lanka)

The report on the Efficiency and Effectiveness of Aid states that "one of the critical bottlenecks in crisis countries is the shortage of well-trained and motivated tutors in health training schools." Some countries are addressing this. The Virtual Nursing School project also addresses issues such as what skills and knowledge nurse tutors need to handle e-learning students effectively.

Partnering with UK or other nursing and medical schools is a good way for training institutions to see what can be achieved and how to go about it. "They need more institutions of better quality with a stronger emphasis on practical, clinical skill rather than theory and stronger international support to increase the basic standards expected." (International Volunteer, Ethiopia)

In Malawi a certain amount of CPD as part of annual registration has been made mandatory for all nurses and midwives. A CPD Evaluation research project is being carried out by VSO and I-TECH (International Training and Education Centre for Health) to look at how nurses, midwives, teaching staff and managers perceive the CPD programme, potential challenges and possible ways to improve it.

4. QUALITY, LICENSING AND ACCREDITATION

The foundation of a strong CPD system is agreed standards of patient care, accredited by a licensed organisation within each country. The health professional must be registered with their professional association and gain a set number of CPD points a year to be re-licensed to practise.

[10] AMREF, Strategic Direction Six, Annual Report 2011, 2011

Licensure and certification verify that a health professional meets the basic minimum standards of competency to perform their work safely and effectively. Licensure and certification also apply to health facilities and educational institutions: they are also eligible for accreditation as an organisation capable of delivering reliable quality training and support. Accreditation is also a means of ensuring the best results for funding. [11]

Countries where VSO operates are at various stages of formalising and legislating for CPD. For example, in Malawi CPD "has been aligned to the required annual re-licensing process and has therefore become a mandatory requirement supported with accompanying legislation." Other countries operate on a more voluntary basis."The Medical Association of Tanzania (MAT) endorses Continuing Professional Development (CPD) as one means of maintaining and updating professional competence. The system rests on a foundation of trust; that health professionals will commit themselves to meeting the requirement for continuing education." (Tanzania) In some countries there is no link between CPD, quality of care and licensing to practise; the original qualification may have been up to 30 years ago, with little or no updating.

At government level regulation is now receiving more attention in countries where health sector reform and decentralisation are taking place. Under this new framework, "regulation becomes one of the critical functions for ministries of health to guarantee the efficiency, quality and equity of health care." [12] There is also an element of social accountability for accreditation, defined by WHO as "directing education, research and service activities towards addressing the priority health concerns of the community, region and/or nation they have the mandate to serve."

5. HOW CPD CAN CONTRIBUTE TO SOLVING HEALTH CHALLENGES

Health systems in VSO countries are under unprecedented pressure from a variety of factors, all of which require a skilled, motivated workforce to address them. CPD is essential in making this possible.

5.1 Weak health systems

Shortage of health workers as outlined in the WHO report [13] is well known and impacts greatly on countries where VSO works. CPD is a vital tool for success in all the initiatives undertaken to address this problem.

- *Increasing Productivity* - "In Tanzania there is a severe shortage of heath workers to address the health care needs of the population and the country has recognised that a key part of its response must be to increase the productivity of existing health workers through CPD." (Tanzania)
- *Task-Shifting* – "where it is essential that there is CPD for the new tasks within an enabling regulatory framework led by government",[14] as in Mozambique where clinical officers have been trained to carry out caesarean sections, with a good rate of success.
- *Community Health Volunteers* – the WHO study into CHWs (Community Health Workers) found that "there is universal agreement that continuing or refresher training is as important as initial training." [15] CPD for the supervisors is required as well. "The delegation of voluntary counselling and testing to lay workers, for example, may require not only the recruitment and training of lay health workers, but also changes to the roles, skills and workload of nurses who have to supervise them." [16]

Improving the quality of care and the attitude of staff towards patients is an essential part of strengthening the health system. CPD elements such as supervision, mentoring and clinical meetings are key to developing a professional ethos alongside the development of professional competence.

Fragile States are those where health services have been severely weakened and there is a need to use some of the strategies above but also to standardise the skills of health workers, originally trained by different NGOs or in different countries. "In South Sudan, CPD needs to be a government priority, as it will allow current health professionals to update and upgrade their skills." (South Sudan)

[11] The Lancet, 'Health Professionals for a New Century: Transforming education to strengthen health systems in an interdependent world, 2010
[12] Capacity Project, 'Building Stronger Human Resources for Health through Licensure, Certification and Accreditation', 2006
[13] WHO, World Health Report 2006 – Working Together for Health', 2006
[14] Human Resources for Health, 'Task shifting: the answer to the human resources crisis in Africa?, 2009
[15] WHO, 'Community Health Workers: What do we know about them?', 2007
[16] Human Resources for Health, 'Task shifting: the answer to the human resources crisis in Africa?, 2009

5.2 Global Factors and Trends

HIV and AIDS - Donor provided CPD in counselling and ART (Anti-Retroviral Therapy) has done much to contain the spread of HIV and AIDS, but did not usually address the whole health system or things such as basic clinical skills. The WHO 2011-2015 Strategy for HIV and AIDS [17] takes a much wider approach and includes among its recommendations the need to provide policy and technical guidance to build an expanded, well-trained health workforce and to promote efficiencies in service delivery, both of which are reliant on continuing education for the workforce.

Increasing populations make it essential to focus on the skills and productivity of the workforce. "Of the 48 poorest countries, 33 are in sub-Saharan Africa and 14 in Asia, they are growing at 2.4 per cent per year". [18] As an example "Malawi is also vulnerable due to high population growth (averaging 3% increase per year) and a continuing high burden of disease." [19] However, with support from donors and agencies such as VSO, Malawi is building a structured response to its healthcare problems, where "the notion of CPD being pivotal to improving practice is understood" (Malawi) and where a nationally endorsed system of CPD is being set up.

Achieving the Health MDGs (Millennium Development Goals) rests to a considerable degree on CPD for staff and volunteers in the health targets they are addressing eg maternal and child health, TB, HIV and AIDS and malaria. Much can be achieved by taking prevention and health care services to under-served populations in poor and remote areas.

Universal Access to Health Care has been adopted by several developing countries as a medium term goal. Tanzania has a "ten year programme aimed at expanding and improving the provision of health services (curative, preventive and rehabilitative) to the level of every village and every ward. As well as increased enrolment meeting these needs will require inventive approaches to training that are both effective and economical like CPD." (Tanzania)

6. VISION FOR CPD

Most countries have a vision of a skilled, motivated health workforce, which can improve the health of the nation. Human resource plans develop this further by setting out a structure for training, appraisal and life-long learning to develop skills and to respond effectively to change.

"In order for health workers to provide quality care and meet their communities' changing health care needs, they must become life-long learners dedicated to updating their professional knowledge, skills, values and practice. CPD encompasses all of the activities that health workers undertake – both formal and informal – to maintain, update, develop, and enhance their professional skills, knowledge and attitudes." (Zambia)

In some cases the vision of Universal Health Care (UHC) is joined to the vision of a skilled workforce. India has stated that its 2022 vision for UHC is dependent on the provision of "an adequate, equitably distributed, appropriately skilled and motivated health workforce." [20]

7. BENEFITS AND ISSUES

7.1 Benefits

Motivation and Retention – "CPD provides opportunities for professional development, staff are motivated and therefore can be retained." (Zambia) CPD encourages staff to see themselves as part of a profession and to uphold its standards towards patient care.

Updating of Skills – "CME entails in-service training necessary to update knowledge and skills and to maintain an effective and relevant delivery of the health task under changing conditions." [21] "CPD is a must for all the mental health professionals. This can really upgrade the knowledge, skills of the health professionals towards their work." (Sri Lanka)

[17] WHO, 'Global Health Sector Strategy for HIV/AIDS, 2011-2015', 2011
[18] Pro Quest Bureau, 'Fact Sheet: World Population Trends 2012', 2012
[19] DFID, Evaluation of Malawi's Emergency Health Resources Programme, 2010
[20] Health Workers Count, 'Why Health Workers Count for Universal Health Coverage', 2012
[21] E. Ogbaini-Emovon, University of Benin, Nigeria, 'Continuing Medical Education: Closing the Gap between Medical Research and Practice', 2009

Career Development and Performance Management – CPD is an essential part of staff development against known standards and the basis of supervision and performance management in the workplace. Good performance and certification then provides an excellent platform for individual career enhancement.

Improving staff attitudes – "Improving competencies will also contribute to more confidence with consequent improvement in attitudes, since staff who are unsure of the currency of their skills and knowledge are more likely to be defensive and abrupt in their approach." (Mongolia) CPD can therefore indirectly contribute to towards improvements in the way health workers interact with their patients.

Support for Task Shifting – CPD "increases their skills to do task shifting especially in places where it is difficult to employ doctors or clinical officers, for example a nurse can be trained to provide relevant curative, preventive, emergency and rehabilitative services." (Zambia) The UK All Party Parliamentary Group on Global Health report on skill mix said "this report provides many examples from around the world where unqualified health workers have safely taken on extended roles. They have, depending on the example, improved access to services, improved quality or reduced costs." [22]

Effective and Economical – Much CPD can be carried out in the workplace. It is "cheaper than centralised training and can be adapted to meet the needs of health workers in the settings in which they operate." (Zambia) CPD is "effective and economical' (Volunteer Tanzania). As a way of addressing the human resources for health crisis increasing the skills and productivity of existing staff is cheaper and quicker than the longer route of increasing the actual numbers of health workers through pre-service training, which while necessary will inevitably take longer and may not be relevant to the tasks that need to be carried out in primary or secondary care." (Mongolia)

7.2 Risks

The risks to CPD are primarily about poor training or lack of proper engagement by staff. There is a risk that CPD can be "simply unsuccessful in developing skills and competencies." [23]

Weak Training Institutions – in expanding CPD through traditional courses, e-learning or other methods of delivery, it is essential that teaching staff are themselves properly trained and receive CPD. When VSO in Uganda was helping to set up Speech Therapy as a regulated profession, a great deal of attention was paid to training, supervision and mentoring of teaching staff for on-going support of the profession, once the first degree course students had qualified. [24]

Under-staffed Health Facilities may have difficulty in releasing staff for CPD, especially when courses are offered centrally. The opportunity to attend CPD courses can be unfairly distributed or abused leading to absenteeism, whereby the staff who are left behind have an even harder job to care for patients, thereby giving CPD a bad image.

Lack of motivation – at this stage where there is a need to build up the professional ethos of the health professions the will to benefit from CPD may be lacking. It is reported that "trainings are attended only because participants receive per diem" or "Training is taken only to meet regulatory requirements rather than to close a competency gap." (Zambia)

Low salaries – "Many doctors have to pay for their own CPD. In developing countries, salaries are just enough to meet basic family needs." [25]

Retention – At a time of health worker migration within the region or to developed countries "There is a problem with retention as people tend to leave as soon as they have better training." (International Volunteer Ethiopia) "A career path is also needed with supportive supervision." (Mongolia)

Opportunity to put CPD into practice - "Good training needs to be matched with available jobs and equipment to allow well-trained professionals to practise the techniques they have learned." (International Volunteer Ethiopia)

[22] UK APPG on Global Health and Africa APPG, 'All the Talents: How new roles and better teamwork can release potential and improve health services", 2012

[23] Zambia Institute of Medicine, Muala et al, 2004, 2008

[24] VSO, 'Establishing a Speech and Language Therapy Profession in Uganda', 2011

[25] E. Ogbaini-Emovon, University of Benin, Nigeria, 'Continuing Medical Education: Closing the Gap between Medical Research and Practice', 2009

Professional Associations – "have an essential role in the health workforce but can be a significant barrier to innovation, particularly if they are not well consulted or feel that a change threatens the interests of their members." [26]

7.3 Issues

Lack of Evidence for CPD Impact – The WHO report on Task Shifting says that there is plenty of evidence of the benefits of CPD in high-income countries, but "there is a general dearth of such data from resource-constrained countries." [27] The notion of CPD being pivotal to improving practice is understood but to date there is little evidence that CPD maximises nurses and midwives productivity or improves their performance." (Malawi).

Focus on pre-service training – Some governments eg South Sudan focus on pre-service training for nurses and clinical doctors to address health worker shortages. This neglects staff in post and the quality of front line care. "It will take several generations for the Republic of South Sudan to have enough health cadres to support the needs of the country. They need to address health worker shortage today. (South Sudan)

Need for Primary Care Emphasis – the initial focus of CPD tends to be on hospital care. There needs to be equal emphasis on primary care, where the majority of contact with health care needs is made. "Courses are predominantly classroom style and are insufficiently tailored to the health needs of the communities the health professionals are returning to. There is a tendency to focus on repairing the damage and not enough attention to prevention approaches and promotion of healthy lifestyles." (Mongolia)

Access and Rural Areas "There is concern that staff working in the rural areas are unable to attend CPD activities because of poor transport links and the absence of staff to fill their posts when away." (Malawi) This is particularly a problem when annual re-licensing is made compulsory. Together with lack of financial support for travel to District Hospitals for CPD "this makes CPD compliance logistically impossible." (International volunteer Malawi) E-learning is a partial solution but can also present access problems in remote areas where computer connectivity is problematic or non-existent.

Low Health Budgets make it difficult to support CPD effectively, especially as most of the funding for CPD training activities comes from international aid. The ideal must be to prioritise CPD and to move towards commitments, such as the Abuja Declaration 2001, whereby African countries committed to spend 15% of the national budget on healthcare. The UK Royal College of Midwives says "to get that appropriately educated workforce, you do need acceptance by government in policy that is backed by finances." [28]

Reflecting Qualifications in Pay – Disillusionment can arise if significant CPD is not recognised in salary scales and employment policy. "This is especially relevant with task shifting. If people increase their qualifications and responsibilities, we need to ensure that this is reflected in their pay." (South Sudan)

Huge range of Training Providers – There can be a huge number of training providers working in one country, whose work is independent and unrelated to national health workforce plans. (eg Zambia and Papua New Guinea). Zambia reports that training providers include "for-profit health care companies, the pharmaceutical/medical technology industry, consumer organisations, academic institutions, NGOs, ministries of health, district health offices, donor agencies, and for-profit CPD providers." (Zambia)

Low Baseline of Existing Skills – In some countries in which VSO works the current knowledge or skill level of health workers can be low, and CPD needs to be planned accordingly. In South Sudan "knowledge and skills levels can be very low. So there is the challenge of starting from such a low baseline." (South Sudan)

Cultural Issues – "CPD has a huge role to play in changing attitudes and widening professional roles, although there are also very large cultural and societal barriers which CPD alone will not overcome." (International Volunteer Ethiopia) Studies for instance in South Africa have identified that women are expected to take less senior roles and that

[26] APPG on Global Health and Africa APPG, 'All the Talents: How new Roles and Better Teamwork can release potential and improve health services', 2012
[27] WHO, 'Task Shifting: Rational Redistribution of Tasks among health workforce teams', 2007
[28] APPG on Global Health and Africa APPG, 'All the Talents: how new roles and better team work can release potential and improve health services', 2012

progression is difficult, thus hindering 50% of the workforce from its true productivity. Another example would be constraints on mixing of the sexes in training or service delivery, which applies in eg Ethiopia as well as some Islamic countries.

8. ENABLING CONDITIONS FOR BEST PRACTICE

Enabling conditions needed include:

A National Human Resources Plan to set targets for the numbers and cadres of staff the country needs, identify the skills they require and introduce a national training plan to develop and update skills. The plan will also look at the numbers and capacity of training institutions, with plans to develop them. Gap analyses can be conducted to identify the areas to focus on.

National Policy on Licensing and Accreditation to identify and promote country-wide standards in healthcare. Job roles should be linked to competency-based skills, which are understood in the local workplace. Countries should move towards compulsory licensing of staff and training institutions in the interests of strengthening the health system and raising the status of health workers.

Professional Leadership is required from senior clinicians, managers and the professional associations in support of national goals for CPD and international standards of care. Senior clinicians should participate in local supervision and mentoring such as clinical meetings and illustrate the importance of applied knowledge and skills in the local setting, to counter the image of CPD as something undertaken elsewhere.

Partnering with equivalent institutions or associations overseas would help developing countries to set up and maintain structures for continuing training and validation. Nursing and medical skills are transferable world-wide and there is much international support available; for example the UK Royal College of GPs builds partnerships with health organisations in other countries and runs an international accreditation scheme. Individual hospitals in the UK, US and elsewhere have partnerships with hospitals in developing countries and these relationships can be very enriching at the individual and organisational level.

Employer Support in the home facility is essential to the development of CPD at individual staff level and for organisation wide adoption of standards. There must be employer support for job roles linked to competencies and time devoted to CPD. Employer support is needed for the adoption of standards eg training for task shifting and use of clinical pathways. This requires management development and clinical support to carry it out successfully.

Financial Support at local and national level for CPD is essential. There must be investment in human resources planning and training plans. Training institutions must be properly resourced and staff skills developed. Financial support is needed for an effective infrastructure, which supports and offers CPD nation-wide across all staff and volunteers within the health system.

9. VSO Position

VSO strongly supports CPD as a key part of national Health Service Strategy to develop and maintain a skilled motivated workforce. At its heart is life-long learning for all staff cadres to provide quality care nation-wide, to support change and to develop professional ethos as part of an international community of health professionals.

Good health is a pre-requisite for national development and is a core part of VSO's People First Strategy. CPD is fully in alignment with VSO's overall direction whereby bringing people together we can improve access to good quality basic services, encourage individuals to participate in change, and influence governments to support policies that help the poor. This section sets out what is desirable from VSO's research and experience to guide future action.

VSO's approach will be flexible and responsive to the country context and will adopt the following approaches, depending on the current situation and as part of a continuum of progress:

National approach to CPD

Health Service Strategy – support governments in identifying CPD as a core part of their Health Strategy, as part of the national approach to strengthening the health system. To recognise the pivotal role of CPD in improving standards, addressing health worker shortages and motivating staff in a cost effective manner.

Human Resource Plan - ensure the support of the Ministry of Health for development of a Human Resource Plan to address current and projected needs for staff and skills, with a key role for CPD. Support gap analysis for key health professions within a 5 or 10 years plan. Provide support for inter-departmental/ministerial collaboration eg Finance and Education to ensure co-ordinated, properly resourced plans within budget.

Integration of donor programmes with national strategy – work with the government, bi-lateral donors and NGOs to align CPD programmes with the national Health Strategy and HR Plan. Support coverage of all staff cadres and volunteers within the health system, and all areas of the country, especially in remote and rural areas.

New initiatives – work to maintain CPD focus and coherence at government and donor level in the light of new policies and targets eg Universal Health Care and the post MDG framework. Ensure that initiatives such as task shifting and use of community volunteers are fully supported by CPD, following the principle that a new task requires CPD and supervision to be effective.

Responsive regulation – support the development of employment and pay policy, which acknowledges the need for CPD and provides employer direction eg time allocation and policy at institutional level. Work towards licensing and accreditation of staff and training at national level to provide a legal basis for improving standards and the status of health workers.

Planned funding – support governments in increasing the health budget overall and in identifying a specific budget for CPD, which addresses the HR Plan. Support work with donors and NGOs to fund the planned CPD.

Human resources management

Capacity and methodology for planning – work with governments to build capacity in HR planning. Support the government and professional associations in carrying out skills gap analysis projects around particular professions eg midwifery or pharmacists. Include middle and lower level staff such as health assistants, and allied health professionals such as laboratory staff.

Job Descriptions and Competency based skills – promote and support the development of job descriptions for all roles. Support carrying out of task analysis to identify the competency based skills required. Then carry out gap analysis as to the skills that need developing for a group or individual member of staff. Competency based skills can also be the basis of supervision and performance management. Competencies should be adapted to the local context as much as possible.

Develop Training Courses – work with the professional associations and training institutions to develop courses and materials to address skill gaps. Update the skills of clinical tutors to deliver the new training. Emphasise cascade of training to local institutions and on-the-job training. Blend training models to suit the training outcomes required. Review and update existing CPD courses.

Invest in Managers – work with the government and training institutions to develop training for managers. Carry out task analysis related to their work of planning and budgeting, monitoring and evaluation. Support gap analysis of the required skills and support development of the training approach and materials. Include identifying the training required by trainers and provide opportunities to develop these training skills.

Human Resources Information System – support the development of a national Human Resources Information System covering all staff. As well as identifying staff in post, pay and job role it should record the level of certification and ideally planned CPD. The information system is an essential resource for national HR and CPD planning.

Clinical Leadership

Professional Ethos – encourage senior clinicians to emphasise the central importance of the patient, and professional codes of ethics such as the nursing code.

Professional Associations – work with the government and professional associations to build up the capacity of the professional associations. Address issues such as political will and resources in building up their role. Work towards compulsory registration and promote the benefits of membership. Develop and maintain links with international professional associations.

Advocacy – work with senior clinicians to advocate for CPD with central government, district authorities and local institutions. Address issues such as quality of courses, funding, and student access.

Capacity Building – support the development of training relationships between clinicians in the field and tutors in training institutions. Support the coherence and co-ordination of theoretical and practical training on placement. Work with local health facilities to develop structured on-the-job training.

Multi-disciplinary approach – support clinicians in taking a multi-disciplinary approach to CPD, with a team approach rather than working in professional isolation. Support the use of clinical pathways where the role and tasks of all staff cadres are clear. Identify and provide the relevant training.

Evidence Based Medicine -– encourage the development of training using evidence-based medicine. Encourage and enable access to clinical publications and joining of electronic communities of practice. Access clinical pathways and adapt them for local circumstances.

International Networks – enable all clinicians - long standing and newly trained - to align themselves with international networks, to develop their knowledge and skills. Support partnerships with overseas hospitals and primary care organisations to share information on developing CPD structures and validation. Draw on VSO partnerships with UK royal colleges (Paediatrics and Child Health, Obstetrics and Gynaecology, GPs, Nurses and Midwives) to support colleges and professional associations in country.

Value for Money - Efficiency and Effectiveness

Evidence of effectiveness – work with government and other stakeholders to show how CPD materially improves performance, patient care and outcomes. Draw on the Malawi study correlating CPD to practice.

Value for Money – work with government and other stakeholders to identify the most cost-effective ways of up-skilling staff. Draw on the VSO/UNICEF study in Sierra Leone, which is carrying out research into the cost effectiveness of on-the-job training versus centralised workshop training.

Localisation of training – support local training, which is accessible to rural staff. Develop regional and district training, as well as supporting on-the-job training.

Support of Primary Care – encourage CPD for primary care. Ensure that CPD matches the real health needs of the population. Emphasise prevention rather than treatment. Ensure that all staff cadres and volunteers are covered by CPD. Make clear the links between CPD and primary care in support of national initiatives such as vaccination, Universal Health Care and MDGs.

Innovation

Vision – support pilots for new ways of providing CPD and evaluate their scalability. Invest further in those, which can show good training outcomes and value for money such as the virtual nursing school. Draw on innovation in other countries using new ways of thinking or technology, in similar circumstances.

Extend CPD ethos beyond traditional health professions – Enable CPD for new staff cadres which may arise from innovation. Support identified job roles, competency based skills and CPD wherever there is patient contact. This is also true of telemedicine and other innovations to come.
Recognise Solutions in Unexpected Places – Support an open mind in finding the best solution to CPD in resource poor environments. Acknowledge that poorer countries might have something to teach more developed countries as set out in 'Holding the world upside down'. [29]

[29] Nigel Crisp, 'Holding the World Upside Down: the search for global health in the 21st century', 2010

10 RECOMMENDATIONS

National Governments

- Ensure that CPD has a strong place in the Health Strategy
- Support development of a National Human Resources Plan, followed by a Training Plan
- Ensure that CPD matches the real needs of the population, with a strong focus on Primary Care
- Identify clinical champions of CPD. Support joining of professional associations by all staff cadres
- Support the development of pay and employment policy supportive of CPD.
- Agree national policy on licensing and accreditation for health care staff and institutions
- Support innovation with an evidence base from pilots. Recognise the CPD implications
- Ensure planned funding for CPD. Work towards increase of the health budget overall to 15%.
- Support enabling frameworks and capacity building of professional associations and training institutions,.

Donors

- Integrate development work with the Health Strategy of the country
- Invest in the development of Human Resources and Training Plans
- Invest in CPD that addresses the health system as a whole, to develop the health workforce
- Support national systems for licensing and accreditation, in all sectors
- Support development of job descriptions and competency based skills
- Invest in CPD and capacity building for training institutions, professional associations and their staff
- Invest in CPD and capacity building for clinical staff – for all cadres and volunteers
- Support development of trained managers, with skills in planning, budgeting and evaluation
- Support development of institutional partnerships and access to international networks.

Civil Society and VSO Programmes

- Advocate for CPD on the basis of lifelong learning for a skilled motivated workforce
- Work at all levels, with providers to build an evidence base and with government for policy
- Support all national government activities above through eg work with health ministries
- Carry out research and contribute towards a body of evidence that demonstrates the impact of CPD and highlights best value for money solutions
- Develop a knowledge base about which innovation works under what circumstances and associated costs
- Support capacity building of professional associations and training institutions
- Support development of job descriptions and competency based skills adapted to local contexts
- Support the development and implementation of national licensing and accreditation
- Build the capacity of clinical tutors and managers, to upgrade training courses, skills and planning
- Continue to refresh and develop centrally delivered and on-the-job training using varied modalities
- Support the development of CPD infrastructure eg supervision, performance management
- Promote international partnerships and access to international networks for information sharing.

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Appendix VSO Case Studies

On-the-job Training for Anaesthetists, Ethiopia

As the only anaesthetic doctor at Yekatit 12 hospital in Addis Ababa, Dr Tom Bashford helped to improve the entire cycle of surgical care in a country where such specialist skills are rare. During his one year working alongside the hospital team, Tom introduced simple, but life-saving practices. After observing the way operations were being carried out, he implemented the routine use of the globally recognised WHO Safe Surgery Checklist.

"The turning point came early on when I was operating on a boy called Binyam." He had a huge tumour on the side of his face, which started to bleed heavily during an operation, putting his life in danger. Blood arrived from the laboratory just in time to save his life, but Tom observed how it should have been available before the operation. Binyam's surgery prompted Tom to teach colleagues how to use a Safe Surgery Checklist; a simple piece of paper that is shown to reduce surgery related deaths by as much as 50% in the developing world.

Tom was able to introduce other life saving practices and left behind a team with the skills to keep patients alive through surgery and crucially, to be able to train more staff to do the same.

Nurses and Midwives evaluate CPD Programme, Malawi

In June 2010 the Nurses and Midwives Council of Malawi NMCM) launched a mandatory CPD programme for all nurses and midwives practising in Malawi. However, in 2012 the NMCM recognised that meeting the requirements of the CPD programme was still presenting a challenge for some nurses and midwives.

With the support of I-TECH (International Training and Education Centre for Health) and VSO an in-depth evaluation of the CPD Programme was initiated. In September the evaluation team began identifying the objectives and developing gap analysis work plans and in November 2012 began conducting a series of interviews with the nurses and midwives. In an effort to ensure as many health facilities and educational institutions across the country were represented a selection of nurses and midwives were met in either Lilongwe or Blantyre.

The full CPD Evaluation Report will be published in March but preliminary findings indicate a number of key areas where the CPD Programme requires strengthening. One is how nurses and midwives working as lone practitioners in rural health centres require additional support to attend CPD activities. Another is that CPD Facilitators need on-going support to ensure they are kept updated and how to introduce a robust approach to communication and networking which would benefit all stakeholders. It is envisaged that work will now proceed to address the evaluation findings.

Competency Based Training for Management, Mongolia

Recent emphasis on primary health care and implementation of the MoH (Ministry of Health) Sectoral Strategic Master Plan (HSMP) has highlighted the need to improve the management skills in health facilities at all levels of the health service in Mongolia.

The development of a practice-oriented in-service training programme began with the agreement that the core management skills required by the facility management teams were based on the 6 stages of the planning cycle described in the Planning and Budgeting Framework of the HSMP. Using the MoH planning cycle and a Task Analysis Table each stage was divided into the tasks, skills, knowledge and attitudes required to carry out each task. The table was also used to develop training objectives; organization of the training modules; development of training materials and participatory, learning by doing training methods and to guide the training of the trainers. The programme has formalised the use of Competency Based Training.

30 trainers have conducted training of the main tertiary level hospital management teams using the training programme and the MoH has now instructed all hospitals to undergo this training. VSO Mongolia, supported by the Asian Development Bank, was instrumental in designing the approach, processes, materials and various components of the practice oriented Management in-Service Training Programme, the training of the trainers and the demonstration training events.