Wemos input into the Dutch government's online consultation Youth Strategy

1. If you look at the 3 regions that we focus on (MENA, Horn of Africa, Sahel) – can you mention specific trends per region which are relevant for the strategy. Are there, for example, specific sectors where there is much to be gained? Or specific skills that young people lack in a certain region or sector?

From the experience that Wemos has advocating for strong health systems, we know that many of the mentioned countries have sub-optimal health care systems, with considerable shortages in the health workforce, across all cadres. Compared with the threshold density of 4,45 health workers per 1,000 population to achieve the absolute minimum of health coverage, Uganda has 0,74, Kenya 1,79, Burkina Faso 1,06, Niger 0,2, Chad 0,6.

Of the Ebola stricken countries Sierra Leone and Liberia, it is well-known that half of their (qualified) health workers perform their activities as a volunteer, because they cannot be paid properly due to public wage bill and budget restrictions. After the Ebola disaster, there were promises that these volunteers would be absorbed into the health workforce and offered a regular job with regular salaries. This promise was never fulfilled, increasing the likelihood that these health workers quit their work and leave the health sector.

Other countries in the region (for example Nigeria, Ghana) are well-known source countries for health workers moving abroad (for example Ireland, UK, USA, Australia). In a case study on Nigeria in the Brain Drain to Brain Gain project (funded by EU and Norad), extensive mention is made of the continual drain of health workers from the country, due to (among others) meagre salaries, insecure working conditions, heavy workloads, lack of drugs and equipment, and lack of opportunities for professional development. These are widespread phenomena throughout the countries referred to above.

Wemos' basic premise is that stepping up investments in the health workforce serves multiple purposes: investing in quality medical education (and access to that education) motivates young people to become a health worker. The simultaneous creation of decent jobs in the health sector (whether private or public), with living wages, adequate working conditions, social protection and career opportunities creates attractive employment opportunities, and thus: prospects for a better future, leading to stable and secure societies. Thirdly, educating/training and deploying health workers in all cadres helps build

strong health systems, necessary for Universal Health Coverage, including SRHR services. Strong health systems are worth the investment in itself, as it helps build a healthy and productive population. Lastly, employing more young health professionals will help create more youth-friendly health services, necessary to create trust and actual usage of these health services by the growing young population of the mentioned countries. See also this infographic on the health workforce and its relation to SDGs 1, 2, 3, 4, 8, 10, 11 and 17. An essential first step for making such investments is mapping the need, demand and supply of health workers, through a health labour market analysis, in order to assess how to match them – not only in quantity, but also in quality and required skills.

2. Do you have examples of successful "scaled up" initiatives / programs in the field of education and work to increase youth employment, and if so, which ones? Or do you know of certain successful initiatives that are worth scaling up in the 3 regions mentioned?

In Malawi, the Global Fund to fight Aids, TB and Malaria and the US Government (through PEPFAR/HRH 2030) supported the recruitment and temporary funding of nearly 3,000 health care worker salaries in Malawi, with the ultimate aim to eventually absorb these health workers in the government payroll. Such bridge-funding also occurred in Uganda, resulting in an additional 2,000 nurses and midwives. Although this process was not without challenges, valuable lessons were learnt that can help convince other development partners and donors to make more resources available for funding not only health worker training but also health worker salaries in a sustainable manner.

Between 2005-2009 the Government of Malawi and donors implemented a jointly formulated Emergency Human Resources Programme (EHRP), by pooling their available funding. This programme was committed to delivering the Essential Health Package (EHP) to the Malawi population, resulting in (among others) an improvement in the health worker/1,000 population ratio from 0.34 to 0.52 for core health workers, and an increase in health workers retention through a 52% salary top-up. The main donors were DFID and the Global Fund to fight Aids, TB and Malaria. Further contributions came from the World Bank, NORAD, German Development Cooperation, UNFPA and UNICEF.

In the Working for Health Program, WHO, OECD and ILO developed national inter-sectoral investment plans for the health workforce in a number of countries, among which in Niger, Mali, Burkina Faso, Senegal, Guinee-Bissau, Ivory Coast, Togo and Benin. Working for Health has established a multi-partner trust fund, in order to make resources available at the country level for action and implementation.

A number of countries, such as in Ethiopia, work with bonding agreements with their newly graduated health workers, whereby the health worker, in return for the education fees, commits to serving a pre-agreed period of time in a particular health sub-sector or geographical area. Also, pilot programs in Malawi focusing on training youngsters from remoter provinces in educational institutes close to their

homes (instead of in the country's capital or other big city environments) have shown that these youngsters are more willing to remain in their home area to practice their profession after graduation, thus contributing to a more equitable distribution of health workers.

3. Do you have specific ideas or additions about how we can make young people part of this policy? How do we ensure that they participate in the implementation of this strategy?

On a global level, there is the Youth hub of the Global Health Workforce Network that can help shape this strategy.

At country level, there should be outreach to students' organizations, professional associations, unions, other youth organizations as well as youth leaders in general. Several Dutch organizations will have warm contacts in the countries of interest and could be of help in this (KNMG, Mondiaal FNV, CNV Internationaal,…).

You might also want to reach out to the Health Workers for All Coalition to see if they have members in the countries referred to.

In the European context, the European Health Parliament ("Europe's Next Generation of Health") has elaborated interesting and provocative new ideas for the education of the future generations of health professionals. Although aimed at a different geographical context, their general approach to tackle the increasing complexity and scope of future health systems is worth looking into and could be an inspiration on how to tackle similar questions in the contexts and countries of MENA, Horn of Africa and the Sahel.

4. Anything else you feel is worth mentioning?

1- Globally speaking, 70% of the health workforce is female. Therefore, investing in the education of young women, in an enabling environment for them to continue and successfully finish their education/vocational training, and in employment opportunities for them in decent, safe and secure jobs in the health sector, would be a powerful driver for their economic and social empowerment.

2- In the current development narrative there is a lot of attention for a private sector fix for public sector failures, and many development oriented initiatives are meant to run through public-private partnerships. Wemos believes that a strong and stable society needs a solid **public** health infrastructure, with stable and sustained employment opportunities. Private sector health

service delivery is prone to be driven by the expectations of economic returns on investment, instead of expectations of public health impact. Services may be set up and then discontinued again when profits are deemed too low. Since governments have the responsibility of organizing health for all, reliable and continued health service delivery is of paramount importance. Private sector can play a role in this, but the level of their commitment should not be left to the whims of profit-driven companies or individuals.

3- As to the question how governments will be able to create more fiscal space for investments in the health sector, including salaries for health workers: Wemos has, together with in-country civil society organizations, undertaken fiscal space analyses in Malawi and Uganda (report to be released shortly). The findings of these country case studies have yielded relevant information that can be (and is currently being) used for in-country advocacy to increase investments in health.

4- A promising additional angle is that it might be especially interesting to educate and involve (more) young people in the development of digital and other tech-driven solutions for health sector challenges. Combined with measures to stimulate entrepreneurship, this might result in interesting start-up companies that deliver relevant products and services.

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