Government of the Republic of Vanuatu

Second Health Workforce Plan 2004 - 2013

Ministry of Health
Directorate of Planning and Administration

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ACRONYMS

ASAS	Australian Staffing Assistance Scheme
AusAID	Australian Agency for International Development
FSM	Fiji School of Medicine
HPMP	Vanuatu Health Sector Planning & Management Development Project
HRDT	Human Resource Development & Training Office
MBBS	Bachelor of Medicine & Bachelor of Surgery
MCH	Maternal and Child Health
MFEM	Ministry of Finance and Economic Management
MoE	Ministry of Education
MoH	Ministry of Health
NDH	Northern District Hospital
NHCG	Northern Health Care Group
NA	Nurse Aide
NP	Nurse Practitioner
NZODA	New Zealand Overseas Development Agency
O&G	Obstetrics and Gynecology
PH	Public Health
PPA	Personnel & Performance Appraisal Office
PSC	Public Service Commission
P&A	Planning and Administration Directorate
SHCG	Southern Health Care Group
TSCU	Tertiary Scholarships Coordination Unit
VCH	Vila Central Hospital
VCNE	Vanuatu College of Nurse Education
VHW	Village Health Worker
UPNG	University of Papua New Guinea
WHO	World Health Organization

Executive Summary

This is the second Health Workforce Plan prepared by the Ministry of Health, covering the period from 2004 – 2013. The Plan is intended to provide strategic direction for the training and management of health workers. It will facilitate effective collaboration between the MoH and other agencies involved in training and the allocation of scholarships. It identifies strategies for increasing efficiency in workforce utilization and improving workforce productivity. Recommendations address wider health sector issues that influence human resource requirements, including the implications of current policies and health financing.

This Health Workforce Plan reflects Government and MoH policy, and responds to trends in health and health financing. The Government of Vanuatu expenditure on health per capita is less than half that of governments in Samoa, Fiji or Tonga (World Health Report 2002). These fiscal realities require a balance to be found between expensive tertiary health care and more affordable primary health care, and demands greater efficiency in management and delivery of services.

Staffing projections included in this Plan are based on the MoH 2004 staffing levels, assuming that the MoH budget submitted for 2004 will be approved, including "new initiative" funding for termination of 96 staff, and employment of 5 newly graduated ni-Vanuatu doctors. The MoH workforce will be reduced by 12% to 714 staff in 2004, in response to a 45 million vatu budget cut. MoH funded posts will include 23 doctors, 235 nurses, 34 nurse practitioners, 50 midwives and 43 nurse aides, and 84 allied and other health workers. There is a concentration of health workers in hospitals and urban areas, with only one-third of staff working in community health services. There are staff vacancies that cannot be filled because of budget shortfalls. Vanuatu has fewer health workers per population than most other countries in the Pacific region. It is recognized that there is a gap between the health services and health workforce the people of Vanuatu need, and what the MoH can afford to provide.

Workforce projections are based on expectations of future health service needs. The MoH will develop a Master Health Services Plan that will formally identify services to be provided at each level of the health system, including minimum staffing standards. This Workforce Plan was based on current and expected services and staffing norms, and includes assumptions about growth in demand as the population increases, workforce attrition, and improvements in the efficiency of the workforce. A 14% growth in the nurse workforce is required, with an additional 56 posts created by 2013 for nurses, nurse aides, nurse practitioners and midwives. The number of doctors is expected to grow by 30% to a total of 43, with the proportion of ni-Vanuatu doctors (compared to expatriates) increasing from 40% to 90%. The allied and other professional health workforce is projected to grow by 38%, from 84 to 116 posts.

The professional MoH workforce will need to grow by 13% between 2005 and 2013, or 103 new posts. This is an average increase of 1.5% per annum, or 11 new posts per year. The growth of the MoH personnel budget will need to be slightly higher than this, to accommodate inflation and the fact that all new posts are professional posts. At today's salary costs, the price of establishing the new posts is estimated to be around 75 million vatu.

The achievement of these targets will require a range of training interventions. The Vanuatu College of Nurse Education and the programs offered will need to be strengthened. Four intakes of nurse aides will be trained to meet a short-term deficit of nurses. A general nurse training program will need to be offered every second year. Overseas training needs will require the allocation of between 6 and 14 overseas scholarships for health related tertiary study each year, including 3 – 4 scholarships for MoH staff to undertake post-graduate training. Current trends indicate there are sufficient school leaver scholarships available to meet the requirement, but 1 – 2 additional public servant scholarships will need to be allocated to the MoH each year. Places at regional training institutions will need to be secured, and the MoH will need to provide career counseling to school leavers regarding workforce needs and employment opportunities. A Workforce Training Plan will be developed over the next 6 months to guide all training activities.

The Workforce Plan also includes workforce management strategies to improve recruitment and retention of staff, rational deployment of the workforce, and to strengthen performance management. It is expected that efficiency gains of around 1% can be achieved through better workforce management and staff motivation.

The Workforce Plan is a compromise between health service needs and health service affordability. It seeks modest growth of the health workforce; the minimum required to assure essential health services to the population. Meeting the workforce projections will require ongoing commitment from the Government of Vanuatu, the Ministry of Health, donors and health development partners, and the population. If budget cuts continue, the MoH will not be able to maintain the current level of services. Health is the foundation for an economically and socially productive society, and should be prioritized by the Government of Vanuatu, even in the current climate of fiscal constraint.

1.0 Introduction

The first Health Workforce Development Plan was published by the Ministry of Health in 1993, and covered a period of fifteen years from 1992 to 2006. The Plan was intended to guide the training and re-training of health workers, and the recruitment of new staff. It was expected that the Plan would be regularly reviewed and updated in response to changes in population, socio-economics, health and morbidity patterns of the country.

In the decade since the development of the first Plan, there have been significant changes in many factors that influence health human resource requirements. Many of these changes are described below in section 2.0. In response, the MoH has developed their second Health Workforce Plan for the period from 2004 – 2013.

The MoH will use the Plan to provide strategic direction for the training and management of health workers. It is intended to facilitate effective collaboration between the MoH and other agencies involved in the planning and implementation of training and the allocation of scholarships. It identifies strategies for increasing efficiency in workforce utilization and improving workforce productivity. Recommendations address wider human resource issues within the health sector, including the implications of current policies and areas where additional policy direction is needed.

The Plan will form the basis for ongoing evaluation of the health workforce, allowing changes to be measured over time and inform future decision-making. Regular review of the Plan will enable the MoH to identify emerging issues that have an impact on health human resources and respond appropriately.

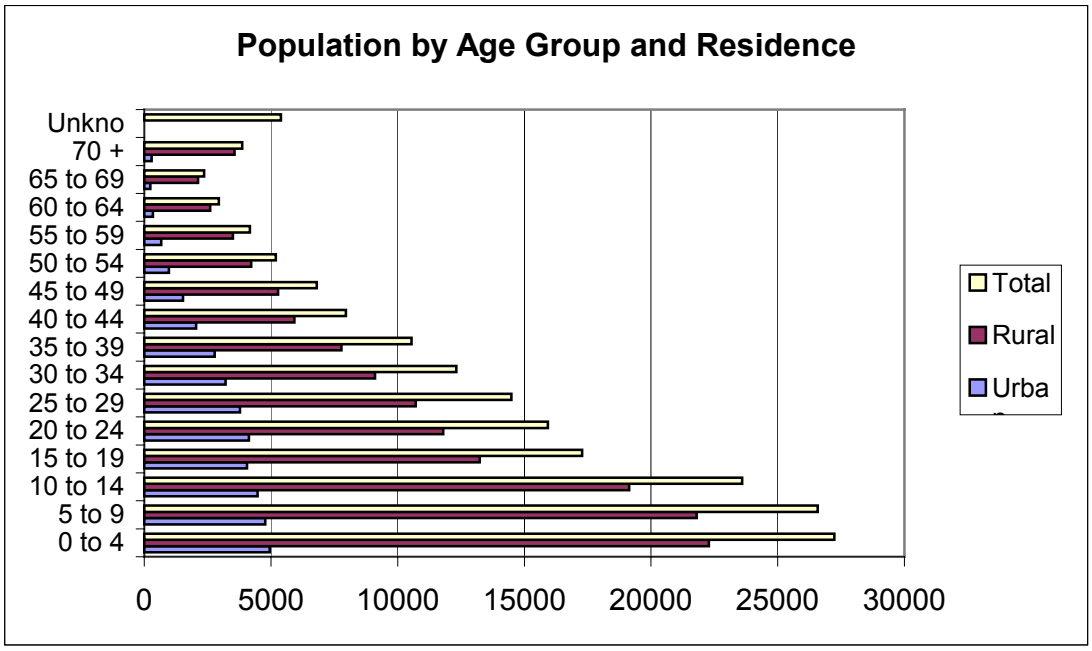
2.0 Background

2.1 Population and trends

The 1999 Vanuatu National Population and Housing Census provides a snapshot of the population at that time, and when compared with previous Censuses in 1989, 1979 and 1967, it allows trends to be identified. A total population of 186,678 persons was reported in 1999. Most people (78.5%) lived in rural areas, with the urban centers of Port Vila and Luganville home to 21. 5% of the population. There were 65 inhabited islands, with the population per island varying from 1 person to 42,128 persons. The islands were divided into 6 provinces, with the population per province varying from 7,757 to 54,439 persons. The geographical distribution and variations in population density across Vanuatu present significant challenges to the MoH in the delivery of health services.

Over 42% of the population was less than 15 years old, with only 3.4% 65 years or older.

Figure 1. Population by Age Group and Residence (1999 Census)

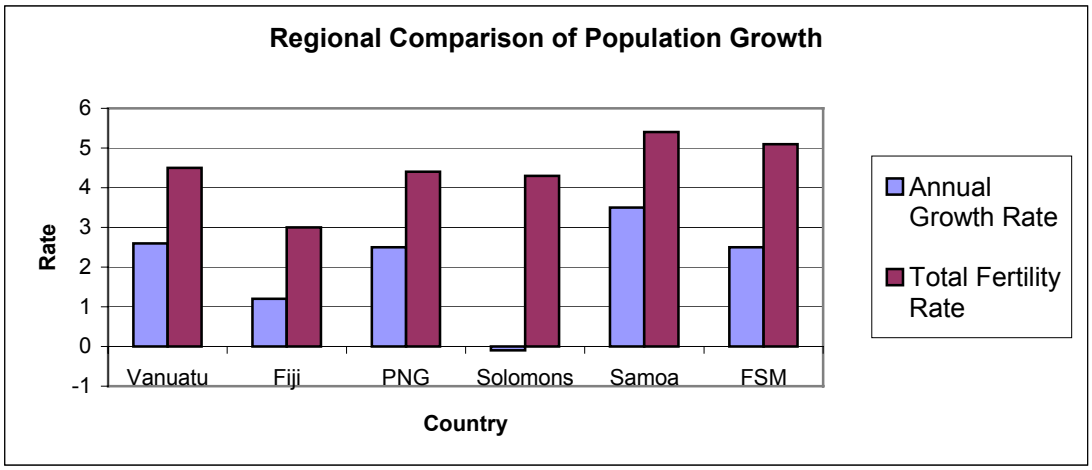


In contrast to the ratio in most other countries, there were more males than females in most age groups in Vanuatu. Males accounted for 51.3% of the population, and females only 48.7%.

The population of Vanuatu grew by an average of 2.6% per annum between 1989 and 1999. The most rapid growth was seen in urban areas (4.2%) while rural areas averaged only 2.2%, suggesting a pattern of urban migration that is supported by other census data. There was considerable variation in growth between provinces, with Malampa province demonstrating the slowest growth of 1.4% per annum.

Growth rate is influenced by birth and fertility rates. The table below compares Vanuatu with a number of other countries in the region.

Figure 2. Regional Comparison of Population Growth



Source: 1999 Vanuatu Population Census, and WHO World Health Report 2002

2.2 Health situation and trends

There has been progressive improvement in key health indicators over the past 40 years in Vanuatu, as demonstrated in Table 1. below.

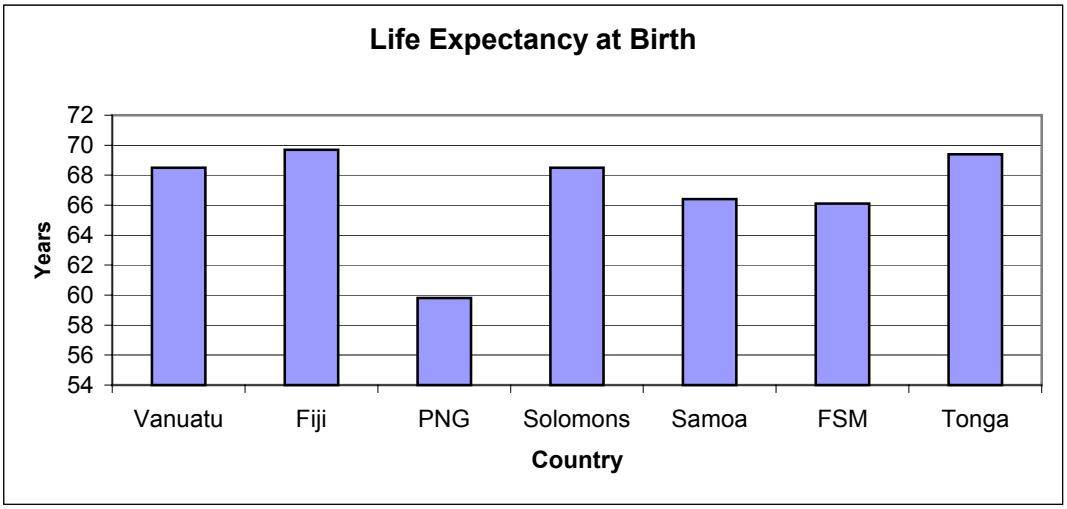
Table 1. Trends in Vital Statistics, Vanuatu 1967 to 1999

Vital Statistics	1967	1979	1989	1999
Crude Birth Rate	45	45	37	33
Total Fertility Rate	6.8	6.5	5.3	4.5
Crude Death Rate			8 – 10	6
Infant Mortality Rate	123	94	25	25 – 26

Source: 1999 Vanuatu National Population and Housing Census

Life expectancy in 1999 was 70 years for females and 67 years for males. Regional comparisons show life expectancy in Vanuatu is relatively high compared to a number of neighboring countries

Figure 3. Regional Comparison of Life Expectancy at Birth



Source: 1999 Vanuatu Population Census, and WHO World Health Report 2002

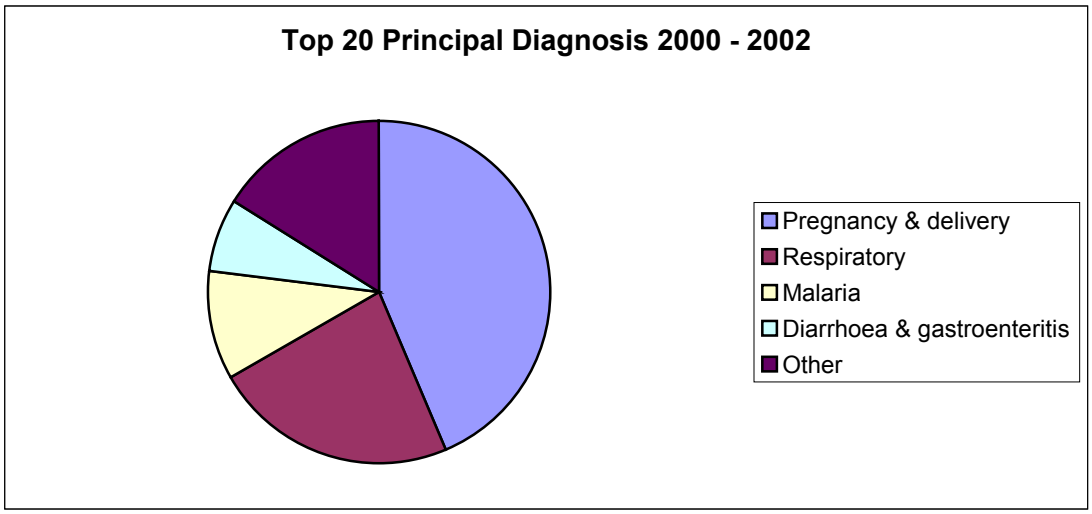
The general health situation in Vanuatu is in a period of transition, with communicable diseases still accounting for a large proportion of illness and death, but with a rising incidence of non-communicable diseases. The MoH health information system allows identification of causes of illness and health service visits from hospital data, outpatient diagnosis, and public health statistics.

The major causes of death in hospital 2000 – 2002 were from respiratory illnesses such as pneumonia. Other major categories included: malaria, tuberculosis, diarrhea, malnutrition, hypertension and heart disease, stroke, fetal and newborn deaths, cancer, diabetes and renal failure.

The major reason for hospitalization was for delivery and/or complications of delivery, making up about 30% of all discharges from 2000 – 2002. Other major causes of

hospitalization were injuries, respiratory disease and infections, malaria, diseases of the digestive system, intestinal infections, diseases of the skin and heart disease.

Figure 4. Top 20 Principal Diagnosis 2000 – 2002 (all hospitals)



NOTE: Respiratory includes pneumonia, asthma, upper and lower respiratory tract infections and respiratory tuberculosis

The main reasons for presentation at outpatient clinics in hospitals, health centers or dispensaries during 2002 included: respiratory infection or disease, suspected malaria, skin disease, diarrhea, ear discharge/infection, tooth/gum disease, arthritis and injuries. Acute respiratory infection among children less than 5 years old was the most common reason for attending outpatient clinics. Arthritis and hypertension were the most common new cases of non-communicable diseases seen in outpatient clinics, followed by diabetes, heart disease, stroke and cancer. Overweight and obesity are strongly associated with diagnosis of hypertension and diabetes. Malaria was the most common environmental health disease treated, followed by diseases related to water or poor hygiene such as scabies and eye infections

2.3 Health services and utilization

2.3.1 Health facilities

There are four types of health facility in Vanuatu: hospital, health center, dispensary, and aid post. The MoH is responsible for Hospitals, Health Centers and Dispensaries, while the community, local government or church groups are responsible for Aid Posts.

MoH health facilities are planned based on both population and accessibility factors. In areas where transportation is difficult or limited (e.g. Ambrym) there may be more facilities per capita than in areas where transportation is easier (eg. Efate)

There are 5 hospitals in Vanuatu, one in each province except Torba. Two of these hospitals, Vila Central Hospital and Northern District Hospital, are major referral centers for the whole country. Each Hospital provides obstetric, medical, pediatric and surgical services, inpatient and outpatient services. VCH and NDH provide the majority of specialized surgical and outpatient services. Hospitals are staffed by a full range of health personnel, including medical doctors, although this depends on personnel availability and budget.

There are 27 active Health Centers in Vanuatu, 1 to 6 Health Centers per province. They provide outpatient and inpatient services, including acute care such as care during labor and delivery, health promotion and preventive health services such as immunization. Health Centers are usually staffed by a nurse practitioner, who also acts as manager, a midwife and general nurse(s). Health Centers act as referral centers for Dispensaries and Aid posts, although urgent referrals may go directly from Dispensary or Aid Post to Hospital.

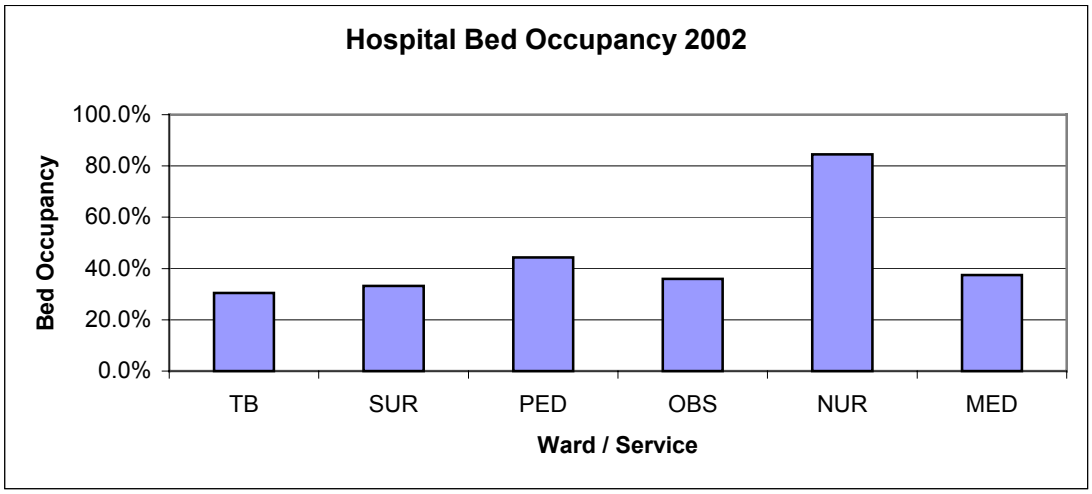
There are 74 active Dispensaries, 6 to 18 per province, with at least 1 Dispensary on most inhabited islands. Dispensaries provide outpatient services with a focus on basic essential health care including health promotion and preventive services. Dispensaries refer complicated cases, or those requiring admission, to a Health Center or Hospital. Dispensaries are usually staffed by a general nurse.

There are about 180 Aid Posts in Vanuatu, 15 – 41 per province, with an Aid Post in most populated areas. Aid Posts are established and funded by the community in which they are based, the local or provincial government, or church groups, with the MoH providing basic medicines and some training for staff. Aid Posts are staffed by Village Health Volunteers, who have had 1 – 3 months of training. Aid Posts provide first aid and community education.

2.3.2 Health service utilization

The utilization of health services is difficult to quantify. Hospital and outpatient statistics are incomplete, with only 50% of expected health information system reports submitted to the national health information office in 2002. Based on available data, it would appear that hospital utilization is low compared to facility capacity, with average bed occupancy of 36 – 44% between 2000 and 2002. There was significant variation in bed occupancy between hospitals, from a low of 26% at Lolowai Hospital in 2002 to a high of 52% at Vila Central Hospital in 2001.

Figure 4. Hospital Bed Occupancy 2002



Source: MoH Health Information System (see note above)

Surgical, medical, pediatric and obstetric patients accounted for roughly equal proportions of discharges from VCH and NDH from 2000 – 2002, (with slightly more

obstetric patients than those in each other category). At Norsup, Lenakal and Lolowai hospitals, surgical patients made up a smaller proportion of discharges, reflecting their limited surgical capacity.

A total of 251,585 outpatient clinic attendances were reported for 2002, about 1.25 visits per person based on population projections. This is low compared to international standards, but may be a reflection of incomplete reporting rather than actual use.

6,613 new family planning clients using temporary methods were reported in 2002, representing about 70% of women between 15 and 19 years of age, or 37% of women between 15 and 24 years of age. The most common contraceptive methods used by new clients in 2002 were Depo-provera and the oral contraceptive pill (45% & 39% respectively of all methods used).

68% of children where reported to be fully immunized on their first birthday in 2002, with wide variation between provinces, from 23% in Torba, to 90% in Penama. 38% of primary school students were reported to have a school health examination in 2002.

3,674 deliveries were reported in 2002, with 2,465 deliveries occurring in hospitals, 608 deliveries at Health Centers, an additional 140 deliveries attended by medically trained staff outside Health Centers, and 461 deliveries reported as conducted by traditional birth attendants. 186 hospital deliveries (7.5%) were reported to teenage women. 2,331 first antenatal visits were reported in 2002, representing 63% of women delivering. 2,118 postnatal examinations of mothers were reported in 2002, representing 58% of women delivering.

Anecdotal evidence suggests that most people with mild illness seek treatment by traditional healers before seeking treatment through formal health services. It also suggests that most people with a serious illness or injury will seek treatment by traditional healers at the same time as receiving treatment through formal health services.

Consumers choose which health facility they attend based on perceived quality of the services provided, including health personnel qualifications and attitude, the accessibility of the facility, and user fees or associated costs such as transport or lost income. Cost has been used to promote appropriate use of facilities. When hospital services were free, many outpatient attendances were for minor illnesses or problems, but since small user fees were introduced many of these patients go instead to a Health Center or Dispensary, which is a more appropriate facility for their type of illness.

2.4 Health policy and plans

2.4.1 Mission and goals of the Ministry of Health

The mission of the Ministry of Health is “to protect and promote the health of all people living in Vanuatu”. The Ministry of Health has prepared a series of Corporate Plans and annual Business Plans over past years, expressing how they intend to achieve this mission.

The Corporate Plan for 2001 – 2003 was developed to reflect health priorities identified in a consultative process involving key stakeholders. The goals of the MoH for the Plan period include:

- Incorporation of principles of equity and being a good employer into human resource management and development of policies/practices;
- Development and implementation of improved mechanisms for raising revenue and allocating financial resources;
- Activities for:
    - control, promotion and protection of rational drug use
    - implementation of minimum standards for health facilities, registration and practice of health personnel;
- Development and implementation of prioritized, activities based planning cycles, in collaboration with MFEM, DESD, donors and NGO's;
- Development and implementation of rules and regulations for recognizing private health services;
- Protection and promotion of the health of the people of Vanuatu through public health program activities founded on primary health care principles and community based public health management;
- Development and implementation of legislation which protects and promotes the health of the people of Vanuatu and the health of the environment;
- Improvement of the health status of rural individuals through both curative and preventative health care services;
- Provision of efficient, equitable, effective, accessible and continually improving hospital health-care services that are professional and compassionate; and,
- Efficient and effective management, through Planning and Administration Department, of health care groups and public health.

The annual Business Plan allocates individual responsibility for the management and implementation of activities within the framework of the Corporate Plan.

2.4.2 International agreements

The Government of Vanuatu has ratified a number of international health agreements, including Health for All in the 21st Century and the Raratonga Agreement (based on the Healthy Islands concept). In signing these agreements, the Government has made a commitment to a taking a primary health care approach in delivery of health services, including working inter-sectorally with government, non-government and community organizations and agencies, and emphasizing health promotion and health protection.

2.4.3 Health policies

The MoH endorsed a range of health policies in 2002, including policy principles or statements specifically relevant to the health workforce, addressing health services priorities, planning, human resource management, human resource development and financing.

Key policies include:

Health service priorities

- Priority programs include non-communicable diseases, environmental health, oral health, reproductive health, communicable diseases, preventable cancers, health promotion; and,
- Allocate resources to pursue greater access and equity in use of health services to respond to recognized health needs and to prioritize preventative health practices.

Planning

- Development of an integrated health service delivery plan, manpower and human resource development plan, training and capacity plan, resources distribution and budgeting for these in a comprehensive business plan; and,
- Define different types of health facilities and determine the ideal number of facilities of each type and the ideal number of staff working in each.

Human resource management

- Ensure proper [merit-based] recruitment, staff appraisal and other personnel procedures are implemented at all levels;
- Strengthen supervision and management;
- Ensure adequate numbers of staff at Health Centers and dispensaries;
- Provide adequate accommodation/facilities for health staff;
- Develop proper career paths for health worker categories;
- Define and facilitate a broader role for doctor, to include advisory and supervisory responsibility for community health services;
- Clarify the role of nurse practitioners and other cadres of staff, particularly in relation to community and hospital based services; and,
- Develop and maintain a record of all health workers (including VHW) qualified and working in Vanuatu.

Human resource development

- Develop a Workforce Plan according to MoH objectives (which includes strategies to retain recruited staff) and develop a functional HRD unit with adequate staff, equipment and facilities;
- Implement a Human Resources Development Plan to ensure integrated support for Corporate and Business plans;
- Review and define standards for both initial and continuing education, and endeavor to ensure that staff trained for specialist positions are not transferred to other positions not requiring the specialist skills;
- Allocate an appropriate budget for in-country training; and,
- Ensure external training is in-line with MoH HRD needs.

Financing

- Allocate resources taking into account minimum requirements for hospitals, health centers and dispensaries;
- Endeavor to ensure that resources be allocated to improve remuneration and benefits to all staff, and provide more incentives to health care specialists and those working in rural areas; and,
- Ensure overall staffing costs will not exceed 60% of total operating costs.

2.4.4 Relevant laws and regulations

The regulatory framework in which the health workforce is planned, trained and managed includes laws specific to the professional practice of health workers, and those related to the employment of public servants.

Along with the Employment Act, the Public Service Act No. 11 of 1998 governs the employment of public servants. It aims to establish an independent Public Service that is efficient and effective, provide a legal framework for the effective and fair employment, management and leadership of employees, and establish the rights and obligations of employees.

The Public Service Commission (PSC) is responsible for implementation and administration of Act. The PSC is responsible for setting salaries and allowances, staffing establishments and grading of posts. They contribute to appointment and promotion decisions of the MoH, approval of overseas training, and resolution of employment disputes and disciplinary matters. A Public Service Manual sets out guidelines, procedures and employment conditions for all public servants, which the MoH is bound to follow.

The Health Practitioners Act (Chapter 164) of 1988 and the Nurses Act No. 20 of 2000 address the registration and professional practice of health practitioners. The Health Practitioners Board and the Nurses Board are the main mechanisms through which these Acts are implemented. The Health Practitioners Board meets irregularly and it is recognized that some aspects of its operation need strengthening. The Nurses Board is relatively new, and still developing its operational procedures. Registration and licensing of nurses by the Board has not formally commenced, although it is likely to begin soon. Registration divisions for general nurse, midwife and nurse practitioner will be kept, with annual renewal of registration required, based on continued competency to practice. The method/s by which competency will be demonstrated has not yet been decided.

The Control of Pharmacists Act (Chapter 23) of 1988 has never been fully implemented, and there is no official Pharmacists Practitioners' Commission established. Pharmacists have instead applied for licensing through the Health Practitioners Board.

2.5 Health service financing

The major source of funding for the MoH is the recurrent government budget, although donors provide additional funds for specific purposes. The recurrent budget of the MoH increased between 0.2% and 2.2% per annum from 1998 to 2003, except for 2000 when it increased by 7.6%. For 2004, the budget ceiling for the MoH was cut by 5% from 2003 levels (after adjustment for inclusion of the Health Cabinet in the MoH budget). The MFEM predicts that due to difficulties in raising revenue to fund government expenditure, there may be further reductions in recurrent budget available to MoH and other government services in the future.

Personnel expenditure has accounted for 56.6% to 62.0% of total MoH expenditure since 1998. Government policy seeks to restrict personnel expenditure to 60% or less of total recurrent funding, and the MoH is striving to achieve this goal. Experience suggests that when personnel expenditure exceeds 60% of total recurrent funding,

the MoH has difficulty providing the resources required for effective utilization of the staff employed, and is unable to fund adequate maintenance and replacement of assets. A major constraint in reducing personnel expenditure is the capacity of the MoH to pay termination benefits to staff who retire or are made redundant.

Most capital investment in the MoH is funded through donor contributions or use of maintenance allocations in the recurrent budget. Maintenance allocations in the recurrent budget are about 1.5% of the value of assets, significantly less than the 4% that is recommended by most advisers.

The MoH is utilizing the financial management information system implemented by the MFEM, which enables detailed costing of operations down to dispensary level. Devolution of budgetary control to lower level managers has resulted in better understanding of financial management, and increased interest and expectations regarding accountability and responsibility.

User fees do not contribute significantly to the available budget of the MoH at present. Financing regulations currently require that all revenue collected by government services must be paid into the government's general account. Inpatient charges, and charges for health services provided to non-citizens, are collected, or invoiced for collection by MFEM, in accordance with this requirement. The MoH hopes that this revenue will be made available to it through the new initiatives scheme in the next budget year. Many MoH facilities generate a small amount of revenue through collection of user fees for outpatient services by Health Committees or Trusts. These funds are generally used for capital improvements or maintenance of facilities. Exemptions from user fees are provided for chronically ill patients, those with very low incomes and those with medical conditions that are considered exempt

2.6 MoH organization

The MoH is organized into four directorates: Planning and Administration, Public Health, Southern Health Care and Northern Health Care. Hospitals, health centers, dispensaries and other community health services are under the responsibility of the Southern and Northern Health Care directorates. Public Health manages programs in health promotion, family health, malaria and other vector borne diseases, environmental health, and oral health. Planning and Administration includes units with responsibility for finance, health information, health planning, personnel, human resource development, and donor coordination. There are plans to review the MoH structure, with an expectation that a flatter organizational structure will be established.

Under the current structure, responsibility for workforce planning within the MoH is shared between several units in the Directorate of Planning and Administration: Health Planning, Personnel, and Human Resource Development & Training. For the development of this Workforce Plan, a working group was established, with the Director of Planning and Administration as the chair. The working group included key units within Planning and Administration, as well as representatives from the Southern and Northern Health Care groups and the directorate of Public Health.

2.7 Workforce planning assumptions

A number of assumptions guided the development of this Workforce Plan. These were drawn from the situational analysis, from Government and MoH policy, and from the realities of health sector financing. Key assumptions include:

- The 2004 budget submitted by MoH to the MFEM will be passed, including funding under new initiatives for termination payments to selected staff and employment of 5 ni-Vanuatu graduate doctors as interns;
- The population will grow at 2.6% per annum or less for the planning period;
- The Government budget allocated to the MoH will not grow at the same rate as the population over the planning period;
- The MoH will seek to meet the government target that personnel expenditure should not exceed 60% of total expenditure;
- The MoH will seek to ensure there is no reduction in the level of health services provided over the planning period;
- Primary health care, including community health services, will continue to be a priority of the Government and MoH for the planning period;
- Donor support for the health sector, including scholarships for university level training overseas, in-service training provided in Vanuatu, support for ASAS and visiting specialist teams, will be maintained at the current level; and,
- The MoH will seek to increase the proportion of ni-Vanuatu doctors and other senior health staff, compared to expatriate staff, over the planning period, to improve the sustainability of health services.

These assumptions have significant implications for the strategic directions of the Workforce Plan. Given the available budget and the MoH policy on personnel expenditure, it is clear that the MoH workforce cannot be expected to grow significantly in size. It is also clear that the MoH will seek to maintain the current level of health services despite this, while population growth increases the demand on those services.

This has necessitated an approach to workforce planning that seeks to:

- Increase the efficient utilization of the current MoH workforce, including to better match the workforce to health service requirements (through, for example, multi-skilling of staff working in rural areas);
- Improve the productivity of the current workforce;
- Increase the impact of health workforce training on provision of services; and,
- Explore opportunities for health service provision by private and/or non-governmental organizations to complement MoH services.

3.0 Current health workforce

3.1 Overall health workforce

3.1.1 Workforce size

The MoH employed 810 people in 2003. The 2004 budget, awaiting approval by the Ministry of Finance and Economy, includes just 714 people. This reduction, the result of a 45 million vatu cut in allocated budget, represents almost 12% of the total workforce. The termination of the 96 staff identified as eligible for retirement or occupying posts no longer required, is dependent upon "new initiative" funds being allocated for termination payments.

It should be noted that there are an additional 6 doctors working for the MoH who are not included in MoH staff numbers as their salaries are funded by the Chinese government. Including these positions brings the total MoH staff to 721. Although not included in budgeted posts, for the purpose of workforce planning, these doctors are included in the calculations of current and projected service provision.

3.1.2 Workforce deployment

MoH staff are distributed over 5 areas or directorates: Cabinet, Southern Health Care Group, Northern Health Care Group, Public Health, and Planning and Administration.

Table 2: Overall MoH staffing – 2003 & planned for 2004

Year	Cabinet	SHC	NHC	PH	P&A	Total
2003	17	314	404	34	41	810*
2004	16	266	369	28	35	714*
Change	-1	-48	-35	-6	-6	-96

*Plus 6 doctors and 2 dentists not funded by the MoH

Approximately 25.5% of MoH staff work in providing community health services through health centers and dispensaries. These staff account for 22% of the MoH personnel budget for 2004. An additional 11% of MoH staff work specifically in public health, with about two-thirds of these staff employed at provincial level. Table 3 and the Annexes provide further information about deployment of MoH staff in community health and public health services.

Table 3: MoH staffing by program – 2003 & planned for 2004

Year	Cabinet	Corporate Services	Hospital Services	Community Health*	Public Health**	Total
2003	17 (2%)	314 (5%)	467 (58%)	251 (31%)	34 (4%)	810
2004	16 (2%)	266 (5%)	402 (56%)	233 (33%)	28 (4%)	714

* Includes public health staff employed at provincial level
** Public health staff employed at national level only

3.1.3 Workforce composition

The MoH employs a wide variety of staff, including staff with health qualifications, others with technical qualifications, such as in finance or management, and those with work skills in support areas such as laundry or cleaning. As is the case in many

countries, a number of staff with health qualifications are employed in administrative or management roles, where their health qualifications may or may not be fully utilized. Table 4 provides a summary of MoH staffing by post for 2004.

Staff are employed as permanent, temporary, contract employees or daily rated workers. The Public Service Commission has recently approved new procedures for the employment of temporary salaried employees, daily rated workers and contract employees. At present, about 25% of MoH staff are daily rated workers, who are not eligible for many of the allowances paid to permanent employees. Many of these staff are in administrative roles, or providing support services in hospitals such as cleaning, laundry, transport or catering. Some, however, are health professionals working long term for the MoH, and would be more appropriately employed as permanent employees. The MoH is attempting to resolve this inconsistency in employment conditions, but budget shortfalls are a significant constraint.

Table 4: MoH staffing by post for 2004

Post	Cabinet	P&A	PH	NHCG	SHCG	MoH Total	Non MoH Funded
Doctor Specialist				3	5	8	6
Registrar/Resident				5	10	15	
Nurse Practitioner				22	12	34	
Nurse				138	97	235	
Nurses Aide				30	13	43	
Midwife				33	17	50	
Pharmacist		1		3	1	5	
Dispenser				3	3	6	
Public Health Officer			20	35	19	77	
Laboratory Officer			3	8	10	18	
Radiographer				4	6	10	
Dietician				1	1	2	
Catering Officer				6	7	13	
Dentist			1	1	1	3	2
Dental Tec/Therapist			1	2	3	6	
Physio/Rehab Officer					3	3	
Educator (VCNE)		7				7	
Maintenance Officer		1		37	27	65	
Stores Officer		7		1	2	10	
Transport Officer		1		8	6	15	
Porter				4	7	11	
Manager	1	3	1	8	3	16	
Administrative Officer	2	15	2	17	13	49	
Minister's Office	13					13	
Total	**16**	**35**	**28**	**369**	**266**	**714**	**722**

Note: Maintenance Officer includes cleaners, laundry staff, groundsmen and maintenance staff

3.2 Descriptive information by category

3.2.1 Nurses

Nurses, including nurse practitioners and nurse aides, make up the largest proportion (44%) of the health workforce. They are the primary service providers for the majority

of the population, through their work in Dispensaries and Health Centers. They also provide much of the day-to-day care to patients in Hospitals. A small number of nurses (approximately 10) work outside the MoH in health related programs funded by non-governmental organizations and 2 or 3 are working in a private practice in Port Vila. About another 10 nurses are reported to be working in non-health related occupations.

Nurses in hospitals are augmented by a small number of nurse aides. In contrast to other countries, the differential between the base salary of a nurse and a nurse aide is relatively small, with little cost saving made by employing a nurse aide instead of a nurse.

3.2.2 Midwives

The MoH employs 50 midwives, who work in both community and hospital settings. In Health Centers, midwives provide a wide range of maternal and child health services, including reproductive health services, unsupervised care of the pregnant woman, care during labor and delivery, and extended postnatal care. In addition, these midwives participate in the provision of general health services to the community, including after hours emergency services to men, women and children. In hospitals, midwives work in the maternity ward under the direction of doctors, providing care during labor and delivery and in the immediate postnatal period.

3.2.3 Nurse Practitioners

Nurse practitioners work as senior health service providers in Health Centers and in certain areas within Hospitals. They provide assessment and clinical management of patients, as well as community health services. They participate in on-call rosters to ensure 24-hour health service coverage.

The MoH employs 34 nurse practitioners. Nurse practitioners are often in-charge of Outpatient areas in hospitals, and in smaller hospitals may be the most senior health worker present in the absence of the doctor.

3.2.4 Doctors

There are currently 29 medical doctors employed by the MoH, including 9 ni-Vanuatu doctors, one of whom will retire in 2004. An expatriate medical workforce augments the ni-Vanuatu doctors. These include Australian doctors (mainly specialists) contracted by the MoH with financial support from AusAID under the ASAS program; doctors working under various “volunteer” schemes such as the New Zealand VSO program; and Chinese doctors funded by the Chinese government. Some of these doctors have worked in Vanuatu for many years, while others fill posts for periods as short as 6 months at a time. There are also 2 ni-Vanuatu doctors practicing solely in the private sector. In 2004, the MoH hopes to secure funding to employ 5 ni-Vanuatu medical graduates for internship at Vila Central Hospital.

In addition, visiting specialist health teams, including doctors, visit Vanuatu regularly, providing services in fields such as diabetes, orthopedics, plastic surgery, ophthalmology, heart care, and ear, nose and throat. These teams are mainly funded by AusAID with some donation of services from staff involved. New Zealand ODA is currently discussing opportunities for further involvement in this program. Historically,

the New Zealand government has provided support for selected ni-Vanuatu patients with illnesses that cannot be treated locally, to be treated in New Zealand.

It is important to note that almost 70% (20 of the total of 29) doctors working for the MoH are employed at Vila Central Hospital.

The Government of Vanuatu currently funds 23 of the 29 doctor posts, although some expatriate doctors receive additional salary supplements from donor agencies.

3.2.5 Dentists and other oral health workers

There are 5 dentists working in Vanuatu for the MoH. In addition to the 3 ni-Vanuatu dentists employed, there are 2 Chinese dentists working in Luganville supported by the Chinese government. There are 6 dental technicians or dental therapists also employed by the MoH. A number of oral health workers provide private dental services in Port Vila and Luganville.

3.2.6 Allied health workers

The allied health workforce includes staff working in diagnostic services such as laboratory and radiology, those working in rehabilitation or in dietetics. A total of 52 staff are employed in the allied health area plus 1 vacant budgeted post. There are no private practices, although sessional services may be offered.

3.2.7 Pharmacists

There are 5 pharmacists and 6 dispensers working for the MoH, mainly in the larger hospitals or central medical stores. The principal pharmacist post is current vacant.

3.3 Summary statistics

3.3.1 Distribution of workforce per population

The MoH workforce is responsible for the provision of services across the country. Geographic and population density issues, as well as budget constraints and staff availability all contribute to an uneven workload. There is great variation between the number of people per doctor or nurse in different provinces, with the best coverage in Shefa and Sanma, and worst coverage in Tafea.

Table 5: Population per MoH health worker for 2004

Health Worker	National Average	Provincial			
		Best Province		Worst Province	
Doctor	7580	Shefa	3399	Malampa	35059
Nurse Practitioner	6242	Torba	4388	Tafea	8216
Nurse	903	Sanma	687	Torba	1254
Nurse + Nurses Aide	763	Sanma	575	Tafea	1060
Nurse + NP + NA	680	Sanma	519	Tafea	939
Midwife	4245	Penema	2899	Tafea	10955
Nurse + NP + NA + MW	586	Sanma	453	Tafea	865

3.3.2 Regional comparisons

The MoH workforce is relatively small for the size of the Vanuatu population in comparison to regional standards. The ratio of doctors to population is one of the lowest in the region, and is not compensated for by a higher rate of nurses to population.

Table 6: Health Workforce per 1000 population – Pacific region

Country	Year	Doctors	Per 1000 population	Nurses*	Per 1000 population	Midwives	Per 1000 population
Vanuatu	2004	29	0.14	312	1.47	50	0.24
Fiji	1999	271	0.34	1576	1.97	NA	NA
PNG	2000	275	0.06	2841	0.65	NA	NA
Solomons	1999	54	0.13	338	0.83	23	0.05
Samoa	1998	56	0.34	248	1.49	NA	NA
FSM	2000	64	0.59	410	3.83	7	0.06
Tonga	2001	35	0.34	322	3.2	19	0.19

* Includes nurses, nurse practitioners and nurse aides
Source: WHO WPRO 2003 except Vanuatu (MoH Personnel Office)

Figure 5: Doctors per 1000 population – Pacific region

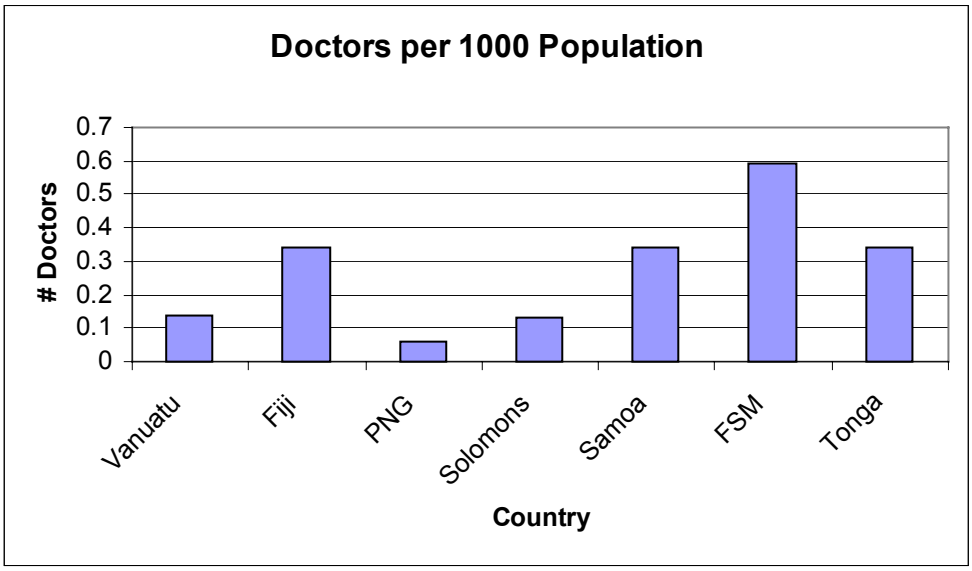
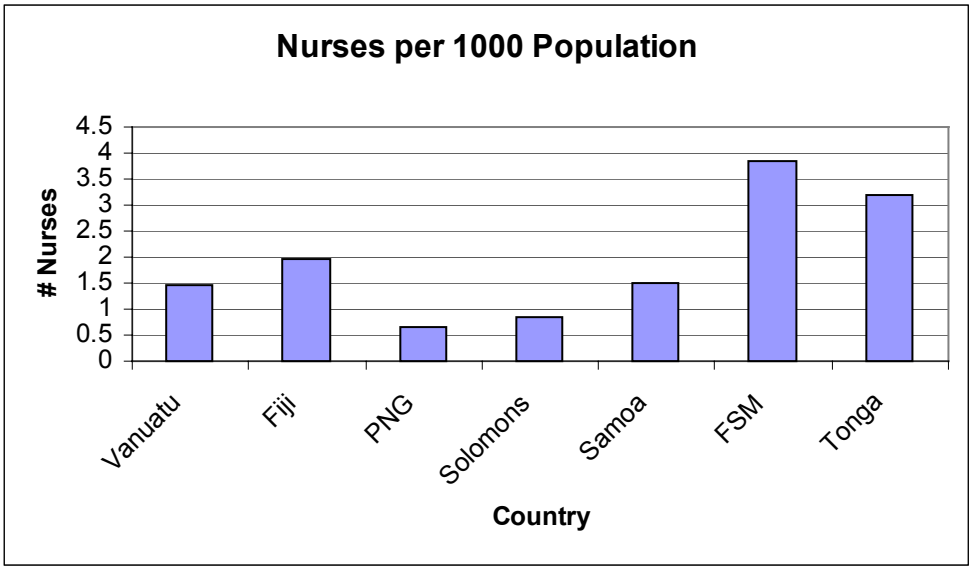


Figure 6: Nurses per 1000 population – Pacific region



3.4 Staffing problems and issues

3.4.1 Staff numbers and skill mix

There are a number of issues related to staffing levels and skill mix that need to be addressed. Historically, there has been more emphasis in employment on the individual health worker than on the post they occupy within the MoH organizational structure. This has contributed to difficulties in objectively measuring necessary staffing levels and identifying vacancies to be filled. In addition, the absence of a master plan for health services, including staffing standards and skill mix for the different levels of facilities, has limited the capacity of the MoH to make workforce plans. Clarification of the roles and functions of the different categories of health worker is required, particularly as the situation changes with increasing numbers of medical doctors and staff with allied health qualifications being employed.

In the MoH 2004 budget there are 47 identified vacancies to be filled. Almost half of these are for general nurses, and many are for posts at Dispensary level, requiring experienced staff. The capacity of the MoH to fill these vacancies is limited to the available pool of applicants. There are 19 general nurses graduating at the end of 2003, but after this graduation there will be no more until at least 2006. There are 2 vacancies for Nurse Practitioners for 2004, but no graduating staff, and only 1 Nurse Practitioner identified as not currently working for the MoH. Filling vacancies for medical doctors, particularly specialists, and for allied health workers such as laboratory technicians, is very difficult. In the absence of qualified ni-Vanuatu applicants, expatriates need to be recruited, requiring budget support from donor agencies and a prolonged lead-time to complete administrative requirements. The alternative is that important posts remain vacant, reducing available health services and/or service quality.

It is important to note that the vacancies identified in the MoH budget for 2004 are only those that the MoH has prioritized for filling in a year of tightly constrained budget. There are other gaps apparent in staffing of certain health centers according to MoH staffing “norms”, plus recognized shortages in certain categories of health

worker, which have not been included in vacancies as filling them is considered unrealistic.

The recruitment and retention of highly qualified health workers, including medical doctors, requires that the MoH makes plans in advance of their return from training, identifying or creating an appropriate post and allocating budget for salary and allowances. Establishing career paths for all health cadres is an important aspect of retaining staff, providing them with realistic, equitable expectations regarding promotion and access to further training as they progress in their career.

3.4.2 Human resource management

Human resource management needs strengthening at all levels of the system. There is a need to standardize conditions of employment within the framework of the public service structure. Recruitment and promotion based on qualifications and merit; appropriate utilization of permanent, daily rated, contract and temporary staff classifications; grading of posts; salary increments and career pathways are all areas that could be improved within the MoH. There is no flexibility of employment within the MoH. All posts are full-time, there is no pool of part-time or casual staff who can called in when needed, and there is no legal framework in which government staff can work in the private sector outside of normal working hours.

At present there is no relief staff to cover sick leave, maternity leave, annual leave, study leave or other planned or emergency absences of staff. This creates significant hardship for the remaining staff, particularly in smaller facilities. There is the potential for better utilization of staff to help cover staff absences and variations that occur in workload. In hospitals, staff in wards that are quiet could provide support to wards that are busy, for a more equitable distribution of workload. This could also occur at the provincial level, where, for example, provincial reproductive health staff could support maternal and child health services in health centers currently without a midwife. Managers at all levels require skills in human resource management appropriate to the size and complexity of the facility or department they are responsible for.

Supervisory and disciplinary activities need to be strengthened as a part of an overall strategy to increase staff motivation and improve staff performance and productivity. Allocation and distribution of staff based on both health service needs and individual preference needs to be reinforced by ensuring appropriate disciplinary measures are taken if staff fail to present regularly for work at their allocated workplace. This is particularly a problem in rural areas.

Staff attrition has historically been low, around 1.5% of the workforce per year. Although the Public Service Manual sets retirement age at 55 years, this has not been strictly applied. The inability of the MoH to fund termination payments for retiring staff has been one factor contributing to this situation. In recent years, the number of retirements on medical grounds has been rising. This is likely to be a reflection of increasing rates of non-communicable diseases such as diabetes and hypertension in the older adult population. There has also been a slight rise in the number of staff terminations on disciplinary grounds. Limitations of the government personnel databases, particularly related to date of birth, make it difficult to project the staff retirements.

3.4.3 Staff performance

Staff performance is a combination of "can do" and "will do". Staff need both the ability or skills required for their job, and the motivation to do it well. Skills audits have identified that some staff lack the skills needed to perform well in their job. While the MoH program of in-service training is attempting to address this, funding constraints limit the accessibility of training. In addition, some staff with specific skills are working in posts where their skills are not appropriately utilized.

Staff motivation varies between individuals, but there is an overall concern that the concepts of professional ethics, quality of service and time management need further development within the workforce. Low motivation is due to many factors, including weak supervisory systems, a perception that salaries and/or benefits are inadequate, that some benefits are not paid per entitlement, and that there is inconsistency in rewards for good performance and discipline for poor performance. Staff working at the community level need regular management and clinical supervision, including on-the-job and other in-service training, regular communication with clinical supervisors regarding complex cases, and transport to enable referral of patients when necessary.

It is possible within PSC rules to discipline staff for unprofessional behavior, but this must be done according to proper procedures, so action not often taken. Managers need to develop the skills required to improve staff productivity, and to intervene when staff are performing below the required minimum standard.

4.0 Current workforce training

4.1 Planning for training

Historically, the MoH has planned pre-service training of nurses, midwives and nurse practitioners based on training capacity within the Vanuatu College of Nurse Education (VCNE) and available funding, rather than on identified health service needs. Student selection has been based on academic standards, without consideration of the student's island of residence and MoH specific staffing needs. In addition, budget constraints within the MoH resulted in difficulties recruiting graduate nurses into government service after training. By the late 1990's, the MoH recognized the problems with this un-strategic approach, and began to consider alternatives. A decision was made to cease nursing training intakes, and undertake a comprehensive review of workforce needs and training capacity. The final batch of general nurses currently in training will graduate at the end of 2003.

Pre-service training of other cadres of health workers has been dependent on donor funding for students to attend overseas training programs. In the absence of clear MoH targets for different categories of health worker, this training has reflected individual preferences and scholarship opportunities, rather than health service needs. Potential students have applied for scholarships in their preferred field of study with little understanding of the career options available to them on graduation. The MoH and scholarship providers have recognized this problem, and the MoH intends to introduce career counseling for high school leavers to guide them towards health professions in which there are greater job opportunities. The development of a

long-term Health Workforce Plan, including projections of staff needed, is seen as a major strategy for improving the effectiveness of scholarships.

Regarding in-service training, the MoH has prepared a number of documents that address training needs, including the *2001 Human Resource Development Plan*. This Plan was based on a comprehensive skills audit of MoH staff, with clinical and non-clinical skills gaps identified. This was used to plan in-service training interventions in 2001/2002. The extent of training needs identified, however, meant that it was impossible for the MoH to provide all required training. Annual *Training Plans* have also been developed for the past 2 years, outlining in-service training activities planned, but again implementation has been limited by funding availability.

A number of the public health programs, including reproductive health, immunization and child health, provide in-service training to community health staff to maintain or upgrade their skills. This training is planned with little, if any, consultation between organizers and the MoH HRD and Training unit. Steps are being taken to improve linkages between all those contributing to in-service training of MoH staff.

A Health Training Committee was established to oversee staff training and strengthen selection processes to improve the impact of training. Unfortunately the Committee does not meet regularly, and much of the responsibility for planning training falls to the Acting Manager of the HRD and Training unit.

4.2 Training institutions

4.2.1 Vanuatu Center for Nurse Education

The VCNE is under the Directorate of Planning and Administration, within the HRD and Training unit. The Acting Manager of the HRD and Training unit manages in-service and overseas training, while the Principal Nurse Educator manages VCNE. In addition to the Principal, there are five other tutors: a Nurse Practitioner, a Midwife and three General Nurses. One other staff member works on the Village Health Worker training program. Five of the staff have at least certificate-level qualifications in education. Nurse tutors are responsible for theoretical training and clinical supervision of students during practice. WHO has provided significant technical support to the VCNE in recent years.

The VCNE is housed in the same building complex as the Ministry for Health, the former George Pompidou Hospital. There are two classrooms, a small demonstration room, library and storage room, plus office space for the tutors. The space is considered inadequate for the number of students, provides no change rooms or student dining room, and is in disrepair. The area that was used for Nurse Practitioner training has been condemned by the Department of Public Works. Much of the furnishings and equipment is outdated or broken.

The MoH hopes to build a new Center, including student dormitories, on land that has been made available near the Korman stadium. Government funding has been requested under New Policy Initiatives, but given the extent of budget cuts for 2004, there is concern that funding will not be made available.

During 2001/2002 there was discussion on the possible transfer of VCNE from the MoH to the Institute Nationale Technology Vanuatu (INTV). This was proposed as a

strategy to improve the educational resources available to the Center. Concerns were raised about the risks of losing MoH influence over the training of nurses. No final decision has been made on the issue.

There will be no students at VCNE during 2004, a situation that has been created to allow a comprehensive review of all aspects of the Center.

4.2.2 Overseas institutions utilized for training

A large proportion of Vanuatu students participating in health worker training overseas attend the Fiji School of Medicine with sponsorship from the Australian or New Zealand governments. The Fiji School of Medicine offers a wide range of health related undergraduate and postgraduate courses including: medicine and specialities, dental surgery and dental therapy, public health, environmental health, dietetics, health promotion and health services management. The School has a strong Pacific focus, with well-developed students support services for participants from other countries and procedures in place for dealing with donors and scholarship offices in the countries served.

The University of Papua New Guinea has also trained a number of ni-Vanuatu health workers, particularly medical doctors. The University has a high quality medical education program, but only allocates places for international students if these are not required by local students. With the smaller number of international students at the University, mechanisms for student support and liaison with donors and scholarship offices is not as effective as at the Fiji School of Medicine. For these reasons, and general security concerns, the Scholarship Office has been directing health related students towards courses at the Fiji School of Medicine instead of University of Papua New Guinea.

Scholarships are also offered to training institutions in Australia and New Zealand for particular study programs not available in the Pacific. There are occasional scholarships offered to universities in the United Kingdom, Europe or Asia by donors from these areas. AusAID has recently developed policy to support more regional scholarships and fewer scholarships in Australia, to improve pass rates and the cost efficiency of investments in education.

4.3 Training programs

4.3.1 Nurses

General Nurses are trained by the VCNE in a three-year course leading to the award of a Diploma in Nursing. Theoretical training is in Port Vila, with practical attachments at Vila Central Hospital and selected community health service settings. The course is fully funded by the Government, and students are provided with a scholarship to cover living expenses. Annual intakes average around 20 students, although only 60 - 80% of students enrolling graduate. The nursing curriculum has been under review for several years, and is expected to be finalized during the student-free period in 2004.

The high drop-out rate has been attributed to both academic and personal factors. Students may be asked to leave if they fail to attend regularly, or do not comply with disciplinary standards. Pregnant students are asked to leave once the pregnancy is

confirmed, although they may be eligible to rejoin the class in the following year. The languages of instruction are Bislama, English and French, with most handouts and all examinations in English.

Following graduation, normal practice has been to place the new nurses at Vila Central Hospital for at least a year, to allow them to practice with close supervision before going out to work in community health services. The last batch of nurses currently in training will graduate in December 2003.

There are a number of Nurse Aides working in hospitals and health centers in Vanuatu. Most of these staff have completed part of the General Nurse course, but for some reason were unable to finish. Further training is provided on the job.

4.3.2 Midwives

Midwifery training is a nine-month post-basic Certificate course offered to general nurses by the VCNE. Participants are MoH employees who meet selection requirements set by an interim selection body, with the Training Committee expected to take over this role in time. Male nurses are eligible to participate in the course, however only 2 of the 62 graduates to date have been men. The course has been offered 8 times since it commenced in 1983. Participants are paid their government salary plus living allowances to cover extra expenses. Financial support for course has been provided by a number of donors.

The midwifery course focuses on the development of clinical skills, with clinical practice undertaken at Vila Central Hospital. The tutors are midwives with teaching qualifications. The last midwifery course was held in 2001, with 11 midwives graduating. No further courses are planned until after the review of VCNE in 2004.

4.3.3 Nurse Practitioners

The training of Nurse Practitioners has also been a nine-month post-basic Certificate course offered by VCNE. The course focus is on the development of advanced clinical skills and management skills, to prepare graduates for their expanded role as a senior health worker in hospitals and health centers. Participants are MoH employees, who continue to draw their government salary during training, with the Vanuatu government providing funding for course costs. There have been a total of 7 courses since 1983, with 8 to12 participants per course. The last program completed in 2000. The tutor is a qualified Nurse Practitioner and educator.

4.3.4 Doctors

The small size of the Vanuatu population makes the provision of a medical education program in Vanuatu cost-inefficient. Instead, doctors have been trained through programs in the Pacific or occasionally elsewhere, with scholarships provided by donors. The Bachelor of Medicine/Bachelor of Surgery (MBBS) course is generally of six years duration.

Until recently, graduates remained in the country of training for their internship period of 1 – 3 years supervised practice, before being registered as a doctor in that country. Recently, the Fiji School of Medicine accredited Vila Central Hospital for internships in Medicine, Surgery, Pediatrics, Obstetrics and Gynecology. Now,

graduating medical doctors from FSM can return to Vanuatu for their intern program, under the supervision of senior specialist doctors, and gain registration locally. At present, the supervising doctors are all expatriates, employed by the MoH with support from the Australian Staffing Assistance Scheme (ASAS).

The internship program in Vanuatu is still under development, with recommendations from a recent study *(C.J. Tari, 2003, "Medical Internship and Registration in Vanuatu", Pacific Health Leadership and Management Development)* including formalizing supervisory mechanisms, strengthening the use of logbooks, and amending the Health Practitioners Act.

Post-graduate training for doctors is also dependent on donor scholarships. Without a clear Workforce Plan, this training to date has mainly reflected the individual preferences of the applicant, rather than specific needs of the MoH. Post-graduate training takes doctors out of country for a period of around 3 years. It is critical, therefore, that careful consideration of long and short-term health service needs is made before sending doctors for post-graduate training.

4.3.5 Dentists and other oral health workers

Dentists and dental therapists are also trained outside Vanuatu, mainly in FSM, but also in other institutions depending on donor funding. At FSM, a Bachelor of Dental Surgery takes 5 years, with other exit points available, including Diploma of Dental Therapy after 3 years and Dental Technology after 4 years.

4.3.6 Allied health workers

There are small numbers of qualified health workers in allied health worker categories, including: laboratory technology, radiography, dietetics and physiotherapy. These staff were trained overseas with donor scholarships.

There are also staff who have attended short-courses in allied health fields to develop specific skills, and are now working in that field without formal qualifications. Some of these staff originally trained as nurses, and so have a formal health qualification plus additional specialized skills.

Strengthening the allied health workforce is recognized as an urgent need for the MoH, particularly in the area of laboratory technology.

4.3.7 Village Health Workers

Although not MoH staff, Village Health Workers (VHW) are an important part of the health workforce in Vanuatu, staffing Aid Posts that are the first level health services in most villages. An extensive training/retraining program has been undertaken by the MoH, with support from Save the Children. To date, almost all VHWs have completed an 8-week training program, followed by a 2-week refresher course.

4.3.8 In-service training

The MoH HRD and Training unit, within the Directorate of Planning and Administration, manages in-service training, which is delivered by a range of local and overseas training providers. Several public health programs also plan and

implement in-service training on specific topics related to reproductive health, child health, control of vector borne diseases, immunization etc.

In-service training provided in-country includes workshops, short-courses and clinical attachments, which are being used increasingly to update staff skills in specific clinical areas. There are many more requests for in-service training than opportunities available. Under the new Nurses Board, there are plans to link re-licensing of nurses to in-service training. If professional associations become involved in the provision of in-service training, training opportunities could be significantly increased.

Senior MoH staff have occasional opportunities to participate in in-service training overseas, through conferences or technical meetings in their field of practice. There are also a number of in-service training programs available that lead to formal qualifications. The post-graduate Certificate in Pacific Health Leadership, for example, is management training aimed at mid-level managers, jointly sponsored by the South Pacific Community and AusAID, and provided by National University of Samoa. It is an 18-week work based training program, with only a brief attendance required in Samoa. Three Vanuatu participants attended the last course and the MoH hope to secure funding for more participants in the next course. UNFPA sponsors 2 Vanuatu reproductive health workers per course to attend a post-graduate Certificate in Reproductive.

4.4 Funding for training

4.4.1 Training in Vanuatu

The Vanuatu government provides the majority of funding for pre-service and post-graduate training of health workers in country. The MoH budget includes funds for personnel and operating costs of the VCNE, although as indicated above, funds for capital improvements are not available through the recurrent budget. The government provides scholarships for student nurses, plus living allowances, and pays the salaries and allowances of nurses undertaking midwifery or nurse practitioner training. Accommodation and meals for student nurses, previously provided by the government at VCH, has been discontinued, and students are expected to live with relatives during training. Donors have contributed to training programs for midwives and nurse practitioners.

4.4.2 Training overseas

All overseas training is funded by donors, or funded privately by the student's family. Scholarships are processed through the Ministry of Education's Training and Scholarships Coordination Unit (TSCU). The major donors for under-graduate and post-graduate scholarships in health are AusAID, NZODA and the French government, with the Vanuatu Government also providing scholarships for the first time in 2004. WHO funded scholarships for overseas training are organized directly by WHO in discussion with the MoH, without input from the TSCU. AusAID's "open equity" scholarships for undergraduate or postgraduate study overseas are also advertised and awarded by AusAID without input from TSCU.

For 2004, the TSCU received 507 applications for overseas training scholarships. Of these applications, 306 applications were complete and eligible for consideration. 91

scholarships are available; 32 funded by AusAID, 34 by New Zealand, 15 by the Vanuatu government and 10 by the French government. The majority of these scholarships are for programs offered in the Pacific region, with only 11 available for programs in Australia or New Zealand. The TSCU, under the direction of the National Education Commission (NEC), will allocate 73% of scholarships to school leavers, 16% to public servants, and 11% to private applicants. With equitable distribution of public servant scholarships across all government ministries or departments, the MoH could only expect to receive 2 postgraduate scholarships for its staff in 2004. There are 5 AusAID "open equity" scholarships available each year, with applicants for health related programs competing with applicants in all other fields.

There are 12 school leavers short-listed for scholarships for undergraduate training in health related fields in 2004. The TSCU does not direct students in their choice of training, so the courses students have applied for reflect their personal interest. In 2004, 9 short-listed candidates have applied for MBBS, and 1 each for physiotherapy, dentist, and radiology studies. It is anticipated that over half of the short-listed candidates will successfully secure placement in their course of choice. In addition, WHO has allocated 4 scholarships for overseas undergraduate training in health fields in 2004, including 2 for MBBS.

4.4.3 In-service training

Historically, in-service training has been implemented using mainly donor funds, particularly from AusAID, WHO, NZODA, UNFPA, South Pacific Community, JOCV, UNICEF, and the Chinese and French governments, with Government funds covering only a small proportion of costs. Funds have been provided in response to MoH requests, and to address identified donor priorities. More recently, some Managers of community health services have budgeted for in-service training in their annual Business Plans, using government funds. The integration of in-service training into overall health service planning and management is seen as a signification improvement in approach. The cost of providing in-service training is high, particularly transport costs, as participants must travel by plane from remote islands. There is potential for increasing the cost-effectiveness of in-service training funds by improving collaboration between the HRD and Training unit and the Public Health Directorate.

4.5 Training intakes and outputs

There are currently 19 general nurses in training at VCNE. They are expected to graduate at the end of 2003. A summary of nurse training intakes and graduates is presented below.

Table 7: General nurse training intakes and outputs 1993 – 2003

Year of Graduation	Enrolling Students			Graduating Nurses*		
	F	M	Total	F	M	Total (%)
1995	12	8	20	9	8	17 (85%)
1996	8	14	22	8	12	20 (91%)
1998	16	16	32	6	12	18 (56%)
1999	8	16	24	6	11	17 (71%)
2000	10	9	19	8	7	15 (79%)
2002	8	12	20	2	9	11 (55%)

2003	10	9	19	4	6	10 (53%)
Dec 2003+	13	12	25	8	11	19 (76%)
Total	**85**	**96**	**181**	**51**	**76**	**127 (70%)**

*Includes students who re-entered training from a previous intake
+ Anticipated graduates

There is no midwifery or nurse practitioner training underway at present. A summary of previous student intakes and graduates is presented below. It is obvious that the attrition rate for the post-basic training courses is very low compared to that of the general nursing course. The courses are shorter, the students older and already MoH employees established in their careers.

Table 8: Midwifery training intakes and outputs 1983 – 2003

Year	Intake	Graduates
1983	6	5
1984	6	5
1986	7	6
1988	6	6
1990	8	8
1992	9	9
1998	12	12
2001	11	11
Total	**65**	**62 (95%)**

Table 9: Nurse Practitioner training intakes and outputs 1983 – 2003

Year	Intake	Graduates
1983	8	8
1984	8	6
1987/1988	8	8
1989	8	7
1991	8	8
1993	8	8
1999/2000	12	11
Total	**60**	**56 (93%)**

There are 33 ni-Vanuatu students currently enrolled in health related training programs overseas. Almost half of these students are studying medicine; other study areas include dental science, nursing, physiotherapy, laboratory technology and environmental health.

Table 10: Overseas training in progress

Course	Number of Graduates Expected (by end of year)												Total
	2003		2004		2005		2006		2007		2008		
	F	M	F	M	F	M	F	M	F	M	F	M	
MBBS		5		1	1		1	1	1	2		3	**15**
Bac Dental Science	1			1	1			1					**4**
Bac Pharmacy					1								**1**
Bac Nursing					1		1						**2**

Dip Physiotherapy				1		1							**2**
Dip Pharmacy			1										**1**
Dip Environmental Health		1											**1**
Dip Medical Lab Tech	1				1								**2**
Dip Dental Therapy					1								**1**
Post-Grad Radiography				1									**1**
Information Technology				1									**1**
Finance & Auditing				1									**1**
Cert Hospital Managem't			1										**1**
Total	**2**	**6**	**2**	**6**	**6**	**1**	**2**	**2**	**1**	**2**		**3**	**33**

In addition, there are 2 students expected to enroll in MBBS in 2004 under WHO sponsorship, with graduation in 2009, and 1 student each in Diploma of Laboratory Technology and Diploma of Radiology, with graduation in 2005.

4.6 Training problems and issues

4.6.1 Training of nurses, midwives and nurse practitioners

Significant problems have been identified in relation to pre-service training of nurses and other training at VCNE. A major concern is regarding student intakes. There is an urgent need to specify MoH needs for nurses, midwives and nurse practitioners in the future, to enable cost-effective planning of future training courses. The Workforce Plan is expected to provide this information. Nurses are the backbone of the Vanuatu health workforce, and it is particularly important that the training of nurses responds to workforce needs.

A comprehensive review of VCNE facilities, staff, curricula, procedures etc. is planned for 2004 during a student-free period set aside for this. The review is expected to address many issues including:

- Future funding of the VCNE, including funding of capital improvements;
- Strengthening student selection;
- Improving the quality of teaching and learning, including:
    - Finalizing the new nursing curriculum;
    - Identifying numbers and qualifications of tutors required;
    - Strengthening the knowledge and skills of tutors;
    - Increasing resources for teaching and learning;
    - Reducing high drop-out rates;
    - Reviewing the language of instruction and implications;
    - Strengthening clinical teaching and supervision of students during clinical practice;
    - Improving the clinical skills of graduates to assess, diagnose and manage common illnesses; and,
    - Improving procedures for student assessment.
- Potential for a program of supervised practice (like an internship) for newly graduated nurses; and,
- Future of midwifery and nurse practitioner training – based on workforce needs, is there enough demand for each course to be offered in-country? Should the courses be changed or combined?

4.6.2 Scholarships

Improving the impact of scholarships is another area that needs addressing in regard to selection of candidates, programs of study supported, and utilization of graduates. Appropriate selection of scholarship candidates is an important aspect of ensuring value from educational investments. Candidates not only need the academic capacity to successfully complete the course, but also a commitment to an ongoing career with the MoH in the field of study. Without a clear MoH plan projecting workforce needs, donors offer scholarships based on their own assessment of priority fields of study and on candidates preferences. Major donors and the TSCU have indicated they are willing to work more closely with the MoH in providing scholarships based on identified MoH workforce requirements once the Workforce Plan is developed. With only 2 TSCU scholarships available for MoH staff each year, it is very important that the MoH assess staff applications against the Ministry priorities before forwarding their recommendations to the TSCU.

In order to maximize the impact of scholarships awarded to school leavers, the MoH needs to provide career advice to senior high school students and those undertaking foundation studies at University of the South Pacific. This would have benefits both for students and the MoH. If students choose to study in fields that are MoH priorities, the students are more likely to be employed when they graduate, and the MoH workforce needs will be met. The TSCU reports that currently the majority of health related applications from school leavers are for training as a medical doctor.

Appropriate utilization of graduates requires interventions to support good candidate and study program selection, monitoring of student progress and advance planning for recruiting, deploying and retaining the graduate in a job where they can apply the knowledge and skills they have acquired. At present this is not done systematically, and there are examples of graduates returning to Vanuatu without employment, or being employed in areas unrelated to their skills.

Another important issue related to scholarships is the failure of some graduates to return to Vanuatu on completion of their studies. The small number of highly qualified health workers means that the loss of even one graduate is a serious problem for the MoH. Graduates remain overseas for personal, professional or financial reasons. Some meet and marry nationals from other countries while they are studying, others go directly on to post-graduate study, some report that the employment conditions and/or standard of living offered in another country is more attractive than that available in Vanuatu. It is estimated that 15 well-qualified ni-Vanuatu health professionals are currently working overseas, including 5 doctors.

Table 11: Ni-Vanuatu graduates working overseas

Qualification	#	Current Place/s of Work
MBBS	5	UK, PNG, Fiji, Palau
Bac Dental Science	1	NZ
Bac Pharmacy	1	Australia
Nurse Anesthetist	1	Palau
Ultrasound Technician	1	Palau
Medex/Nurse Practitioner	1	? Working in Australia (with wife)

Bac Nursing	2	NZ
Nurse Midwife MHPEd	1	Solomon Islands
Laboratory Technician	1	NZ
Nurse Midwife	1	NZ

4.6.3 Training of medical doctors

There has been considerable discussion about the need for ni-Vanuatu medical doctors. The MoH aims to become self-sufficient in terms of medical doctors, including ni-Vanuatu residents, registrars and specialist doctors. It is acknowledged that this cannot be achieved overnight, as presently more than half of doctors, and all senior specialists, are expatriates. In the short-term, there is an urgent need to train and employ sufficient ni-Vanuatu doctors to provide medical care in all five hospitals, and to support health centers in terms of consultation, referral and staff development. At this level, experience and/or Diploma level qualifications in the four core areas of specialty – surgery, medicine, pediatrics, and obstetrics and gynecology – are considered sufficient. In the longer term there will be a need for a wider range of ni-Vanuatu medical specialists with qualifications at Masters level, who could eventually take over the role of supervision and support for interns from the expatriate doctors who currently provide this.

4.6.4 In-service training

There are a number of issues around in-service training that also need addressing. Some of these relate to strengthening the quality and impact of in-service training, others to improving access and relevance of training. Currently there is high demand but not enough opportunities for all staff to participate regularly in in-service training, teaching methods are mainly theory based with little clinical practice, and there is very limited follow up to support application of learning on the job, such as through supervision.

The high cost of bringing rural staff to urban centers for in-service training requires further exploration of other approaches, such as mobile training teams, the role of the supervisor as on-the-job trainer, potential for distance learning etc. Given the high costs involved, it is also important that the impact of in-service training is strengthened and monitored, including the appropriate selection of participants, prioritizing training based on MoH needs, and improving coordination between providers.

5.0 Projected workforce requirements

5.1 Projected workforce requirements

5.1.1 Long-term vision for health services

The health workforce is responsible for the provision of health services. Accurately projecting workforce needs requires a clear vision for the future of health services. While the MoH 2000 – 2003 Corporate Plan and annual Business Plans provide short to medium term expectations, there is currently no long-term plan for health services on which to base the Health Workforce Plan.

In the absence of a long-term health services plan, the working group responsible for developing the Health Workforce Plan have drawn on available policy and plans,

current workforce "norms", stakeholder perspectives and analysis of health and demographics in Vanuatu, as well as staffing standards of neighboring countries, to estimate workforce requirements.

5.1.2 Health workforce needs versus affordability

The Ministry of Health is the major provider of formal health services to the people of Vanuatu. At present there are only a very small number of health professionals providing outpatient services in the private sector. Government budget cuts, therefore, have an immediate impact on health service provision.

In the current situation of public sector budget cuts, there is a clear difference between what the population needs in terms of health services – and therefore health workforce – and what the MoH can afford to provide. Comparison with other Pacific island countries regarding health services, health workforce and health status, provides an indication of what can be achieved through increased investment in the health sector. Fiji and Tonga have significantly better health outcomes for most indicators than Vanuatu; they also have many more doctors and nurses per capita than Vanuatu. Only Papua New Guinea and the Solomon Islands have fewer doctors or nurses per capita than Vanuatu.

By current staffing norms, there are 12 vacancies for nurses, midwives or nurse practitioners at the Health Center level that cannot be filled in 2004 due to budget constraints. This represents close to 20% of professional Health Center posts. The three smaller rural hospitals have staffing levels in some wards that do not come close to meeting minimum 24 hour coverage standards by regional norms. Medical services provided by the government workforce is augmented by doctors placed through "volunteer" programs or donor funded posts.

Analysis suggests that the workforce required to provide even the current level of health services to a growing and aging population, with rapidly rising levels of non-communicable diseases, is significantly more than the MoH can afford through it's recurrent budget at present levels. As the foundation for an economically and socially productive society, health should be prioritized by the Government of Vanuatu, even in the current climate of financial constraint. The budget provided to the MoH needs to reflect this priority, and the Government's commitment to ensuring essential health services are available to all citizens.

5.1.3 Opportunities for reducing the MoH workforce requirement

There is the potential to utilize the MoH workforce more efficiently, thus reducing some of the need for additional staff. Efficiency gains can be made through more flexible deployment of the workforce, to allow it to respond to changing service needs resulting from variations in consumer demand or staff absences. It is also possible to increase the services provided by the current staff within their allocated work hours, through improved performance management, including more effective time management, more efficient procedures, and increased skill levels.

Given the amount of household expenditure believed to be spent on traditional healers, there is a need to explore the potential for increasing private sector provision of modern health services, and the private health workforce. This is consistent with

overall Government policy to promote private sector growth. Recent progress towards regular licensing of health professionals provides a mechanism for monitoring private practice and a legal framework for setting minimum standards and ensuring quality.

5.1.4 Projected requirements by workforce category

The projections presented here represent a compromise between the health service needs of the population and health service affordability. Meeting these workforce projections will require an ongoing commitment from the Government of Vanuatu, the Ministry of Health, community groups and the population in general, as well as donors and other health development partners.

5.1.4.1 The nurse workforce

The nurse workforce is crucial to the effective provision of health services in Vanuatu. For the planning period it is expected that nurses, midwives and nurse practitioners will continue to staff community health services (health centers and dispensaries), with support from nurse aides in selected facilities. Nurses and nurse aides will provide nursing service in hospitals, with midwives staffing maternity outpatient and inpatient areas and nurse practitioners providing some hospital outpatient services and medical services when a doctor is not available.

The 2004 budget of the MoH identifies 362 nursing workforce positions. These include 235 registered nurses, 50 midwives, 34 nurse practitioners and 43 nurse aides. The current ratio of nurse, nurse aide, midwife or nurse practitioner to population is 1:586 (or 1.71 nurses per 1000 population). This is well below the level in most other Pacific island countries, as discussed in section 5.1.2 above. However, given the government budgetary constraints, it has been agreed that this ratio be maintained for the next few years, with consideration being given to increase it in about 2010.

Projections of nurse workforce requirement for the MoH are based on a number of assumptions. An attrition rate of 0.5% per annum has been used, assuming that those staff at or over retirement age will have been terminated in 2003, and that workforce management strategies can contribute to a reduction of the current rate of around 1.5%. An efficiency gain of 1.0% per annum has also been assumed, based on expectations that more flexible utilization, improved nursing practices and strengthened workforce management will enable nurses to achieve more during their time at work. An efficiency dividend of 1 – 2.5% is considered the norm in most health services so this is a modest assumption. Population growth of 2.6% or less is predicted based on the 1999 Census. Expected efficiency gains reduce the workforce growth to meet increased population demands to 1.6% per annum.

To achieve the projected nurse requirement, based on these assumptions, a program of training and employment is required, as set out below. The implementation of the planned actions will result in achievement of nursing workforce goals with only small surplus or deficits from 2007.

Table 12: Projected nurse requirement

ACTION	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	TOTAL
Registered Nurse											
Graduates employed	19	1	1		8		8		10		**47**
New posts required	0	1	1		8		8		10		**28**
Nurses Aide											
Graduates employed		6		6		6		6			**24**
New posts required		6		6		6		6			**24**
Nurse Practitioner											
Graduates employed			5		1		1		1		**8**
New posts required			0		0		0		0		**0**
Midwife											
Graduates employed		6		1		1		1		2	**11**
New posts required				0		0		0		0	**0**

The next undergraduate training of general nurses has been deferred until 2005, to provide time to complete a curriculum review and organise student supervision and graduate placements. Workforce projections indicate that intakes every second year will be sufficient for 2005 – 2013, with 8 – 10 graduates per course. This plan would alter if the ratio of nurse to population is increased, which is recommended should the budget position improve.

The delay in providing the next general nurse training program causes a shortfall in available nurses until the next graduates enter the workforce at the end of 2007. To mitigate this deficit, the number of nurse aides will be increased, with courses conducted by the VCNE every alternative year from 2004 until 2010. This does not completely resolve the anticipated shortage, but is considered the best solution in the circumstances. The increase in nurse aides over the period of the Plan will result in a ratio of 8.5 registered nurses per nurse aide. It should be noted that the Nurses Act needs to be amended to include a register for Nurse Aides.

Workforce figures indicate that there is a shortage of midwives and nurse practitioners at Health Centre level. There is growing recognition of the need for multi-skilling of staff at the Health Center level, to enable provision of midwifery services by nurse practitioners and management tasks by midwives. Further development of a career structure for nurses may require midwifery training as a pre-requisite for training as a nurse practitioner. To address these issues, a decision has been made to increase the number of midwives in the workforce and train midwives as nurse practitioners. To achieve this, a midwifery training course will be conducted in 2004, followed by a nurse practitioner course for midwives in 2005. After this time, the continuing workforce requirement for nurse practitioners and midwives is relatively small. It is therefore proposed that a scholarship be made available each year for one registered nurse to complete a midwifery or nurse practitioner course overseas (alternately). This approach will require reassessment of scholarship arrangements, but will free up current tutors to contribute to clinical supervision and support of graduates, in-service training of current staff, and provision of clinical services if necessary.

Detailed projections and training plans are included in the Annexes.

5.1.4.2 Doctors

The MoH is committed to achieving an effective and sustainable health workforce, including replacing expatriate doctors with qualified ni-Vanuatu staff. At present, there is 1 doctor per 7,500 population, but if funding for 5 interns is secured for 2004, this will increase to 1 doctor per 6,250 population. The MoH is aiming to improve this further to 1 doctor per 6,000 population over the planning period. This is a modest goal that is still less than that of most Pacific island countries, but is considered realistic in the current financial climate.

The achievement of this goal will require the MoH to employ all students currently enrolled in MBBS programs on graduation. It will also require an increase in the number of ni-Vanuatu students enrolling in MBBS programs, successfully graduating and being employed by the MoH. Donor support for MBBS scholarships will need to be maintained at the present level during the planning period. The 9 ni-Vanuatu doctors currently employed represent only 30% of the medical workforce, but the MoH funds 23 of the 29 doctor positions at government salary and allowance levels. This means that by gradually replacing the expatriates currently occupying posts, the MoH can employ 14 ni-Vanuatu graduate doctors without the expense of creating additional posts. From 2005 onwards, the MoH need to create between 1 and 3 additional posts for medical doctors per year to accommodate ni-Vanuatu graduates and slowly replace expatriate doctors. By 2009, the MoH will have achieved an employment ratio of 1 doctor per 6,000 population.

Table 13 below sets out the levels of graduation and employment required, based on a workforce growth of 2.6% per annum (in line with expected population growth) and an attrition rate of 1% per annum. The Annexes provide full details of progress towards replacement of expatriates by ni-Vanuatu during the planning period.

Table 13: Projected requirement of ni-Vanuatu doctors

ACTION	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	TOTAL
Graduates employed	5	1	1	2	3	3	5	4	4	4	4	**36**
New posts required	4	1	1	2	3	2	3	2	3	2	1	**24**

Post-graduate training of ni-Vanuatu doctors will remove them from the available workforce for several years, and so effectively reduce the ratio to population. Training a doctor to Masters level requires 4 years of additional training; one year to obtain a Diploma, and an additional 3 years for a Masters. The number of students currently in under-graduate training limits the capacity of the MoH to increase workforce growth before 2010. Decisions made regarding student enrollment from 2004 will influence graduating numbers from 2011. Even under the best of circumstances, the MoH only hope to achieve a surplus of doctors to provide replacement for doctors doing postgraduate training from 2015 on.

Under the best of circumstances it is possible to numerically achieve a ni-Vanuatu medical workforce sufficient to replace all expatriate doctors by 2015. It is not possible, however, to develop ni-Vanuatu doctors with the qualifications required for the country to be self-sufficient in terms of basic medical services before 2020 at the

earliest. Care must be taken when replacing expatriate doctors with ni-Vanuatu doctors to ensure that specialist services can be maintained. The last expatriate doctors to be replaced should be those with specialist qualifications who are responsible for supervision of interns during their rotation through surgery, medicine, pediatrics, and obstetrics and gynecology at VCH. These expatriates cannot be replaced until there are sufficient ni-Vanuatu doctors with Masters level qualifications and experience who meet the requirements of training institutions for accreditation of the intern program. This will extend well beyond the current planning period. There are no ni-Vanuatu doctors with Masters level qualifications currently working in clinical services provision in Vanuatu. There are three doctors with Diploma level qualifications, one in Surgery, one in Medicine and one in Obstetrics and Gynecology (see Table 14 below).

Training sufficient ni-Vanuatu doctors in the essential specialty areas will require 2 – 3 doctors to be out of the country every year from 2005 to 2021 participating in post-graduate training. At present the MoH is only allocated around 2 scholarships per year for all post-graduate training. Replacing expatriate doctors by 2020 will therefore require scholarship donors to review their allocation, and specifically increase available places for post-graduate training of ni-Vanuatu doctors. There are also a number of ni-Vanuatu doctors currently working and/or studying overseas who have relevant post-graduate qualifications. If these doctors were to return to work in Vanuatu, this would reduce the training requirement projected here.

Most MoH doctors will not need to undertake post-graduate training overseas. Only 6 doctors with Masters level training are required under current projections, around 14 with Diplomas, plus a few who have completed residency attachments in specific areas (see Table 14 below). This is less than half the projected medical workforce. The majority of doctors will be adequately prepared for the work required of them by the MoH through their rotation across clinical areas during internship and residency in Vanuatu.

Table 14: Post Graduate Training Projections – Ni-Vanuatu Doctors

Post-Graduate Qualification	Current # at MoH	Minimum # for Self-Sufficiency	Yrs of Overseas Training Needed
Medicine Diploma	1	2	2
Medicine Masters	partial	2	5
Surgery Diploma	1	2	2
Surgery Masters	partial	2	4
Pediatrics Diploma		2	2
Pediatrics Masters		1	4
O & G Diploma	1	2	2
O & G Masters		1	3
GP Residency		20	
Anesthetics Diploma		5	5
Ophthalmology Diploma		1	1
Pathology Residency		1	4
Radiology Residency		2	4
Psychiatry Residency		1	4
Management Certificate	1		
TOTAL		**44**	**42**

It is clear that the continued provision of highly specialized medical services, such as cardiac surgery, by visiting teams from Australia and New Zealand will be needed well beyond 2014.

5.1.4.3 Allied and other health workers

It is difficult to project allied health workforce needs in the absence of a clinical services master plan. Established staffing norms for hospitals or public health services tend to be based on available staff rather than identified need, making it difficult to estimate future requirements. Training of allied health workers has been based on student preference and available scholarships, so the number of students enrolled varies between categories, and does not necessarily reflect stated MoH priorities. The projections of future requirements presented here have been based on regional norms and presumed needs. These will need to be reviewed once a Master Health Services Plan has been developed.

Table 15: Allied and other health workforce requirement 2004 - 2013

Post	2004 Workforce		Estimated Future Requirement	Additional Staff Needed
	Filled	Vacant		
Senior Pharmacist	0	1	3	3
Pharmacist	3.5	0	5	1.5
Dispenser	6	0	6	0
Senior Lab Officer	2	0	4	2
Med Lab Tech	14	1	17	3
Assistant Lab Tech	14	0	12	-2
Entomologist	1	0	1	0
Environ Health Officer	6	0	6	0
Senior Radiographer	3	0	2	-1
Radiographer	2	0	6	4
Assistant Radiographer	5.5	0	6	0.5
Dietician	1	0	6	5
Assistant Dietician	1	0	2	1
Dental Surgeon	3	2	4	1
Dental Technologist	1	0	2	1
Dental Therapist	3	2	6	3
Senior Physiotherapist	0	0	2	2
Junior Physiotherapist	1	0	5	4
Rehabilitation Officer	1	0	1	0
Orthotist	1	0	2	1
Occupational Therapist	0	0	2	2
Social Worker	0	0	2	2
Educator (VCNE)	7	0	7	0
Biomedical Engineer	0	0	2	2
Statistician	1	3	5	4
Total	**75**	**9**	**116**	**32**

In addition to health professionals, the MoH also requires staff with high-level skills in finance and economics, information technology, management, policy and planning, human resources etc. These posts are mainly at the central MoH level, in the Directorate of Planning and Administration, and their specialist skills provide support for MoH program and facility managers in planning and managing health services and the health workforce.

The number of these specialists employed is quite small. Most posts are currently occupied, so the approach taken is usually to provide these staff with appropriate further education, rather than identify and employ new graduates. There is one senior officer from the Finance Department currently studying at post-graduate level in Australia, and a senior officer from the Health Information office also studying overseas at present. The Human Resource Manager is studying human resource management subjects in-country. The emphasis for workforce planning for non-

health professionals is therefore on succession planning, to ensure it is possible to replace qualified staff as they retire or move to other positions.

5.2 Expected workforce losses

5.2.1 Retirements

Projection of expected workforce losses due to retirement is difficult. Data on the age of MoH employees is not considered accurate enough to provide a reliable projection of retirements at this time. Historically, many retirements have been delayed past the official retirement age of 55 years because the Public Service Commission and MoH have been unable to fund termination payments. In the 2004 budget, the MoH has requested “new initiatives” funding from the Government for termination payments to 96 staff at or over retirement age or occupying redundant posts. If this funding is made available, the MoH will be able to move forward without the burden of a large termination payment responsibility in future. Instead, there will be appropriate annual retirements of staff as they reach 55 years of age.

There are reports that retirements on medical grounds, although still small in number, have been rising in recent years. Many of these retirements are due to non-communicable diseases such as hypertension and diabetes. Health statistics for the population suggest that this trend could be expected to continue.

5.2.2 Resignations and terminations

Public service has historically been a highly desirable occupation in Vanuatu. In the health field, there are very few private sector employers. The small number of private sector health workers are generally self-employed in outpatient service provision. As a result, resignations from the MoH are rare. Disciplinary terminations have increased in recent years, but the numbers are still quite small, and likely to fall as staff become more aware of the potential consequences of inappropriate professional behavior.

It is estimated that the attrition rate for the MoH as a whole is between 0.5% and 1.5% per annum. Managing the attrition rate of key workforce categories, particularly nurses, will be very important to avoid exacerbating staff shortages.

5.3 Projected training capacity

5.3.1 Nurses

The Vanuatu Center for Nurse Education has historically provided pre-service training for general nurses, and post-basic training for midwives and nurse practitioners, and it is expected it has the capacity to continue in this role. There are concerns, however, that the quality of teaching and learning has fallen in recent years. It is essential that the MoH implement planned strategies to strengthen the Center, if value from training investment is to be realised, and nurses graduated who can effectively contribute to health services in Vanuatu. The current review of curricula, clinical teaching and supervision and other aspects of VCNE will support improved teaching and learning outcomes. The development of the nurse aide curriculum must be completed by the end of 2003 for the training course to be implemented in 2004.

The projected teaching load will be limited to training general nurses and nurse aides from 2005, with midwifery and nurse practitioner training provided by other

institutions in the region. This will make between 1.5 and 3 nurse educators available at various times to plan and conduct in-service education courses and provide clinical supervision and refresher programmes.

There are midwifery and nurse practitioner programs available in Fiji and Papua New Guinea that would be appropriate for Vanuatu students. Fiji is seeking to establish itself as a center for regional training, and can be expected to be able to accommodate 1 ni-Vanuatu student per year. Sufficient scholarships will have to be identified/allocated to enable nurses to undertake this training.

5.3.2 Doctors

The Fiji School of Medicine currently allocates 3 places per annual intake for ni-Vanuatu MBBS students. The TSCU has asked that this be increased to 4 or 5, subject to the recommendations of the MoH Health Workforce Plan. The TSCU reports that almost all (probably around 95%) of ni-Vanuatu students enrolling in the MBBS program at Fiji School of Medicine (FSM) successfully graduate.

There is also potential to re-explore the capacity of the University of Papua New Guinea (UPNG) to provide additional undergraduate and post-graduate training for ni-Vanuatu doctors, particularly if the FSM is unable to accommodate sufficient numbers of Vanuatu students in the medium term.

Post-graduate training in the four core specialities is also available at Diploma and Masters level at FSM and UPNG. This training is Pacific focused and relevant to the health needs of Vanuatu. Residency attachments in fields such as pathology and radiology may be best undertaken in large hospitals in Australia or New Zealand, but need to be focused on preparing doctors for practice in Vanuatu. Potential training institutions will be identified in the development of the MoH Training Plan.

Sufficient scholarships will have to be identified/allocated to enable doctors to undertake pre-service and post-graduate training in the numbers required to meet the projected needs.

5.3.3 Allied and other health workers

Allied health training is most fields is available to Pacific island countries through FSM in Fiji. The FSM has Certificate and/or Diploma courses available for regional students in pharmacy, medical laboratory technology, diagnostic radiology, dietetics, dental surgery, dental technology and dental therapy, physiotherapy, occupational therapy and other public health fields. Suitable training in social work, biomedical engineering and medical records/health statistics needs to be identified elsewhere. This will occur during the preparation of the MoH Training Plan.

6.0 Plan to meet workforce requirements

Meeting the workforce requirements projected will require an overall growth in the professional workforce of 103 posts, or 14% from the size of the MOH workforce in 2004. This represents the creation of an average of 11 additional posts per year from 2005 to 2013. The MoH budget for 2004 has already been submitted, so no further adjustments can be made for this year.

Table 16: Projected professional workforce growth 2005 - 2013

Workforce Category	2005 - 2013	
	Growth	**New Posts**
Nurses	8%	28
Nurses Aides	51%	24
N. Practitioners	18%	0
Midwives	16%	0
Doctors	30%	19
Allied Health & other professionals	38%	32
TOTAL	14%	103

The projected annual professional workforce growth averages 1.5% per annum from 2005 to 2009, then 1.4% per annum from 2010 to 2013. The MoH personnel budget will also need to increase an average of 1.5% per annum, plus inflation. The actual cost, however, will be slightly more, as the posts that are added are all professional posts, with some entry-level gradings at P19, and most at P6 or above. Based on salary costs only, at 2004 rates, the total cost of the projected workforce growth from 2005 – 2013 is 75 million vatu.

No allowance has been made for a growth in the size of the non-professional workforce such as cleaners. It is recognized that as patient numbers increase with population growth, there may be increased work for this category of staff. There is, however, an expectation that considerable efficiency gains could be made in this area. There is potential for partial or total privatization of services, increased community participation, and other strategies to reduce overall costs to the MoH.

6.1 Workforce training strategies

The achievement of the projected workforce targets will require the allocation of between 6 and 14 overseas scholarships for health related tertiary study each year, including 3 – 4 scholarships for MoH staff to undertake post-graduate training. Current trends indicate there are sufficient school leaver scholarships available to meet the requirement, but 1 – 2 additional public servant scholarships will need to be allocated to the MoH each year.

6.1.1 Master Training Plan 2004 - 2013

The MoH will follow the development of the Health Workforce Plan 2004 – 2013, with the development of a master Training Plan covering the same period. It is important that a long-term approach is taken, because of the length of time required to train many of the workforce cadres. The Training Plan will specify courses, numbers of students, entry and graduation timing, and estimated costs for the plan period. This Plan will be developed during late 2003 and early 2004, with consultant support for development and initial implementation.

It should be noted that, like the Workforce Plan, the Training Plan will need to be regularly reviewed during the plan period and adjusted to ensure it continues to reflect MoH service needs.

6.1.2 Pre-service training in country

Nurses and nurse aides will be trained in Vanuatu at the VCNE, using new or revised curricula. The MoH will strengthen the VCNE, with technical support from WHO, to improve teaching and learning outcomes. Clinical supervision of students during training will be improved, through the identification and utilization of senior nurses as preceptors during students' clinical practice. The current practice of paying students during training will be discontinued, and appropriate fees for training introduced to mitigate the impact of MoH budget cuts. Training intakes will reflect anticipated MoH health workforce needs, and strategies will be implemented to reduce student attrition during training. A graduate program to provide new nurses with appropriate supervision during their first year of clinical practice will be initiated at the major hospitals.

6.1.3 Pre-service training overseas

Doctors and allied health workers will be trained in appropriate programs in the Pacific region. Further discussions will be held with the Fiji School of Medicine and the University of Papua New Guinea to negotiate student placement and support. Donor support for scholarships will be secured, using the Workforce Plan and Training Plan as the basis for negotiation on scholarship numbers and priority fields of study. Active collaboration with the TSCU on scholarships will be maintained. The MoH will implement a program of career counseling for high school leavers and students enrolled in foundation studies at the University of the South Pacific campus in Vanuatu, to encourage students to apply for scholarships in health related fields that reflect MoH workforce needs and provide an opportunity for future employment.

6.1.4 Post-graduate training

From 2006, midwives and nurse practitioners will be trained through appropriate programs elsewhere in the Pacific region. One to two scholarships per year will be allocated for graduate nurses to undertake this training. Options will be explored to meet emerging needs for clinical nurse specialists in fields such as mental health.

Doctors will be trained in the four core clinical specialities in sufficient numbers and to appropriate levels to meet the projected requirement to phase out expatriate doctors around 2020. Training in selected other fields of medical practice, such as pathology, will be supported through residency-type attachments to enable doctors to develop sufficient skills for practice in the Vanuatu context. Training scholarships will be secured for a maximum of 2 – 3 doctors to be out of the country studying each year. Scholarships will be offered based on MoH specialist needs as identified in the Workforce Plan and Training Plan. Based on projected need, not all doctors will require overseas training. More than half the medical workforce will be trained in-country, using a program of supervised rotation through the main areas of clinical practice.

Options will be explored to provide MoH staff currently working in health or non-health technical areas where additional workforce skills are needed with appropriate post-graduate training.

6.1.5 In-service training

The development of the Training Plan will include preparation of short and medium term in-service training plans. Emphasis will be on developing the workforce skills most needed by the MoH to meet its organizational goals. Clinical refresher training will be prioritized. Alternatives to the "workshop" model of training will be explored, including in-country clinical exchanges or attachments, rotation of trainers through health facilities, the use of self-study training packages etc. Staff will be encouraged to take greater responsibility for their own learning, and strategies developed to recognize and reward those staff who actively pursue further education through their own efforts. Integration of training provided by the various departments/units within the MoH will be strengthened, to improve the cost efficiency and impact of training.

6.2 Workforce management strategies

6.2.1 Recruitment and retention

Recruitment will be aimed at filling prioritized vacant posts with appropriately qualified and motivated staff. Not all graduates returning from study in health related fields will be employed by the MoH. There are presently more students enrolled in certain programs than are needed by the MoH. This situation is expected to improve when the MoH implements career counseling of high school leavers, with students made aware of which health professionals are needed by the MoH, and in what numbers, before they embark on training. Those graduates not employed by the MoH will be encouraged to consider establishing or joining private sector health practices. There is significant opportunity for growth of the private sector, although it is recognized that "start-up" costs are prohibitive for many new graduates, and independent practice does not provide the peer support and mentoring that is available when working in larger health facilities. The further development of health professional associations and councils should help to address this.

The Workforce and Training Plans will be used to identify expected graduates at least one year before they return from training, to enable funding of additional posts if these are needed by the MoH.

Retention of well-qualified health professionals, particularly those who are eligible for registration in other countries, is a significant issue that must be addressed. In the current financially constrained environment, the MoH will need to explore creative options to enable doctors and others to earn sufficient income to remain in Vanuatu. One approach could be allocating interested doctors "sessional" time in government facilities to see private patients, for example during evening hours in the outpatient department. The doctor would have free use of the facilities, and would charge and retain fees paid by private patients, in return for seeing outpatient emergency patients free of charge. This approach would also contribute to reducing the hours of on-call cover required. If private patients required laboratory or radiology tests the hospital would provide these services and collect the appropriate fees. Other options should also be explored, including non-financial rewards such as access to further education for those doctors who provide services in rural hospitals for a nominated period of time.

Strategies to improve the retention of all MoH staff include strengthening aspects of human resource management such as consistency in grading posts, attention to

increments, improved staff appraisal systems based on job descriptions, merit based promotion, providing career pathways, and ensuring effective discipline of staff when needed. Supportive supervision and targeted in-service training for staff working in rural areas will also be used to improve retention.

6.2.2 Rationalized deployment

Deployment of staff should be based on clearly defined health service needs. At present there is great variation in staffing levels between the provinces and on different islands. The development of a master Services Plan by the MoH is a key strategy for rationalizing staff deployment. There will continue to be a concentration of well-qualified staff in the two large hospitals, as these provide tertiary referral services for the country as a whole. There will, however, be greater emphasis placed on ensuring adequate staffing of the smaller rural hospitals, health centers and dispensaries, to reflect the government's commitment to community health and health services equity. Greater effort will be made to ensure that staff recruited to fill vacant posts in outer islands and rural areas are willing to work in that location, and disciplinary action will be taken if staff are inappropriately absent. Creative strategies and flexible deployment options will be considered for very hard to staff posts, including rotating staff from a larger health facility to fill those positions.

6.2.3 Performance management

The Workforce Plan calls for efficiency gains to be made in the delivery of health services. Key strategies to achieve better performance include: clarification of job descriptions for all posts and staff appraisal based on these, supportive supervision and in-service training, strengthening pre-service training to better prepare graduates for their work, improving procedures and guidelines for practice, building time and task management capacity, and taking disciplinary action when needed.

Staff motivation will be improved through strengthening merit based promotion and attention to application of increments and grading of posts. Mechanisms for recognition of staff who perform above the expected standard will be developed and applied across the MoH.

6.3 Implementation arrangements

Each program area within the MoH has responsibility for implementation of the Workforce Plan. Oversight responsibility currently lies with the MoH Director of Planning and Administration, and the Planning office within the Directorate. Personnel and Performance Appraisal (PPA), and Human Resources Development and Training (HRDT), are the two offices with direct responsibility for ensuring the strategies and plans are applied and implemented.

HRDT will liaise closely with the TSCU, donor agencies and overseas training institutions to ensure that scholarships for training are allocated according to the Workforce Plan. The MoH Training Plan 2004 – 2013 will assist HRDT in implementation of pre-service training in-country, and the development of annual training plans for in-service training. HRDT will also take responsibility for exploration, development and implementation of the other workforce training strategies outlined above.

The Personnel and Performance Appraisal office (PPA) will work closely with Managers from Southern and Northern Health Care Groups, and the Directorate of Public Health, to identify vacancies and plan for recruitment of staff based on expected and emerging needs. The MoH Master Services Plan will guide this activity. In addition, the PPA will support the Services Groups in exploring, developing and implementing workforce management strategies to increase retention, rationalize deployment and improve the performance MoH staff.

The Southern and Northern Health Care Groups, including community and hospital managers, have a direct responsibility for supporting implementation and regular review of the Workforce Plan. This Plan is intended to provide overall strategic direction for the growth and development of MoH workforce, and can only be effective if there is active cooperation and collaboration between all stakeholders within and outside the MoH.

7.0 Monitoring of plan implementation

Responsibility for monitoring and evaluation of the implementation of the Workforce Plan 2004 – 2013 will lie with the Directorate of Planning and Administration. The Working Group established to develop the Plan will be maintained, meeting quarterly to review planned implementation. Every two years at major review of the Plan will be undertaken by the Working Group, with support from a consultant for the initial review. The review will use the key indicators as set out below to measure the progress achieved and highlight areas that need improvement. Strategies will be developed to address problems and adjustments made to the Plan to accommodate changes in service workforce needs or the financial environment.

7.1 Phase 1: short term (1 –2 years)

Objective	Indicator/s	Verification	Assumptions	Responsible
Strengthen workforce training based on clear policy, strategy and plans	• MoH Master Training Plan 2004 – 2013 developed • Nurse Aide course developed and implemented • Midwifery course implemented • Nurse Practitioner course for midwives developed and implemented • Adequate number of pre-service training places secured in regional institutions • Adequate number of post-graduate training places secured in regional institutions • Required scholarships approved • Donor support for required scholarships secured • National and provincial annual in-service training plans developed and implemented collaboratively • Operation of VCNE strengthened through implementation of planned activities, based on recommendations of WHO consultant	• Master Training Plan • Course documentation • Correspondence, places awarded at institutions • Correspondence, places awarded at institutions • TSCU documents • Donor plans, scholarships awarded • In-service training plans, training reports • Monitoring reports of VCNE activities plan	**Health Workforce Plan 2004 – 2013 completed and approved** • Ongoing regional commitment from FSM and/or other training institutions • Ongoing donor commitment to Vanuatu and health sector • Commitment of MoH to improving VCNE • Continued WHO technical support for VCNE	P&A Director HRDT VCNE TSCU Provincial Managers PH
Strengthen workforce management to	• MoH vision for the future of health services documented • MoH Master Services Plan 2004 –	• MoH document • Master Services Plan	• Commitment and participation of key stakeholders in	GoV Planning NHCG

improve rational recruitment and deployment, staff retention, motivation and performance	2009 developed based on vision • Vacant posts and qualification gaps of current staff identified • Vacant posts funded to enable graduates to be employed on return to fill them • Post grades and increments made consistent across MoH • Actual staffing reflects staffing standards in all provinces • Disciplinary action taken for inappropriate staff behavior • Supervisory visits to Health Centers and Dispensaries undertaken as planned • Community staff participating in in-service training in the same proportion as they represent in overall staff numbers	• Post list & vacant posts • Employment records • Personnel documentation • Staff lists • Documentation • Supervision reports • Training records	development of vision and Master Services Plan • Sufficient GoV budget made available to MoH • Managers have or develop relevant skills • Budget available for supervision • In-service training funds made available, including travel costs	SHCG PH All managers PPA FA

7.2 Phase 2: medium term (3 – 5 years)

Objective	Indicator/s	Verification	Assumptions	Responsible
Strengthen workforce training based on clear policy, strategy and plans	• Review of Workforce Plan and Training Plan every 2 years • Adequate number of pre-service training places secured in regional institutions • Adequate number of post-graduate training places secured in regional institutions • Required scholarships approved • Donor support for required scholarships secured • National and provincial annual in-service training plans developed and implemented collaboratively	• Review Report • Correspondence, places awarded at institutions • Correspondence, places awarded at institutions • TSCU documents • Donor plans, scholarships awarded • In-service training plans, training reports	• Funding and/or technical assistance made available if needed • Ongoing regional commitment from FSM and/or other training institutions • Ongoing donor commitment to Vanuatu and health sector	P&A Director HRDT VCNE TSCU
Strengthen workforce management to improve rational recruitment and deployment, staff retention, motivation and performance	• Vacant posts and qualification gaps of current staff identified • Vacant posts funded to enable graduates to be employed on return to fill them • Actual staffing reflects staffing standards in all provinces • Disciplinary action taken for inappropriate staff behavior • Supervisory visits to Health Centers and Dispensaries undertaken as planned • Community staff participating in in-service training in the same proportion as in overall MoH	• Post list & vacant posts • Employment records • Staff lists • Documentation • Supervision reports • Training records	• Sufficient Government budget made available to MoH • Managers have or develop relevant skills • Budget available for supervision • In-service training funds made available, including	Planning SHCG NHCG All managers PPA FA GoV

	proportion as in overall MoH staffing numbers		travel costs	

7.3 Phase 3: long term (6 – 10 years)

Objective	Indicator/s	Verification	Assumptions	Responsible
Strengthen workforce training based on clear policy, strategy and plans	• Review of Workforce Plan and Training Plan every 2 to 3 years • Adequate number of pre-service training places secured in regional institutions • Adequate number of post-graduate training places secured in regional institutions • Required scholarships approved • Donor support for required scholarships secured • National and provincial annual in-service training plans developed and implemented collaboratively	• Review Report • Correspondence, places awarded at institutions • Correspondence, places awarded at institutions • TSCU documents • Donor plans, scholarships awarded • In-service training plans, training reports	• Funding and/or technical assistance made available if needed • Ongoing regional commitment from FSM and/or other training institutions • Ongoing donor commitment to Vanuatu and health sector	P&A Director HRDT VCNE TSCU
Strengthen workforce management to improve rational recruitment and deployment, staff retention, motivation and performance	• Vacant posts and qualification gaps of current staff identified • Vacant posts funded to enable graduates to be employed on return arrival to fill them • Actual staffing reflects staffing standards in all provinces • Disciplinary action taken for inappropriate staff behavior • Supervisory visits to Health Centers and Dispensaries undertaken as planned	• Post list & vacant posts • Employment records • Staff lists • Documentation • Supervision reports	• Sufficient Government budget made available to MoH • Managers have or develop relevant skills • Budget available for supervision	GoV Planning NHCG SHCG All managers PPA FA

	undertaken as planned • Community staff participating in in-service training in the same proportion as they represent in overall staff numbers	• Training records	• In-service training funds made available, including travel costs	

8.0 Recommendations to strengthen health workforce planning, management and training

Recommendations are presented here in three sections, and reflect the most important and/or difficult of planned action. The first group of recommendations addresses the context in which workforce planning occurs, particularly health financing, health policy and planning. The other two groups are specifically related to health workforce training and management.

Responsibility for implementing the recommendations lies with the MoH Workforce Planning Working Group, and the Directorate of Planning and Administration. Most recommendations require action to be taken by the MoH, either directly or through advocacy to the Government or other agencies.

8.1 Workforce planning context

8.1.1 Health financing

The MoH requires sufficient recurrent budget to enable it to provide essential health services to the population. If the government budget is insufficient, it is inevitable that the quantity and quality of health services will have to be reduced.

Recommendation 1:
The Government of Vanuatu prioritize the funding of health services to ensure minimum essential services are available to the population, and provide sufficient increases annual budget to enable implementation of the Workforce Plan 2003 – 2013.
Implementation responsibility: Minister & Director General (advocacy)

Recommendation 2:
The MoH explore alternative means of raising revenue or reducing costs, such as through user fees or community contributions to service delivery, privatizing support services etc.
Implementation responsibility: FA, NHCG, SHCG, Planning

Recommendation 3:
In collaboration with professional associations and registration bodies, the MoH explore alternatives to government provision of health services, including opportunities for private practice of health professionals and public/private service mix.
Implementation responsibility: Planning, NHCG, SHCG, FA

8.1.2 Health policy and planning

The long-term vision of the MoH regarding health services needs to be clearly articulated, to provide the basis for workforce and facilities planning. There also needs to be better links made between service utilization and resources provided.

Recommendation 4:
The MoH document its vision for health services into the future, including the balance between community based and hospital based health services.
Implementation responsibility: Director General, Planning, NHCG, SHCG, PH

Recommendation 5:
The MoH develop a Master Health Services Plan, identifying services to be provided at each level of service, with associated minimum standards for staffing, equipment and financial resources; the Plan should also include objective population and other criteria for the establishment of new facilities and changes in facility categorization.
Implementation responsibility: Planning, NHCG, SHCG, FA, PPA, Assets

Recommendation 6:
The MoH implement a community awareness campaign to inform the community about the services available and appropriate utilization of the different levels of health services/facilities.
Implementation responsibility: Planning, NHCG, SHCG, PH

8.2 Workforce management

Improvements in human resource management are expected to have a positive impact on the quality and utilization of services. Filling priority vacant posts with appropriately qualified staff, ensuring proper staff skill mix in the different facilities and managing staff performance will lead to better service delivery.

8.2.1 Overall human resource management

Recommendation 7:
The MoH strengthen overall human resource management, including recruitment and deployment of staff based on service needs, merit based promotion, standardizing approaches to post grading and increments, establishment of career pathways for different cadres and improving the workforce database.
Implementation responsibility: Director General, PPA, NHCG, SHCG

8.2.1 Performance management

Recommendation 8:
The MoH strengthen workforce performance management, including the supervisory system and referral network, performance appraisal based on job descriptions, orientation and supervision of new graduates, rotation of staff through relevant posts, provision of essential in-service training, appropriate staff discipline when necessary and an increased emphasis on professional ethics.
Implementation responsibility: PPA, NHCG, SHCG, Managers, HRDT

8.3 Workforce training

The goals of the Workforce Plan 2004 – 2013 cannot be achieved without the necessary training inputs. These are dependent upon financial support from the Government and donors, and upon the availability of appropriate training courses in-country and in the Pacific region. In the current financially constrained environment, it is particularly important that the available budget is spent with maximum impact in terms of health service outcomes.

8.3.1 Training policy and plans

Recommendation 9:
The MoH review existing policy and prepare a Master Training Plan for 2003 – 2013 based on workforce needs identified in the Workforce Plan 2003 – 2013.
Implementation responsibility: HRDT, NHCG, SHCG, PH

Recommendation 10:
The MoH advocate and negotiate with the TSCU, donors and training institutions to secure the necessary overseas training places and scholarships to allow implementation of the Workforce Plan and Training Plan 2003 – 2013.
Implementation responsibility: HRDT (advocacy)

Recommendation 11:
Donors support the MoH in its pursuit of long-term health service sustainability through the provision of sufficient scholarships in the prioritized areas of study for ni-Vanuatu school leavers and current health professionals to allow achievement of the Workforce Plan.
Implementation responsibility: Director General, HRDT (advocacy)

8.3.2 VCNE

A review of the VCNE is currently underway with technical support from WHO. Recommendations will be made to strengthen the College and the training programs offered. It is essential that changes be made in response to these recommendations, in order to achieve the goals articulated in the Workforce Plan.

Recommendation 12:
The MoH actively implement plans made to strengthen the VCNE, including regular quarterly monitoring of progress and outcomes.
Implementation responsibility: Director P&A, VCNE

8.3.2 In-service training

There is room for significant improvement in efficiency, equity, outcomes and impact of in-service training. The development of a Master Training Plan 2003 – 2013 will provide direction for efforts to address this problem.

Recommendation 13:
The MoH develop annual national and provincial training plans, using a collaborative approach and based on directions set out in the Workforce Plan and Training Plan, describing training activities to be implemented each year, including how outcomes, equity and governance will be measured.
Implementation responsibility: HRDT, NHCG, SHCG, PH

Recommendation 14:
The MoH explore alternative mechanisms/opportunities for provision of in-service training to staff in Vanuatu, including the use of supervision as a training opportunity, identifying and implementing regional training programs or packages through distance learning.
Implementation responsibility: HRDT, NHCG, SHCG, PH

Recommendation 15:
The MoH develop and implement a system for recognition and reward for staff who actively pursue in-service training, particularly in their own time and/or at their own expense, and make available self-learning packages in key areas of clinical service and health services management.
Implementation responsibility: HRDT, PPA, NHCG, SHCG, PH

9.0 Conclusions

The Workforce Plan is a compromise between health service needs and health service affordability. It seeks modest growth of the health workforce; the minimum required to assure essential health services to the population. Meeting the workforce projections will require ongoing commitment from the Government of Vanuatu, the Ministry of Health, donors and health development partners, and the population. If budget cuts continue, the MoH will not be able to maintain the current level of services. Health is the foundation for an economically and socially productive society, and should be prioritized by the Government of Vanuatu, even in the current climate of fiscal constraint.

The Workforce Plan will be reviewed and adjusted as necessary every 2 years, with an emphasis on measuring progress, checking that the planning assumptions are still valid, and ensuring it reflects service needs.

ANNEXES