



*Photo of Karungi Gatrude, Nursing Officer in Uganda,
by Esther Ruth Mbabazi for IntraHealth International.*

STRENGTHENING RESPECT AND RECOGNITION FOR HEALTH WORKERS: STRATEGIES AND RECOMMENDATIONS

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For the literature review and key informant interviews, we referred to the **Center for Health Worker Innovation's definition of respect and recognition**, which states that we must ensure health workers':

- Voices are heard
- Work is fairly compensated
- Working conditions are safe and decent
- Roles are formalized and integrated within the health system.

As the Center supports and champions nurses, midwives, and community health workers at the heart of primary and community health systems, we focused our research and this report on these three cadres.

This report explores why respect and recognition matter for the health workforce, and what are some promising strategies and recommendations for increasing respect and recognition.

BACKGROUND: THE STATE OF THE HEALTH WORKFORCE

Lack of respect and recognition is a factor driving shortages.

Ongoing lack of respect and recognition of frontline health workers lies at the heart of many of the workforce-related challenges that impede global progress toward universal health coverage.

One of the most pressing challenges in health care delivery is the shortage of health workers. While a complex array of economic and social factors has caused these shortages, lack of appropriate respect and recognition for health workers plays a central role in poor recruitment and retention of the workforce.

Even before the COVID-19 pandemic, the world was facing a shortage of 18 million health workers by 2030, primarily in low- and middle-income countries (WHO 2016). The [2020 State of the World's Nursing report](#) found that countries would need to educate and employ at least 5.7 million additional nurses by 2030 to reach universal health coverage and sustainable development goals targets (Empuls 2021; Nursing Now, WHO 2020). According to the [State of the World's Midwifery 2021 report](#), there is a current shortage of 900,000 midwives to meet sexual, reproductive, maternal, newborn, and adolescent health needs (UNFPA, ICM, WHO 2021).

Low- and lower middle-income countries are particularly impacted by the shortage of health workers. The African region reports the highest burden of disease and the least number of health workers at 2.2 health workers per 1,000 people (Muthuri et al. 2020). Overall, health worker shortages are more than 50% higher in rural areas than in urban areas (Human Resources for Health Observer, WHO 2020).

Poor planning by ministries of health and fragmented aid flows often lead to health worker shortages but health workers' daily working conditions must also be considered, including lack of fair compensation, long working hours, lack of time off, insufficient access to protective gear, and unsafe working conditions including sexual harassment, a common problem in the workplace. For example, a [2017 study in Uganda](#) reported that sexual harassment of female employees in Ugandan public health workplaces appeared to be widespread and women seeking economic security or career growth found that sexual harassment and professional advancement were often tied to one another (Newman 2021).

Compensation for some health workers is particularly inadequate. For example, [according to the World Health Organization](#) (WHO), only 14% of community health workers (CHWs) in Africa receive a salary, despite playing key roles in the delivery of primary health care, and contributing to reductions in child morbidity and mortality, encouraging immunization uptake, promoting breastfeeding, and improving health outcomes (WHO 2021a).

The COVID-19 pandemic is a health workforce crisis.

The COVID-19 pandemic is exacerbating the shortage of health workers. [According to the WHO](#), as of May 2021, at least 115,000 health workers had lost their lives to COVID-19 (WHO 2021c). Scores of others are leaving the health workforce due to insufficient access to personal protective equipment (PPE), long lasting psychological effects, increased workloads, and worsening working conditions. Health workers continue to express concerns about their own loved ones, their personal safety, and shortages of staff and equipment (Empuls 2021).

According to a [March 2020 policy brief published by the International Council of Nurses](#) (ICN), the nursing shortage could increase to 13 million nurses in the aftermath of the pandemic due to the aging nursing workforce and the “COVID-19 effect” triggering nurses to leave the profession. A December 2020 survey reported that 90% of national nursing associations are somewhat or extremely concerned that heavy workloads and insufficient resourcing, burnout, and stress related to the pandemic response are contributing to a high rate of nurse attrition (ICN 2021). Additionally, more than 70% of national nursing associations said that they received reports of mental health distress from their nurses due to the COVID-19 response (Empuls 2021; Nursing Now, WHO 2020).

Lack of safety on the job is contributing to this stress. During the first wave of the virus, health workers faced a multitude of acts of aggression ranging from being denied access to public transport to social ostracism, eviction, and even being attacked while practicing (Bagcchi 2020).

Health workforce challenges have had a documented impact on the progress of efforts to end the pandemic. In a [WHO survey of 129 countries published in February 2022](#), health workforce challenges were the most cited bottleneck affecting COVID-19 testing, treatment, and care for those suffering from the disease. These challenges were “caused by a combination of pre-existing shortages coupled with unavailability [of health workers] due to COVID-19 infections and deaths, mental health issues and burnout and departures from service due to a lack of decent working conditions,” according to the WHO (WHO 2022).

A 2021 evidence review by the WHO found that CHWs in the Southeast Asia region expanded their usual roles to ensure continuity of essential health services and meet the demand for COVID-19 response activities, playing critical roles in assisting in surveillance and contact tracing, and in ensuring that people followed isolation and quarantine guidelines. However, despite such contributions to pandemic response, these workers encountered numerous challenges including stigma, a lack of adequate training or protective equipment, and limited levels of incentives and recognition (Bezbaruah et al. 2021).

DEFINITIONS AND BEST PRACTICES

“To be honest, not a lot of respect is being given to nurses and midwives. You get to work, you get insulted after working really, really hard. You get insults from the employers, the patients, from everybody. A young nurse or midwife comes in very enthusiastic about helping people and changing the world, but then two, three years down the line they’re already tired of the job. The compensation is not good, the labor is not dignified. It doesn’t feel like we’re being appreciated for all the work that we do, and the environment is not really safe. Especially for women, especially as midwives—they’re scared of being raped at work, or being sexually assaulted, or they’re scared of being killed. If I don’t feel safe at work, I don’t think I will be able to provide proper care to the patients.” - Olajumoke Adebayo, nurse-midwife and advocate in Nigeria (key informant interview 2021)

Health worker recognition

Research shows that frontline health workers thrive in environments where they are provided with clear job expectations, opportunities to learn, and adequate supplies and equipment and given constructive feedback, respect, and recognition. Yet, employers do not consistently provide such environments, particularly in many low- and middle-income countries, which undermines their motivation to succeed. Health workers in such countries, particularly nurses and other frontline health workers, have less training than in higher income countries for the same professional degree and fewer professional development opportunities to continue their education or receive personal recognition and appreciation (Pham 2021).

Recognition is generally defined as receiving positive feedback based on certain results or performance. The recognition may be formal such as an award, bonus, promotion, or raise, or informal such as a verbal “thank you” or a handwritten note. Although it is performance-based, recognition also takes into account previous behavior and is subject to others’ opinions (primarily senior leaders) (Robbins 2019). Both formal and informal recognition can be motivating.

Motivation

Recognition is critical for worker motivation. Motivation is an individual’s desire and effort to act a certain way to attain an organization’s goals (Pham 2021; Okello and Gilson 2015; Tripathy et al. 2016).

Productivity and satisfaction levels trend upward when employees are motivated. Employees who feel that their voice is being heard are 4.6 times more likely to achieve high standards in their job (Empuls 2021). Recognizing and empowering employees can lead to increased employee satisfaction, productivity, motivation, and performance and can raise organizational retention levels. (O’Flaherty, Sanders, and Whillans 2021).

It is important to understand different kinds of motivation and how they arise. Based on a [systematic review \(2009-2019\) of health workers in East Africa](#), intrinsic motivation is driven by a health worker's internal interest, which includes satisfaction for completing their work and the desire to help others (Muthuri et al. 2020).

The study also found that societal level determinants of motivation are important. These include appreciation, encouragement, support, recognition, and respect and admiration (sense of status) from clients, family, and the community. These provide validation and motivate health workers regardless of compensation. Sharing health-related knowledge and skills with their communities, in health facilities, and as a mentor, is perceived as exhibiting a sense of responsibility and commitment to the community and public health. Conversely, being undervalued by clients and/or community and a lack of security and safety is a demotivator (Muthuri et al. 2020).

Other factors such as a lack of understanding of health worker roles; overlapping roles; complaints from clients; and lack of career progression, promotion procedures, and opportunities for work-life balance have all been identified as demotivating societal-level determinants for health workers (Muthuri et al. 2020).

Motivation is considered extrinsic when it is driven by the external consequences of performing a task and external rewards or outcomes. Health workers may be motivated by expectations of remuneration, incentives, rewards, competition, promotion, and recognition from superiors.

For many cadres of health workers, motivation is determined by a mixture of intrinsic, societal, and extrinsic factors. For instance, according to a [2016 study of CHWs in India](#), love for work and financial incentives were individual-level motivators, whereas community support and recognition, organizational commitment and pride, and regular training were identified as environmental level motivators. This same study cited the importance of non-financial incentives such as positive interpersonal relations, family support, and skill and career development opportunities; alternative income-generating activities such as low-interest loans, opportunities for career advancement; professional development opportunities including training and supportive supervision; and non-monetary substitutes for remuneration, including transportation and supplies (Tripathy et al. 2016).

Management approaches intended to increase motivation must reflect this complexity. For instance, interventions focused on extrinsic motivation alone continue to yield mixed results, often creating competition among employees and undermining trust. Instead, approaches should include intrinsic motivations—tasks that are performed for internal fulfilment or enjoyment of the activity itself—such as social interactions, responsibility, cooperation, self-esteem, and a feeling of belonging, particularly since this is linked to a health worker's quality of work and job retention (Okello and Gilson 2015).

Recent research suggests that symbolic awards—including thank you cards, public recognition, and certificates—can significantly increase motivation, performance, and retention rates. But

these should not replace financial rewards altogether and timing and frequency of the recognition must be considered (O’Flaherty, Sanders, and Whillans 2021).

According to a [2008 global systematic review on health worker motivation and retention](#), financial incentives, career development, and management improvement should be coupled with recognition to motivate health workers. The study demonstrated that, similar to adequate resources and appropriate infrastructure, recognition and appreciation had a clear impact on morale among health workers in Africa and Asia (Willis-Shattuck et al. 2008).

Examples of meaningful recognition

Some examples of meaningful recognition include:

- **Opportunities for personal growth and professional development:** Continuous professional development and training opportunities (e.g., on-the-job learning, supportive supervision, workshops, seminars, refresher courses, and continuous training) recognize workers’ potential for growth and have been identified as the top organizational-level determinants of motivation among health workers (Muthuri et al. 2020). Employees may be supported, provided with technical assistance, and coached on communication skills, human management practices, processes, resources, structures, and how to establish positive workplace practices and culture (Perkins 2021). Personal growth may also include career progression or a reward framework (Clayton-Hathway 2020).
- **Opportunities for leadership:** Establishing leadership positions and leadership development programs with input from health workers is a critical way to support recognition. For example, many countries have a national nursing leadership position, which helps build a stronger, more enabling environment for nurses (Empuls 2021; Nursing Now, WHO 2020).
- **Social recognition measures:** Social recognition strategies include conferring nursing titles; publishing profiles of workers; and celebrating designated days, weeks, months, or years, such as the [2021 International Year of Health and Care Workers campaign](#), [International Nurses Day](#) and [International Day of the Midwives](#), and [World Health Worker Week](#).
- **Demonstrated recognition:** Strategies to provide recognition should go beyond occasional appreciation and should be a planned, year-round program that acknowledges, recognizes, and rewards health workers consistently with tangible and intangible rewards. Tangible awards may include increased benefits, such as time off, prizes, money, etc. Intangible rewards may include formal recognition systems, recognition and appreciation from colleagues, and support from family (Catherine Kane key informant interview 2021).

“The program that has done the most in terms of meaningful recognition, is [The DAISY Award for Extraordinary Nurses](#). It started out recognizing nurses in direct care positions and expanded to nurse leaders in clinical settings and nurse

faculty.” – Liz Madigan, chief executive officer, Sigma Theta Tau International Honor Society of Nursing (key informant interview 2021)

Respect

Respect is a critical foundation for a healthy working environment. A respectful work culture encourages productive growth by establishing standardized compensation, demonstrated recognition, and rewards. This includes making sure health workers’ opinions are consulted, work is fairly delegated, and roles are clearly established to increase productivity and collaboration. Health workers who feel respected have demonstrated better performance standards, are more innovative, and display greater resilience (Heathfield 2021; Khan 2020).

Respect includes critical, extrinsic motivating factors for a health worker, including career advancement, fair compensation, being paid on time, safe and decent working environments, accreditation, and formalization of roles.

Accreditation and formalization of nurses

Nursing accreditation is the process of using an independent, nongovernment established authority to review nursing training programs and provide peer reviews on whether the program meets the minimum quality standards and whether potential graduates may pass the registered nursing examination and therefore practice as nurses (Deshaies 2021).

According to the [2020 State of the World’s Nursing report](#), 97% (152 out of 157) of the countries that provided data have developed programs for nurses that are at least three years in duration, 91% maintain standards for education content and duration, 89% develop and implement accredited mechanisms, 77% uphold national standards for faculty qualifications, and 53% have established advanced practice roles for nurses.

Professionalization of community health workers

Community health workers make critically important contributions to health but have not received appropriate respect and recognition.

“CHWs are not counted [in national health worker registries]. In the absence of them being counted, in the absence of them being paid and equipped, they are not formalized and integrated within the health system—they’re informal, they’re volunteers, they’re a ‘nice to have’ but not a ‘need to have.’ And that’s just not true from an epidemiological standpoint. We know that community-based care is not second best, it’s the standard of care for things like chronic disease, for reaching various marginalized populations, for preventative care.” - Dr. Madeleine Ballard, executive director, Community Health Impact Coalition (key informant interview 2021)

“CHWs working forty hours, treated like volunteers—it is inhumane. Despite them providing contact tracing, they were denied PPE.” - Baba Aye, health and social services officer, Public Services International (key informant interview 2021)

However, progress has been made to recognize the crucial role of this cadre. In 2018, the WHO released its [guideline on health policy and system support to optimize community health worker programmes](#) to professionalize CHWs and integrate them into health systems and communities (WHO 2018). Since then, some countries (Bangladesh, Ethiopia, Kenya, and Mali) have moved toward formally integrating CHWs into their health systems and pay stipends or consider them formal volunteers with benefits (e.g., paid transportation, airtime, etc.).

According to Dr. Janet Muriuki, Kenya country director for IntraHealth International, Kenya has community health assistants (CHAs) similar to community health extension workers in other countries, and community health volunteers (CHVs) who are not formally recognized as a cadre or paid a salary. Recently, there has been movement towards inclusion of CHVs on the country payroll in Kenya (Dr. Janet Muriuki key informant interview 2021).

Liberia initially integrated CHWs into the national health system in 2016, and, as of December 2021, is deploying 4,000 paid, professional CHWs and 400 clinical supervisors (mainly nurses based in community clinics). Liberia’s CHW integration program ensures retention and quality by focusing on recruitment standards, national training, remuneration requirements, management and supervision protocols, supply chain support, and robust monitoring and evaluation systems (Pittman et al. 2021).

In Mali, CHWs receive a stipend of \$100 per month (paid for by donors such as the Global Fund, Unicef, and USAID) to provide family planning methods, malaria drugs, and HIV preventative services. These donations are managed through Community Health Center (CSCOM), which allows for more unification and standardization across all Mali health centers (Dr. Cheick Touré key informant interview 2021).

Nigeria instituted a new cadre of Village Health Workers in 2012, paid with a monthly stipend. A 2022 study found that this monthly payment was considered the most important motivational factor by these workers. It also showed that feelings of confidence, acceptance, happiness, and hopefulness/expectation of valued outcome among the workers were linked to training and supervision by skilled health workers and provision of first aid kits (Mbachu et al. 2022).

Counting CHWs and collecting CHW data can involve a wide range of data sources including program service monitoring data, coverage assessments, patient registers, CHW logs, and health management information systems (HMIS). This data is collected through routine monitoring and evaluation systems as well as community-led monitoring, including community scorecards and community-based surveys.

The WHO Monitoring & Evaluation/Accountability (M&E/A) Framework provides a standardized set of assessment measurements and indicators to monitor health workforce information

sources, stakeholders, and systems most relevant to quality of care, optimizing distribution and management, and reducing workforce attrition. Key recommendations from the M&E/A framework include investing in information systems metrics to monitor community selection of CHAs, frequency and quality of supportive supervision, availability of health supplies, remuneration and active labor stock, and continuing professional development and career pathways. The framework also encourages countries to develop a CHA registry map of the existing and desired functionalities for the electronic community-based information system (eCBIS) and electronic logistics management information system (eLMIS) to help operationalize strategies to monitor and disaggregate priority CHA metrics.

Population Council's CHW Performance Measurement Framework is centered around a subset of scales and offers 21 domains, including CHW development, CHW competency, and CHW well-being (Population Council 2021). Within these domains, there are 46 community health indicators for CHW performance, including the multi-dimensional motivational scale (for CHWs) and the trust in CHWs scale (for clients). Following this process, a recommended set of indicators can be used to assess community health systems or CHW program performance (i.e., % of CHWs satisfied with support received from supervisor and % of CHWs motivated in their work).

Fair compensation and adequate benefits

Fair compensation is a critical component of respect and recognition and includes fair and timely payment of salaries, allowances, bonuses, compensation, and performance-based financing programs. In an East African systematic review, evidence suggests that health workers' levels of motivation to deliver high-quality health services was associated with salary level (Muthuri et al. 2020).

"I would like to say to governing bodies: you cannot work without pay. If the government wants to strengthen health systems, let's start from the bottom up, with respect and recognition of paying those who take care of the community—CHWs. CHWs spare the community from polio. CHWs provide vaccinations. We should be recognized as health workers. We need the same respect. If we get some money in our pockets, we do not go hungry." - Margaret Odera, community health volunteer, Kenya (key informant interview 2021)

The WHO's Health Labor Market Approach may be used to help countries analyze health worker needs and task health workers appropriately (WHO n.d.). Some of the factors that must be considered include basic salary, overtime allowance or compensation for overtime, hazard allowances or harmful work conditions allowance, other allowances, performance pay, per diems, or salary supplements.

Compensation offered to health workers is often compared to one or more benchmarks to determine whether it is fair, adequate, and a living wage for the health worker to support themselves and their family. To derive this type of data, it is important to have comparable data

of health workers in the private sector. This, coupled with moonlighting data from public sector workers, offers a fuller picture of government health care worker compensation.

Another important indicator is health worker perception of compensation relative to other sectors. This comparison often speaks to job satisfaction and can result in internal migration between the public and private (both nonprofit and for-profit) health sectors.

“No matter where it is, if the clinic is set up under substandard rules or health workers have not been paid in the past three months, they will not receive the community’s respect.” - Chipso Nduna, qualified emergency medical technician, Zimbabwe (key informant interview, 2021)

Hazard allowance/pay: Hazard allowances are payments for working conditions that are considered risky to the individual worker. Hazard pay must be fair and equitable for frontline health workers, and employers should ensure it is based on clear criteria, temporary, easy to verify, and based on lump sum supplements to health workers as opposed to a percentage of pay (Hasnain 2020).

Performance-based payment (P4P): P4P is based on a health worker achieving a specific goal. To date, this approach has been primarily implemented by nonprofits and private sector companies rather than governments. Similar to hazard pay, P4P may be a challenge for governments to implement despite its advantages for long-term sustainability.

Payment coupled with non-financial incentives: According to the WHO, research demonstrates that, by itself, increased compensation, financial incentives and benefits rarely have the desired effect on performance. Other non-monetary incentives, such as job aids, logistics, and support for conferences, are also important motivators. In one study in Rwanda, the monetary determinants ranked lower compared to non-monetary determinants (Muthuri et al. 2020).

According to Dr. Andrew Brown, family support, such as access to housing and good schools for children, is often preferred to a wage increase, especially in the presence of a minimal living wage (Dr. Andrew Brown key informant interview 2021; Pallares 2020).

Safe and decent working conditions

The State of the World’s Nursing Report 2020 states that legal protections for nurses, including working hours and conditions, minimum wage, and social protection have been documented in several countries but they are not in place across all regions or within locales.

Oxfam has documented industrial disputes or strike action by health workers in 84 countries since February 2020, wherein 38% of strikes were linked to poor working conditions and 29% were due to a lack of PPE. Just over one third of countries (37%) reported measures in place to prevent attacks on health workers (Rose and Flynn 2021).

Sexual harassment is another workplace factor that reduces productivity and affects patient care; however, more than 50 countries still have no law against sexual harassment in the workplace. In 2018, less than half of the participants surveyed in a health workplace environment by the American Nurses Association (ANA) said their organizations had a zero-tolerance policy against verbal abuse of staff. Only 60% reported their organizations had a zero-tolerance policy against physical abuse of staff (Ulrich et al. 2019). Research has also shown that over half of all health workers have witnessed or been subjected to bullying in the workplace (Perkins 2021).

In June 2019, the International Labour Conference adopted [ILO Convention No. 190](#), the first international labor standard to address violence and harassment within the workplace. This sets a standard for work based on trust, dignity, and respect. The Convention has been ratified by six countries including Argentina, Ecuador, Fiji, Namibia, Somalia, and Uruguay since it was released in June 2021 (Closing the Leadership Gap, WHO 2021).

Some countries, such as Uganda, have existing national employment and labor laws that include protections for health workers' rights to violence- and harassment-free workplaces. In countries where those law are weak or non-existent, ratification of the ILO Convention No. 190 on violence and harassment could increase pressure for legal changes (Newman 2021).

Healthy work environment

High-performing organizations place an emphasis on compensation, benefits, attitudes, and work-life balance, resulting in employees feeling safe, respected, and appreciated. In 2005, the American Association of Critical Care Nurses' [Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence](#) was released outlining standards necessary for creating a healthy work environment. These included making sure nurses are valued and committed partners in making policy, directing and evaluating clinical care, and leading organizational operations (American Association of Critical-Care Nurses).

In lower performing organizations or unhealthy work environments the leadership style tends to be autocratic, run by fear and bullying. This causes insecurity and distrust and workers often face constant pressure to perform. They also experience more common workplace stressors including lack of paid time off, poor staffing, difficult workloads, high-acuity clients, and poor interpersonal relationships, communication, and recognition. In contrast, healthy work environments are associated with improved patient outcomes, patient safety, high quality of care, improved health worker satisfaction and retention, and decreased risk of occupational injuries (Perkins 2021).

A systematic review of studies about work environments for nurses in the United States from 2005 to 2017 found that healthy work environments tended to be associated with increases in psychological health, job satisfaction, retention, patient care quality, and decreases in patient mortality. Of those participants who had experienced verbal abuse, physical abuse, discrimination, or sexual harassment in the AACN survey, only 58% reported the incident to their supervisor; however, for units that had implemented the American Association of Critical Care

Nurses' healthy work environment standards, 50% of survey respondents reported that the problem was resolved satisfactorily compared to 24% of respondents in units where the healthy work environment standards had not been implemented.

Other studies have documented improved outcomes following health work environment implementation such as increases in job satisfaction, high quality of care in the unit, appropriate staffing, better communication and collaboration, more opportunities to influence decisions, and decreases in staff absenteeism, intent to leave, and patient falls (Ulrich et al. 2019).

COVID-19 and the workplace

Since 2018, the global trade union movement has been calling on governments and occupational safety and health (OSH) bodies around the world to recognize SARS-CoV-2 as an occupational hazard and COVID-19 as an occupational disease. The movement is seeking adoption of protocols similar to International Labour Standards on Occupational Safety and Health.

By adopting COVID-19 as an occupational disease, health workers are afforded the right to refuse to work in unsafe working conditions. Governments would then be required to report and record work-related COVID-19 cases and ensure that full medical care as well as compensation schemes are provided for victims of work-related COVID-19 cases and for the affected families. Current reporting is severely limited and more data collection and accurate reporting are needed (ITF Global 2020).

Providing benefits such as transportation, extra food, rest breaks, and frequent information and feedback sessions with local managers and the broader facility community would help health workers stay focused and empowered (Adams and Walls 2020).

Addressing structural racism and discrimination

To combat systemic racism in health care systems, administrators, managers, and health workers must first identify and understand the multiple forms of racial injustice patients, health care professionals, and health care providers may face in some health care settings. It may involve implicit bias—the tendency to unconsciously associate groups with a negative connotation—in which people of color are refused care or clients refuse care due to the identity of their health worker.

Health workers and students from minority groups may be more likely to experience discriminatory comments, public humiliation, and microaggressions from clients during their medical training. Facilities, clinics, governments, and medical schools need to enforce serious disciplinary measures for such behavior while ensuring that providers, students, and colleagues who report this behavior are not labeled as difficult or disciplined. They also need to encourage supervisors, mentors, and colleagues to support each other in addressing all forms of microaggressions, however uncomfortable the conversations may be with clients.

Globally, there is a lack of published medical school curricula that teach antiracism or specifically address implicit bias and the historical roots of racism in the medical system. Medical schools and health care stakeholders must also urge licensing institutions to adopt measurable competencies and targets (HWN 2020; Essien and Ufomata 2021).

Health care systems must address structural inequalities and discrimination such as patient prejudice toward providers (PPTP). Zero tolerance organizational policies and guidelines must be developed in collaboration with nondiscriminatory care training for health workers, so they have a clear understanding of what zero tolerance is within the confines of the duty to provide care. (Garran and Rasmussen 2019; St. Catherine University 2021).

Addressing gender equity and equality

According to the WHO, 70% of the health and social workforce are women, with nursing and midwifery occupations representing a 90% female workforce. However, only 25% of all leadership positions in health are held by women (WHO 2020). Globally, there is a gender-based pay gap, gender-based discrimination, and overall harassment in the work environment.

“There are challenges in each and every nation. In Zimbabwe, the heads of all district facilities are men. Women will be piling up on the bottom and will not be rising up to take on big roles. In terms of harassment, they tell you, ‘we have taken note of it,’ but then, no action is taken.” - Chipso Nduna, qualified emergency medical technician, Zimbabwe (key informant interview 2021)

Burdens in home care continue for many women in the health and social care workforce. In March 2019, the WHO launched a landmark report, [Delivered by women, led by men: a gender and equity analysis of the global health and social workforce](#). Focusing on gender inequities in the health and social care workforce, the report highlighted four areas for action: gender parity in leadership; occupational segregation; decent work free from bias, discrimination, and harassment, including sexual harassment; and the gender pay gap (WHO 2019).

Following a public consultation first launched in May 2020, the WHO in collaboration with Women in Global Health and the Global Health Workforce Network, released a policy action paper in June 2021 titled, [Closing the leadership gap: gender equity and leadership in the global health and care workforce](#), which outlined several key findings and recommendations:

- Gender leadership gaps are driven by stereotypes, discrimination, power imbalances, and privilege.
- Women’s disadvantage intersects with and is multiplied by other identities, such as race and class.
- Global health is weakened by excluding female talent, ideas, and knowledge.
- Women leaders often expand the health agenda, strengthening health for all.

- Gendered leadership gaps in health are a barrier to reaching the sustainable development goals and universal health coverage.

This policy action paper offers several key recommendations for governments, health care institutions, and providers to help build the foundation for equality and address social norms, stereotypes, workplace systems, and culture to enable women to achieve (WHO 2021a). Women in Global Health has also urged manufacture and distribution of PPE that is designed for female bodies (Women in Global Health 2021).

CASE STUDIES AND PROMISING APPROACHES FOR INCREASING RECOGNITION AND RESPECT OF HEALTH WORKERS

Several promising examples and strategies for strengthening respect and recognition for health workers came to light during key informant interviews. More investment in research and monitoring and evaluation is needed to determine success of these interventions.

Case study: Global guidance for the health workforce

The World Health Organization (WHO) has released global guidance and standards documents countries can use to draft policies to improve respect and recognition for health workers, including the [WHO guideline on health policy and system support to optimize community health worker programs](#), WHO guidance for the health workforce in COVID-19, and [The WHO Global Strategic Directions for Nursing and Midwifery \(2021–2025\)](#) (Catherine Kane key informant interview 2021).

The WHO is currently developing a global care compact for health and care workers based on existing legal instruments, conventions, and resolutions, and will release it during the World Health Assembly in May 2022 (WHO 2021b). According to Catherine Kane, technical officer on the WHO health workforce team, the compact will cover four health workforce domains: health and safety, equality and non-discrimination, social support, and safeguarding rights.

“If a group of nations make a declaration or make a standard, it forces or rallies everyone around it and makes it easier for anyone in the policy space who is proposing a policy. Those declarations have a lot of weight guiding the policy toward a certain direction. So I think that’s the most significant thing—make a standard or direction and let it flow in the water.” - Dr. Gregory Ganda, county executive committee member for health services, Kisumu County, Kenya (key informant interview 2021)

The WHO health workforce department has a set of interconnecting area-specific network hubs that provide opportunities to share these global guidance documents and ensure they are informed by what’s happening “on the ground” (Catherine Kane key informant interview 2021).

More countries however should take steps to implement the global standards and guidance set by the WHO.

“CHWs are often—with notable exceptions like South Africa—not unionized, not represented by any health worker council or decision-making body. We've seen mandates around representation be very successful, for example the WHO guidelines on CHW roles in COVID-19 vaccination recommends including CHWs at the planning stage and not just the execution stage of response. But I think those recommendations are really sporadically taken up.” - Dr. Madeleine Ballard, executive director of the Community Health Impact Coalition (key informant interview 2021)

Case study: A campaign to raise the profile of nurses

The goal of the global [Nursing Now campaign](#) (2018 – 2021) was to improve health by raising the status and profile of nursing. The campaign’s final report highlights several global and national achievements related to respect and recognition for nurses and midwives—Nursing Now convinced the WHO to designate 2020 as the Year of the Nurse and the Midwife, partnered with the WHO and the ICN to publish the first-ever State of the World’s Nursing report, engaged over 800 employers through its Nightingale Challenge to provide development opportunities for young nurses and midwives, and saw an increase in the number of nurses in leadership positions, such as chief nursing officers, who can now exercise greater influence in shaping policy (Holloway et al. 2021).

The campaign’s successful strategies included engaging high-level speakers for campaign launch events, including presidents of countries as chairs of events, creating an online advocacy training program for nurses, and securing two nurses for the first time to speak during a WHO press conference (Barbara Stilwell key informant interview 2021).

“We made an advocacy training program available online to give nurses practical skills, and we also gave them a framework. So we would say, ‘We want you to think about what you want to say to your ministry of health, about where the investment in nursing should be,’ or, ‘We want you to go and get your employers to sponsor a hundred young nurses to do leadership training.’ We gave them very focused messages and I think that was very useful, rather than saying, ‘Raise your voices.’ And they were very responsive to that, especially the young nurses.” - Barbara Stilwell, former executive director, Nursing Now (key informant interview)

Case study: A movement to improve gender equity in the health workforce

[Women in Global Health](#) (WGH), a global movement and organization, is working to improve gender equity in the health workforce—including in pay, representation, and leadership—at the global and national level by mobilizing women health leaders, advocating to existing health

leaders to commit to transform their own institutions, and holding leaders accountable for their commitments (Women in Global Health 2021).

“A lot of our work at WGH is making the case that the issues and inequities we see in the health workforce are gender-related inequities due to the fact that women are overall undervalued in society and that fact playing out in a field where the majority of workers are women.” – Dr. Roopa Dhatt, executive director and cofounder, WGH (key informant interview 2021)

WGH uses a gender perspective to ask for safety, access to PPE that is designed for female bodies, fair pay, and better recognition of the critical role health workers have in the pandemic and in keeping health systems strong and resilient. WGH’s approach is to use quantitative data and personal anecdotal case studies to bring women health workers’ stories in front of policymakers, primarily the WHO, as well as ministers of health and others at the World Health Assembly, the United Nations, and other multilateral spaces (Dr. Roopa Dhatt key informant interview 2021).

“Our strategy has been to work closely with the WHO when and where possible since they have a norm setting role. We cochair the Gender Equity Hub with the WHO’s health workforce unit, which is part of the Global Health Workforce Network. Through that we release global policy products, including the report *Delivered by Women, Led by Men.*” - Dr. Roopa Dhatt, executive director, WGH (key informant interview)

In 2021, WGH used the WHO’s designation of the Year of Health and Care Worker and the 25th anniversary of the Beijing Declaration to bring the gender and health workforce agendas together through the Gender Equality Forum. WGH, the government of France, and the WHO launched the [Gender Equal Health and Care Workforce Initiative](#), which aims to:

1. Increase the proportion of women in health and care leadership roles
2. Recognize the value of unpaid health and care work and the importance of equal pay in the health and social care sectors
3. Protect women in health and care against sexual harassment and violence at work
4. Ensure safe and decent working conditions for all health workers, everywhere.

Eight governments, along with several multilateral organizations and NGOs, have made commitments (Gender Equal Health and Care Workforce Initiative 2021).

WGH is also working with members states that made previous commitments on gender equity in the health workforce and has 40 chapters around the world, half of which are in LMICs, who are shaping the agenda on the health workforce. They are engaging leaders in their country capitals and at the local level to bring visibility to these issues. They are also using social platforms, including WhatsApp, Twitter, and Instagram, at the global and national level to produce and disseminate clear and consistent messaging. On Twitter, both WGH global and

country chapters have been able to target policymakers at all levels. This strategy enables WGH to leverage social media platforms, to disseminate, connect, community build, mobilize, garner commitments, and hold accountable those not living up to their commitments (Dr. Roopa Dhatt key informant interview 2021).

Case study: Health worker storytelling for advocacy training

IntraHealth International, with funding support from Medtronic Foundation, provided frontline health workers who prevent and treat noncommunicable diseases with intensive [storytelling for advocacy training](#). From 2017-2020, 15 health workers from Bangladesh, Brazil, Kenya, India, Ireland, Liberia, South Africa, Uganda, the United States, and Yemen learned the art of storytelling to better share their experiences and gain the confidence and authority to help them become agents for change.

The initiative had three principal aims:

1. To ensure global health policymakers and influencers hear more voices of frontline health workers
2. That frontline health workers who received the training have the tools to continue advocating for policies and investments they feel are important
3. That more organizations and institutions prioritize the voices and stories of frontline health workers in high-level global health policy forums and meetings.

The health workers have shared their stories with policymakers and influencers at key forums such as the World Health Assembly, the UN General Assembly, US congressional briefings, the Fourth Global Forum on Human Resources for Health, the UN Commission on the Status of Women, and the Global Conference on Primary Health Care (Blaser and Nelson 2019).

“Forums like the UN General Assembly can be intimidating, speaking on stage with the WHO Director can be overwhelming. We must consider storytelling as an intervention for increasing respect and recognition for health workers, and among one of the more successful—we keep getting better at it and now there are more multimedia approaches to storytelling.” – Vince Blaser, former sr. advocacy and policy advisor at IntraHealth International and current director of Immunization Advocates, Sabin Vaccine Institute (key informant interview 2021)

Dr. Sanele Madela, a community physician in South Africa who completed the training in 2017, reached millions of viewers when he spoke with Jimmy Fallon during a Global Citizen event in April 2020. He shared his experience providing care in the early days of the COVID-19 pandemic and called for more investment in health workers on the front lines (IntraHealth International 2020).

Margaret Odera, a CHW in Kenya who completed the training in 2020, has gone on to share her perspective and advocacy recommendations at the 2020 Prince Mahidol Award Conference,

AIDS 2020 Conference, 74th UN General Assembly, 74th World Health Assembly, and more than a dozen webinars (Odera 2020). Odera has advocated for CHWs to be recognized as important members of health workforce teams, for fair compensation, and for personal protective equipment, sanitation supplies, and digital tools health workers need to keep themselves, their families, and their patients safe during the COVID-19 pandemic and beyond. She also partnered with CHWs she works with to launch the CHW Champions Network, the first network for community health workers in Nairobi to support one another, encourage greater leadership opportunities, and provide a unified voice for CHWs (Odera 2020 and Margaret Odera key informant interview 2021).

Case Study: A campaign and network for CHW representation and advocacy

The Community Health Impact Coalition (CHIC) launched [CHW Advocates](#) in 2020, initially as a campaign to include CHWs in high-level decision-making and to ensure that when CHWs are discussed, a CHW is in the room.

CHIC exists to make professionalized CHWs a norm worldwide through research, advocacy, and activating. As part of the CHW Advocates campaign, CHIC member organizations agreed to facilitate CHW speaking roles at in-person and virtual events, help CHWs to secure visas to attend in-person events, connect CHWs with advocacy and storytelling training opportunities, and work with organizers to identify and support interpretation services.

In 2021 CHIC expanded CHW Advocates beyond elevating CHW voices in decision-making at key fora. CHIC's goal, suggested by CHWs themselves, is to organize a global network of CHW Advocates engaged in advocacy, through:

- [Advocacy Training for Community Health Workers](#), a free course (available in English, French, and Spanish) offered online or by using a facilitator guide for in-person training, that teaches CHWs skills to effectively share their stories and advocate for the health issues most important to their profession and communities
- A [CHW Speaker Bureau](#), representing CHWs and CHW Supervisors
- Global and national WhatsApp groups.

CHIC is supporting local and transnational CHW groups to advocate for the supplies, training, support, and pay they need to provide dignified care to their communities. More than 1,000 CHWs from at least ten countries have enrolled in the advocacy training. There are currently 26 CHWs available to book through the CHW Speaker Bureau and the campaign has facilitated 30 CHW speaker engagements. Approximately 600 CHWs and CHW supervisors from 14 countries are participating in CHW Advocate WhatsApp groups (CHIC 2022; CHW Advocates 2022).

Case study: An advocacy alliance for frontline health workers

The [Frontline Health Workers Coalition](#) (FHWC) is an alliance of more than 35 US-based organizations urging greater and more strategic US and global investment in frontline health workers, especially in low- and middle-income countries.

Since its inception in 2012, the FHWC's advocacy has contributed to many policy and investment wins that support increased respect and recognition for the health workforce, including:

- The first ever [global strategy on the health workforce](#) (Workforce 2030)
- A specific target on strengthening the health workforce included in the Sustainable Development Goals
- Several new US government commitments across US global health programs
- New US legislative requirements requiring greater reporting by US government agencies on health workforce strengthening efforts
- Health workforce strengthening incorporated into USAID's Global VAX initiative to address COVID-19 vaccine inequity
- Bipartisan US Senate legislation on global health security that includes a USAID pilot program for health systems strengthening and multilateral support for surging and managing additional staff during emergencies.

One of the FHWC's core policy goals is to increase frontline health worker voices in US government and global health policy discourse. The coalition and its members including the Community Health Impact Coalition, IntraHealth International, and Women in Global Health are empowering frontline health workers with advocacy training, talking points, and research, and providing opportunities for them to share their experiences and advocacy asks. In 2021, the coalition featured health worker speakers—including CHWs, nurses, and midwives—at its US Congressional briefings, roundtable discussion with the Centers for Disease Control and Prevention (CDC), event alongside the United Nations General Assembly, and several webinars. The coalition also identified and prepared a nurse in Kenya to speak during President Biden's Global COVID-19 Summit.

The FHWC founded [World Health Worker Week](#) in 2013 to celebrate frontline health workers, elevate their voices, and advocate for increased investment in them. The week has grown into a global movement that occurs the first week of every April. During World Health Worker Week 2021, more than 3,490 Twitter users in 30 countries used the official campaign hashtag (#WHWWeek), reaching 94 million Twitter users.

As of March 2022, the FHWC is pushing for the White House to launch an initiative to address the needs of the global health workforce. As part of its [official recommendations](#), the coalition is urging the initiative to include support for health worker leadership (particularly for nurses, midwives, and community health workers) in global and country-level decision making, and to

address the specific needs of women health workers by fostering safe working environments, equitable remuneration, continual learning, professional advancement, and leadership opportunities.

The coalition regularly releases and disseminates policy recommendations, including its [Policy Recommendations for Sustainable Health Workforce Teams to Respond to COVID-19](#). These recommendations urge the US, as well as other governments, donors, and implementing partners to take specific actions to address the most pressing needs of frontline health workers—including related to respect and recognition—in low- and middle-income countries, including to:

- Share health workers' stories and act on their recommendations
- Prioritize health workers to receive COVID vaccines
- Make PPE available for every health worker, including CHWs and women
- Provide fair pay for all frontline health workers
- Address the barriers women health workers face and open up opportunities for leadership and professional advancement.
- Broaden the workforce components of global health security investments so that they strengthen the public health role of a variety of health workforce cadres.

Case study: Legislation to secure stipends for community health volunteers

Between 2018 and 2020, the nonprofit Living Goods worked with the Ministry of Health in Kenya to develop an investment case for community health, which showed that investing in community health in Kenya can provide a return on investment of up to 9.4 times in terms of increased productivity, averted deaths, and saved treatment costs (Living Goods and Kenya Ministry of Health 2018; Howard Akimala key informant interview 2021). Living Goods is now using this investment case as a tool to advocate nationally and at the county level to ensure community health programs—and community health volunteers—are adequately resourced (Howard Akimala key informant interview 2021).

“In Kenya, we have community health volunteers, as opposed to community health workers, that’s where we started. At Living Goods, we believe if community health volunteers are well compensated, they will have more motivation to work in the area of community health.” - Howard Akimala, senior advocacy manager, Living Goods (key informant interview 2021).

Prior to devolution of health services to the county level in 2010, community health volunteers were retained by the Ministry of Health. After devolution, most counties continued engaging them on a voluntary basis with inconsistent payment. County governments have limited

resources and competing priorities, however, and there was a lack of existing policy frameworks to support payment of community health volunteers.

A few counties opted to pay their community health volunteers, but they were doing so under an executive order that could be easily overturned. Living Goods, along with partners like Amref and Save the Children, advocated for enactment of community health legislation at the national and county level to safeguard financing of community health programs, and to support the revised National Community Health Strategy (2020-2025), which specifically calls for remuneration of community health volunteers (Kenya Ministry of Health 2021). They first targeted the Council of then county health committees, and specific governors. They utilized community health coordinators in counties to advocate to County Health Management Teams and cultivate community health champions.

As of December 2021, nine counties in Kenya had passed a Community Health Services Act that provides a stipend and supervision for community health volunteers. This is a huge step forward for recognizing and respecting community health volunteers, and it forms a legal basis for securing a budget line in the future to mobilize domestic resources for community health. A similar national bill is currently going through the national assembly (Howard Akimala key informant interview 2021).

“This county-level legislation defines how community health programs are to be run in these particular counties, for instance how community health volunteers will get the commodities and medicines they need for their work, and how they will be paid. When these bills are passed into law, this will continue and will not be affected by a change in government, unless they go back to the assembly and pass a different law. And in this case, because there is very clear value being shown of investing in community health work, it would be difficult to come back and repeal that act.” - Howard Akimala, senior advocacy manager, Living Goods (key informant interview 2021).

Additional examples of promising approaches to increase respect and recognition for health workers

Increasing nurse leadership

In Uganda the National Task Force on COVID-19 initially consisted only of doctors and did not include any nurses. Nurses and midwives in the country formed the Nurses and Midwives Think Tank and, in collaboration with Nursing Now, pressured the Ministry of Health to include nurses. There are now several nurses on the national task force subcommittees, including for case management and community engagement. The Think Tank opened up communication channels with government officials: identifying who is approachable, writing them, setting up one-on-one meetings, inviting them to meet with community advocates, deliberating with them on how challenges can be solved, and figuring out how to bridge the gaps (Tracy Kobukindo key informant interview 2021).

According to one key informant, proposed legislation in Kenya could help ensure nurses are able to rise to leadership positions.

“Right now there’s a bill in Parliament about allowing other cadres besides doctors to be heads of facilities at the higher level. So that means is that when advertisements are done for recruitment, then it opens that field up to anyone else who’s not a doctor, including nurses.” - Eunice Ndirangu, Dean, Aga Khan University School of Nursing and Midwifery (key informant interview 2021)

Advocacy for paying community health workers

In October 2021 CHIC launched the [#PayCHWs campaign](#) to make fair pay for CHWs a global norm. The campaign included a virtual event with the Financing Alliance for Health, a short video featuring CHWs, evidence on compensation models that best align with global guidelines for CHW pay, and social media posting using the #PayCHWs hashtag (CHIC 2021).

Networking

Official health professional councils, such as membership groups with subscription fees like the International Council of Nurses and the International Confederation of Midwives are organizing health workers. Unofficial member-led groups without subscription fees that are team-based and have a shared mission such as WhatsApp groups formed by health workers are providing a platform for networking and organizing (Chipo Nduna, Margaret Odera, and Tracy Kobukindo key informant interviews 2021).

Social networking and online platforms allow for increased participation, regardless of ability to meet in person. Zoom meetings and webinars that activate targeted invitations, and use of radio and TV talk shows in the rural areas, have proven to be particularly impactful in Uganda for reaching and increasing member-led groups (Tracy Kobukindo key informant interview 2021).

Using data and research to drive policy

In 2017, IntraHealth and the Uganda Ministry of Health conducted a study—with support from IntraHealth’s USAID-funded Strengthening Human Resources for Health Project—to better understand the nature of sexual harassment and why it so often goes unreported. Following this study, the Uganda Ministry of Health integrated examples from the study into the sexual harassment policy implementation guidelines as low-cost training examples. The data and research also revealed that unchecked, subjective, and arbitrary authority perpetuates sexual coercion and subordination (Newman 2021).

Formalization of Community Health Workers

[Public Services International](#), which represents 30 million workers and union representatives, has been able to win formalization of community health workers in Mumbai, India. The organization

has achieved success on minimum wage issues and union recognition. Public Services International has learned over a two-to-three-year period that international solidarity, funding from affiliates and solidarity organizations (northern countries, foundations, trade unions, etc.), persistence of the workers themselves, building alliances with civil society organizations, intentional use of media, and having a means of protest (e.g., use of courts) are all key tools in organizing/advocating for health worker rights.

RECOMMENDATIONS TO IMPROVE RESPECT AND RECOGNITION FOR HEALTH WORKERS

Further research on respect and recognition for health workers

Given the limitations of this report, donor investment in additional research is required to further explore interventions to increase respect and recognition for health workers. An analysis of how global health initiatives—including the Global Fund, GAVI, and the Global Financing Facility—are currently supporting respect and recognition for health workers would be an essential element of further research, including recommendations for how they can do more to address health workers' needs, provide more flexibility in funding streams, and go beyond their areas of focus.

Fund local advocacy and member coalitions

“We need funding for advocacy at all levels—global, regional, national level—and to train advocates and support advocates and get them in the right rooms where decision-making is taking place. If funders are serious about having decent work for health workers, then they need to fund advocacy efforts in this area. Advocates who are the most powerful are not supported, and even organizations upstream are not getting funding for advocacy yet, and that’s what’s needed for change. Funders should encourage these advocates the same way there’s patient and disease advocates.” - Roopa Dhatt, executive director, Women in Global Health (key informant interview 2021)

Advocacy can be defined as evidence-based strategic actions designed to foster enabling policy environments as well as resources needed to advance a particular goal. Advocacy goes above and beyond educating and raising awareness in that it seeks change in behavior of policymakers and other decision makers. The Democracy Center recommends a set of basic questions can help guide advocacy campaign planning (Whelan n.d.):

- What do we want? (Goals)
- Who can give it to us? (Audiences)
- What do they need to hear? (Messages)
- Who do they need to hear it from? (Messengers)

- How do we get them to hear it? (Delivery—strategy and tactics)
- What have we got? (Resources; strengths)
- What do we need to develop? (Challenges; gaps)
- How do we begin? (First steps)
- How will we know it’s working, or not working? (Evaluation)

“Funders need to engage with nurses and midwives on the ground, as well as those in leadership positions and other stakeholders, to understand what we have we done and what more needs to be done. So the funding goes directly toward addressing the priority issues, then we keep building.” – Eunice Ndirangu, Dean, Aga Khan University School of Nursing and Midwifery (key informant interview 2021)

Health workers (and their allies) must start by asking which decision-makers have the power to give them the respect and recognition that they deserve, and then focus their advocacy accordingly. For health workers such decision-makers operate at several levels, including:

- At the work site, such as a clinic or a hospital, where managers and supervisors have a significant amount of power to determine working conditions, rewards, work schedules, and procedures.
- At the government level, where ministerial officials establish national or local policies and regulations, such as scope of practice and management practices, and legislators establish national laws and budget allocations pertaining to the health workforce, including those related to compensation and the freedom to organize.

A number of member-led and coalition groups such as FHWC, ICN, ICM, and WGH are advocating for policy, legal, and regulatory frameworks at the global, national, and subnational level to foster greater respect and recognition and build solidarity between health worker cadres to fight together for change across disciplines.

Key activity areas that that these groups should expand include:

- Providing advocacy and leadership training on policy and regulatory processes.
- Providing advocacy training on how to engage with governments as well as with northern governments, UN, World Health Assembly and other multilateral spaces.
- Engaging local government ministries (e.g., ministries of labor and of education) using a multi-stakeholder approach while also engaging the private sector.
- Developing monitoring mechanisms and engaging economic bodies to develop investment cases.
- Providing capacity development for local affiliates/member groups on organizational capacity assessments, business sustainability planning, resource mobilization, board

development, succession planning, human resources skills, interpersonal relations, leadership, and psychosocial issues.

- Synthesizing research (quantitative and qualitative) on race and gender inequities, fair compensation, and safe and decent working conditions conducted by in-country, member-led groups.
- Providing media training and storytelling.
- Supporting social media mechanisms to grow local associations and allow community-based health workers to support each other (e.g., WhatsApp groups).

Engage parliaments

“One really important consideration is getting a legal framework for making sure that health workers are fairly compensated, and they have safe working conditions, and that the scope of practice is formalized within that legal definition—a formal, legal approach which spells out who can do these jobs, what qualifications they need, what compensation they should have, and how each of the jobs differs from the other.” - Barbara Stilwell, former executive director, Nursing Now (key informant interview 2021)

Parliaments in many countries have the power to enact legislation to formalize health worker roles, as well as provide other aspects of respect and recognition. However, while some health workforce advocacy campaigns have included parliamentary engagement, such as Nursing Now, to date this is an underutilized approach.

Health worker advocates should consider working with sympathetic parliamentarians, such as those who are former nurses or physicians, to establish ongoing committees (also known as caucuses) of legislators to build political will and promote the interests and concerns of frontline health workers. This would add to pressure on health ministries to budget more for salaries and to enact better policies to establish better working conditions and policies on issues such as violence and sexual harassment, for example.

A “Frontline Health Workers Caucus” could be modeled on the successful [Global Tuberculosis \(TB\) Caucus](#), which is supporting 53 national-level TB caucuses in parliaments around the world. These national caucuses have enacted legislation and successfully pushed for increased budgets for TB programs. Working with existing health or labor committees in the parliament may also be feasible (Sarah Kirk key informant interview 2021).

It is worth exploring parliamentary engagement on this topic and collaborating with other key institutions that already have ongoing programs in parliamentary organizing. For instance:

- The WHO has expressed interest in establishing parliamentary caucuses to focus on UHC, and these could include workforce issues.
- The Inter-Parliamentary Union (IPU) has an advisory committee on health that includes leading parliamentarians. They often work with external partners and funders to execute

specific programs and direct funding could catalyze them to act on this topic. Their standing committee (Forum) of women parliamentarians could also be engaged.

- The Organisation for Economic Co-operation and Development has a parliamentary forum called the Global Parliamentary Network. Advocates could approach them given the labor and economic aspect of workforce issues.
- Parliamentarians for Global Action is another potential partner.
- The Global Fund has a strong and growing interest in the health workforce and they have a strong knowledge of parliamentary engagement (Sarah Kirk key informant interview 2021).

Collect actionable data

There is a need to collect data and link it to action, since without data collection, tracking funding flows is difficult and accountability is weakened.

Governments and multilateral donors must establish indicators that can help track respect and recognition. Funders should increase resources for data collection and evidence sharing, specific to respect and recognition, at both a global level (WHO) and national policy level.

Member-led groups, collectives, and campaigns need to be provided training on data impact and data visualization workshops should be held at the district level for advocates. Advocates can then use this data to better inform ministries of finance, ministries of labor, and local governments based on investment cases showing the benefit of respect and recognition. Member-led groups should also collaborate with local governments to conduct impact assessments that consider how policies and programs can impact welfare and well-being of care workers through the lens of respect and recognition, including gender equity.

APPENDIX A: KEY INFORMANT INTERVIEWS

Name	Title	Organization
Alex Collins	Health Workforce Technical Advisor	IntraHealth International
Amanda Banda	Cochair, Health Workers for All Coalition	Wemos
Andrew Brown	Senior Principal Technical Advisor (MTaPS Program) (Former Sr. Director, Health Workforce Development, IntraHealth International)	Management Sciences for Health
Baba Aye	Health and Social Services Officer	Public Services International
Barbara Stilwell	Former Executive Director	Nursing Now
Catherine Kane	Technical Officer	World Health Organization
Cheick Touré	Mali Country Director	IntraHealth International
Chipo Nduna	Qualified Emergency Medical Technician	Zimbabwe
Dyuti Sen	Masters' student, former program manager with Innovators In Health	
Eunice Ndirangu	Dean, School of Nursing and Midwifery, East Africa	Aga Khan University School of Nursing and Midwifery, Nairobi, Kenya
Gregory Ganda	County Executive Committee Member for Health Services	Kisumu County, Kenya
Howard Akimala	Senior Manager – Advocacy	Living Goods
Howard Catton	Executive Director	International Council of Nurses
Janet Muriuki	IntraHealth Kenya Country Director	IntraHealth International
Jessica Daly	Director of Programs & Partnerships	Medtronic Foundation
Liz Madigan	Chief Executive Officer	Sigma Theta Tau International Honor Society of Nursing
Madeleine Ballard	Executive Director	Community Health Impact Coalition
Margaret Odera	Community Health Worker, Mentor Mother, and Advocate	Mathare North Health Center, Nairobi, Kenya
Michelle Mclsaac	Technical Officer	WHO

Olajumoke Adebayo	Nurse-Midwife in Nigeria	
Rose Byanyima	Senior Health Officer	Ministry of Health Uganda
Roopa Dhatt	Co-Founder, Executive Director	Women in Global Health
Sarah Kirk	Head of the Secretariat	Global TB Caucus
Tracy Kobukindo	Nurse and Technical Advisor	Last Mile Health
Valeria Macías	Director	Partners in Health Mexico
Vince Blaser	Director, Immunization Advocates	Sabin Vaccine Institute

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