

Planning, Developing and Supporting the Health Workforce: H R H A C T I O N W O R K S H O P



Methodology and Highlights

17-20 January, 2006
Johannesburg, South Africa

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Executive Summary

Background

As a key contribution toward increasing human capacity in national health systems, the Capacity Project is hosting a series of Human Resources for Health (HRH) Action Workshops. The initial workshop—held in Johannesburg in partnership with the United Nations Development Programme/Southern Africa Capacity Initiative (UNDP/SACI)—facilitated the exchange of knowledge and best practices in planning, developing and supporting the health workforce.

The Joint Learning Initiative (JLI) meetings in Abuja (December 2004) and Oslo (February 2005) as well as other meetings in South Africa (May 2005) and Brazzaville (July 2005) have focused global attention on critical HRH issues. While these meetings and subsequent reports have provided much needed high-level support and calls for action to address the HRH crisis, the Capacity Project's HRH Action Workshop series is intended to focus on specific operational experiences—what is being done in countries, what is working and what is not.

Workshop Description

The first HRH Action Workshop had four primary objectives:

1. Promote a shared HRH vision across countries in order to facilitate collaboration and illuminate an inspirational better future toward which we are all working
2. Expand the HRH knowledge base by creating opportunities for participants to share knowledge about HRH issues and their potential solutions
3. Help develop a critical mass of HRH advocates and problem solvers that will accelerate the application of appropriate HRH practices and tools in their specific settings
4. Generate action plans for the implementation of new HRH practices and tools after the workshop.

Participants: The three and one-half day workshop brought together **38 HRH leaders** from **11 countries** (Kenya, Lesotho, Malawi, Namibia, Rwanda, Sudan, South Africa, Swaziland, Tanzania, Uganda and Zambia). Almost all of the participants are senior HRH directors or practitioners working at the operational level within the Ministry of Health in their respective countries. Two representatives from faith-based organizations also attended. The Capacity Project organizers took great care to identify two to four optimal participants from each country. This was achieved through consultation with Capacity Project field staff, USAID Missions and Project and global partners. These national colleagues worked together during the workshop, shared their experiences and identified how new information and ideas would be applied after they returned home.

Methodology and agenda: To promote south-to-south dialogue among the participants—a key aim of the workshop—we used a highly dedicated participatory approach. This approach is based on the fundamental assumption that everyone can contribute and that knowledge is distributed among participants and workshop staff. We designed the workshop to facilitate knowledge sharing across countries through carefully constructed discussions during which participants addressed key topics

and facilitators made appropriate inputs to build on the topics as they were discussed. All participants learned and contributed, forming general or issue-based inter-country networks and paving the way for post-workshop follow-up cooperation. Using this methodology, the group focused in-depth on the major HRH challenges each country is facing, solutions being tried at the country level and possible directions for the future.

The agenda had six major components:

- After an introductory session, workshop staff focused on **setting the context** to achieve a shared understanding of the HRH crisis at the country level. Participants addressed these questions: What do you see as HRH progress at the country level where you work? What are the obstacles or challenges you see? What do you think is an area of HRH interest that should get more attention in the future?
- Two sets of **substantive in-depth working group discussions** covered the following “hot topics”: human resources management; retention policies and practices; health care worker productivity; performance management; performance improvement; recruitment, deployment and hiring practices; workforce assessment; and HRH strategic planning. Participants had identified these as key topics in a pre-workshop survey (results available on request).
- At designated times interspersed during the workshop, country groups met to share information and conclusions from the day’s activities and working group discussions and talk over any **emerging implications** for HRH in their country. This helped participants begin to think about possible actions to be discussed on the last afternoon.
- **Specific country case examples** (e.g., Namibia, Malawi) highlighted approaches to HRH issues that have generated much interest in the region.
- During a consultation in December 2005, global partners reached agreement on an **HRH Framework** that will be included in the next World Health Report. Participants had the opportunity to react to the framework and make suggestions for its further development.
- Country groups developed **HRH action plans** during the afternoon of the last day. These plans identify priority areas for work, some next steps, projected dates, technical assistance needed and point persons. The action plans were shared with Capacity Project staff and in some instances may serve as the platform for future country-level technical support from the Project depending on resource availability.

Initial Workshop Outcomes

The strategic participant invitation process and a meeting design that capitalized on having the right people in the room resulted in an extraordinarily successful workshop. In an evaluation, one participant wrote: “What was best was the rich, rich, rich environment created by virtue of who was here and how the workshop was facilitated. The knowledge and experience was phenomenal.”

An unusually intense and effective depth and level of discussion characterized the plenary and, especially, the working groups. Because country-level participants had a professional level and technical language in common and chose which topics to work on, the discussions were driven by shared concerns and questions and quickly got to the point. Little time was wasted in needing to define terms or create understanding about HRH topics or issues. Workshop staff facilitated the

working groups effectively and added their own expertise into discussions in a targeted manner. The following initial outcomes resulted from the workshop:

- **A summary from the first plenary discussion highlights key elements of the HRH context** in the participating east and southern African countries. This includes examples of progress (e.g., putting HRH on the national agenda, advancements in HRH information systems), a variety of challenges (e.g., problems in HRH strategic plan implementation, retention) and areas to be addressed in the future (e.g., looking at productivity as a tool, focusing on plan implementation, mentoring to make decentralization work).
- **Short working group reports were produced on the eight “hot topics”** described above. Using a bulleted format, the reports spell out issues being faced in and across countries, approaches that are being tried, what appears to be working and what does not. The reports constitute a resource for understanding the current “state of play” regarding key HRH issues in the region. They also will provide guidance for those in Africa who wish to continue to network and learn across countries and for those internationally who are looking for specific actions that could be supported by donors or technical cooperation.
- Each country group developed **an action plan**. Workshop organizers intend to share them among all participants so they are aware of one another’s plans. In some instances, inter-country networks are working on the same topics. The intent is to continue sharing knowledge about approaches being tried and results. It is important to note that the **process of producing the plan** is as valuable as the plan itself, as it proved to be a time when participants from each country could work together in a summative activity to choose, from the rich discussions and shared lessons, which approaches are most relevant for their particular context. While the plans themselves will be helpful, they will undoubtedly change with appropriate input and discussions in-country. We hope to learn of these revisions and support country-level progress in suitable ways.
- The commitment exists to **maintain the positive network** that emerged as a result of the workshop. Comments from the evaluations describe how important this sort of inter-country networking is. One participant put it this way: “The networking was not just valuable, it was invaluable.” Another wrote, “The rich networking exchange between a diverse group of HRH country leaders, HRH experts and donors was strategic.” The Capacity Project will continue to share HRH knowledge and results with participants and plans to survey participants after four months to check on action plan implementation progress and to see what further support would help. Participants recommended that we consider inviting one person from each of the country teams to the next HRH Action Workshop, thereby continuing and expanding the HRH practitioner networks in sub-Saharan Africa.
- The **evaluations were extremely positive**. Participants reported that the workshop objectives were generally achieved, and they provided many helpful qualitative statements to support positive ratings. There were also several helpful suggestions for future workshops.

The products described in the first three bullets above are available on the HRH Action Workshop CD, and can be found as links contained in the workshop Agenda. The CD is available at www.capacityproject.org/activity-workshop.



Planning, Developing and Supporting the Health Workforce: Human Resources for Health Action Workshop

17-20 January, 2006

Johannesburg, South Africa

AGENDA

Purpose

Facilitate the exchange of knowledge and best practices in planning, developing and supporting the health workforce.

Objectives

- Promote a shared HRH vision across countries in order to facilitate collaboration and provide an inspirational future toward which we are all working
- Expand the HRH knowledge base by creating the opportunity for participants to share knowledge about HRH issues and their potential solutions
- Help develop a critical mass of HRH advocates and problem solvers that will help accelerate the appropriate application of HRH practices and tools in their respective countries
- Generate action plans for the implementation of new HRH practices and tools after the workshops.

Tuesday, January 17

Opening Session and Reception

- Welcome, introductory work and reception

Wednesday, January 18

Introductory Session

- Opening remarks
 - USAID/RHAP
 - SACI
 - WHO
- Background, objectives and agenda for the meeting (Capacity Project)

Setting the context

- The HRH crisis at the country level: What do we see—Progress, challenges, obstacles, future areas of interest

Key developments to support global HRH work—update presentation

- Recent collaborative work on HRH Framework, linkage to The World Health Report, soliciting reactions, including this group (Friday)

Critical HRH topic working groups

- Topic based working groups (e.g., HRH strategic planning, workforce assessment and planning, recruitment, hiring and deployment, performance improvement): discussion questions like what are the issues facing us around this topic, what is being tried, what appears to be working, not working

Working group report highlights

- Key points from working groups shared in plenary
- Discussion

Closure for day

Thursday, January 19

Implications of Wednesday's sessions

- Country groups meet, share information from the day, discuss any implications for HRH in their country
- Brief sharing in large group

SACI Framework

- Sharing SACI framework and approach to utilizing existing national capacity
- Questions and discussion

Critical HRH topic working groups (Round two)

- Topic based working groups (e.g., HRM, retention, productivity and performance management): discussion around questions like what are the issues facing us around this problem, what is being tried, what appears to be working, not working

Working group report highlights

- Key points from working groups shared in plenary
- Discussion
- Key promising practice examples—presentations/discussion
- **Namibia**—Private-sector recruitment of health care providers
- **Malawi**—Recent findings from incentive and retention schemes

Implications of today's sessions

- Country groups meet, share information from the day, discuss any implications for HRH in their country
- Brief sharing in large group

Friday, January 20

Feedback on Framework from December consultation meeting

- Discussion and input into HRH Framework

Discussion time for remaining HRH issues

- Time allocated to place new or unplanned HRH issues that emerge from workshop discussions

Supporting HRH work at the field level

- Presentation on ways in which WHO, WHO/AFRO, Capacity Project and others are supporting HRH work
- Discussion

Action planning: Country teams work, consult, look for common action themes in the region, develop/refine actions

- Work as country groups to determine actions emerging from workshop deliberations; identify regional or shared actions across country, consider how to support each other
- Discussion

Reviewing progress/looking at next steps/workshop evaluation

HRH Action Workshop Methodology: A Promising Practice

“This methodology represents a paradigm shift that the entire development agenda needs to take. It helps to produce a different level of intensity and spirited discussion, among other things.”

—Ummuro Adano (Capacity Project Partner Leadership Group meeting, March 21, 2006)

The methodology used in the HRH Action Workshop represents a subtle but significant departure from typical workshops and conferences. As a result, it can be considered a promising practice that encourages a different kind of knowledge sharing than often occurs. The participatory methodology assumes that all who participate are partners at some level in the learning process, and this is in alignment with a sound development philosophy wherein stakeholders work together as partners in the development process. While this particular application of the methodology was done for an international HRH practitioner group, it also has many very important applications at the country level (described near the end of this article).

Typical Workshop Approach

Most workshops or conferences tend to be organized around a series of expert speakers and panels. While participation and discussions may be seen as helpful, the main purpose of such a session is generally for experts to provide knowledge to a range of individuals who are attending in order to close a particular knowledge gap. Typically, presentations are accompanied by PowerPoint slides, and there is often a certain time period that is planned for questions and answers, or perhaps for some quick small group discussions. Workshop or conference organizers often intend to integrate participatory aspects by suggesting to presenters that they ask questions at the outset to stimulate initial discussion and thought, and that they limit the length of presentations to allow sufficient time for questions and answers or group discussions.

However, in practice, these typical workshop sessions can be problematic. Speakers tend to exceed time limits or not pay as much attention to organizers’ instructions—there are too many slides, the first panel member takes too much time, thereby reducing the time of other panel members, the question and answer period becomes truncated because of time overages, speakers do not speak to the topic assigned and so on. If there are discussion groups, the time allocated to the smaller group discussions may not be adequate, and the group reports may not be dealt with in a substantive manner. Given these problems, participants learn what they can; they also collect resources and materials, and the breaks are valued as a time to network and to discuss issues.

There is an underlying philosophic assumption for this methodology—that there are experts who have knowledge to share, and there are participants who are largely learners who need to listen, learn and ask questions in order to close a particular knowledge gap.

This kind of workshop or conference—while useful for certain purposes—does not typically produce serious or substantive discussions among presenters and participants (or between participants). Except for the occasional unusually stimulating session (unusual because the methodology itself works against effective, deep discussions), this methodology largely serves two purposes—it allows participants to fill a knowledge gap if they chose the session carefully, and to identify and gather resources that they might use or pursue further at a later date.

However, in settings where technical assistance is being received to improve the HRH situation, this has a deleterious effect, as it assumes there are international (or countrywide) experts who hold

knowledge that must be shared with country-level (or local-level) practitioners who lack knowledge. It creates a comfortable—but somewhat limiting—dependency on the expert, and it does not bring country- or practitioner-level knowledge and experience to bear in meaningful ways. It also does not promote practitioner-to-practitioner knowledge sharing and networking.

Dedicated Participatory Approach

The HRH Action Workshop used a highly dedicated participatory approach that is based on the following principles:

- It is designed to optimize participation and input from all. As such, it places a high degree of significance on south-south dialogue.
- It places a high value on knowledge sharing since knowledge is distributed among participants. That is, it assumes that, ultimately, the “answers” can be located in the room and that the workshop needs to be structured so that they emerge from the process. It is based on the principle that international experts have access to global promising practices and research, while country-level participants have access to practical knowledge of in-country context, actions, schemes being tried and emerging results or challenges. It is only through the active interchange of different levels of knowledge that effective knowledge sharing occurs.
- It emphasizes learning across countries with appropriate technical input being provided at the “right” time from workshop facilitators. That is, discussions are carefully constructed so that participants can address key topics and facilitators can make appropriate inputs to build on the topics as they are discussed. Overall, there are a few carefully chosen technical inputs that include global research or promising practices, but these inputs are carefully complemented by allocating sufficient time for discussion of these topics, and to consider country-level implications.
- It aims to create useful future HRH practitioner networks and to provide the basis for support and knowledge-based resources to help make such networks useful and sustainable. In this very real sense, it is highly action oriented.

Making Participative Workshops Effective

While these principles seem to be relatively straightforward, to design and conduct a workshop that adheres to these principles requires a subtle but sophisticated methodological approach. The following specific tips are offered for two reasons. First, they are important because it is only through examining the specifics that the more general principles will be fully understood. Second, we hope that these tips might provide guidance for people who are undertaking workshops like this.

- At least part of the effectiveness of a highly participatory workshop is to do whatever can be done to ensure that the “right” participants are invited to attend. That is, the goals of the workshop should be carefully crafted, and decisions should be made about the kinds of participants who can best help meet those goals, and who share similar kinds of professional roles, interests and experiences (although it is quite fine if they have diverse perspectives on issues). It should be stressed that it *does take a certain level of effort and time* to find, invite and get approval for the right participants. This happened over a period of four to five months for the HRH Action Workshop, and involved a careful identification and communication process.
- Where possible, it is very helpful to have some degree of advance knowledge from or about the participant group to help make final agenda choices. This can be done through a survey or set of selected interviews. For the HRH Action Workshop, we used an electronic survey that proved instrumental in choosing the highest priority topics for the eight working group sessions.

- At an early stage in development, it is necessary to allow careful consideration of the linkages between the overall workshop purpose, the number of participants, the kind of venue and the level of necessary staff to accomplish the purpose. All of these ingredients must be thought through far enough in advance to make things work well and to make sure that the designers do not get trapped by inadequate consideration of one of these elements. For example, there may be a workshop with 50 participants where working groups are desired; there is a need for five working groups, but no one checks the site—and when checked, the site turns out to have only one break out room. The whole methodology of the workshop might then be stymied as a result. In terms of the HRH Action Workshop, we started the actual agenda planning process about four months in advance of the workshop.
- If the group gets beyond 15, it is likely working groups will be needed in order to optimize participation. As working groups should be between five and ten people, a design decision then needs to be made as to whether to have a (staff) designated facilitator, or to have members of the working groups facilitate. Either way works, but both take planning. If the decision is to use staff facilitators, they must be a carefully chosen team of dedicated people who can facilitate discussions and offer light-handed guidance, and who can carefully make substantive inputs as part of the ongoing discussions. As this role is more difficult than it might appear, there must be a pre-meeting to make sure everyone is clear about roles and facilitator expectations in order to ensure excellent facilitation. If it is not possible to use staff facilitators, then overall instructions to small groups must be exquisitely clear (and small groups monitored periodically) to make sure they are on target.
- The design and facilitation has to take into consideration the careful balance of global and country-level knowledge, allowing a useful mixture.
- The designers need to allocate sufficient time for substantive working group discussions. If participants are given a serious task to consider, then they need to be given an appropriate amount of time. The minimum amount of time is 30 minutes, and it may be necessary to allow up to two hours for a serious task with, say, a group of ten people.
- Just as working group discussions need serious time and attention, so it is necessary to handle products of working groups seriously. One way to do this is to let each group report out highlights and key conclusions, and then to facilitate the group to help them compare and contrast the different reports, and solicit conclusions after all reports have been contributed. Or, if there are more than four groups, then it is helpful to ask for only a few key highlights from each group, and move the reporting process around so that no one group dominates this process. If it is a multi-day workshop, it helps to get the reports keyed in and handed out, and then to allow for corrections, and publish notes as the workshop proceeds. It is also helpful to produce e-copies afterward, either on a website or CD.
- It is important to maintain flexibility in the design of the agenda to allow country teams to re-group periodically during the workshop, to compare notes and share information since they will be in different working groups and to identify relevant HRH issues and lessons learned from other countries for their own country settings. This is especially useful if the meeting is regional as the networks are likely to be easier to sustain after the workshop is completed.
- In addition to distributing electronic copies of reports and contributions, it is very helpful to assist participants to generate ways to build and sustain a vibrant post-workshop network of practitioners that can continue to share knowledge in the future. For the HRH Action

Workshop, we intend to make the Capacity Project's HRH Global Resource Center a key tool in the networking process, as well as in considering opportunities for future face-to-face sharing.

Country-Level Applications of the Methodology

While this HRH Action Workshop methodology can always be useful on an international or regional basis to optimize the sharing of country-level experiences and to expand the HRH knowledge base, it also has several very important potential applications *at the country level*. It can be modified so that it promotes effective country-level alliances for actions like the following:

- To support the design and implementation of efforts to strengthen human resources information systems (HRIS)
- To catalyze joint problem-solving around HRH challenges like data-based workforce planning, decision-making, deployment or retention
- To create stakeholder alignment in the process of generating or revising an HRH strategic plan, and engendering input and commitment and capacity to implement such a plan.

The approach can be used to serve many very important purposes to move country actions forward.

Some Final Thoughts

Overall, it is important to stress four points. First, using a dedicated participatory approach makes an important philosophic statement as it assumes that learning (at least for adults) is a partnership, just as development work should be a true partnership. While there are occasions where less participatory methods may be quite helpful, the long-term goals of technical cooperation will be better served by using a more participatory methodology. And it is probably appropriate to caution that it is not easy to combine approaches, as an increase in the number of speakers, for example, will often reduce the degree of effective participation.

Second, as mentioned earlier, the difference between a dedicated participatory approach and a "typical" workshop is subtle, but one can use these tips to design more participatory workshops, or to assess designs of workshops in general. For assessment purposes, one might examine a draft agenda to determine the number of speakers for particular time periods, whether there are substantive working groups, the amount of time allocated to working group sessions or how working group reports get addressed. These are all indicators that shed light on degrees of participation.

In addition to it being difficult to fully describe the details in writing, the effectiveness of participatory workshops is due—at least to a certain degree—to a somewhat hard to define "art" of facilitation. An experientially oriented facilitator can bring a certain eye to design and implementation that can make a difference between excellent and good, providing small but important advice, decisions and facilitation to balance various workshop elements.

Finally, and perhaps most important, the key input of participatory workshops is often obtained during the design stages—and far enough in advance (depending on circumstances, four months is probably a minimum) so that designers still have the freedom to make qualitative decisions. If the workshop is designed appropriately and thoroughly, then the implementation is often easy.

—Dr. James McCaffery
Interim Director, Technical Resources
The Capacity Project
March 2006



Summary of Highlights from Working Groups

Introduction

The participatory methodology described in the previous section formed the centerpiece of the HRH Action Workshop facilitation and agenda implementation. This section provides a synthesized summary and highlights from the various working group discussions and reports. Lightly edited versions of all these reports with interesting and useful country examples can be found in the appendix, and we would encourage readers to peruse them.

HRH Progress, Challenges and Areas of Future Interest

As part of an important introductory activity for setting the broad context for the HRH Action Workshop, participants were asked to work in small groups on the following three questions: what progress was being made in their countries on HRH issues; what challenges they were still encountering; and what were some of the HRH topics or areas of interest that they would like to see more work being done on in the future.

Discussions in both small groups and plenary settings at the workshop revealed increased levels of awareness and expertise to deal with the various dimensions of the HRH crisis facing the countries. In the same vein, it was promising to learn that several countries are in various stages of developing and implementing policies and practical strategies to address different elements of their HRH challenges.

The following three sections provide an analytical summary of the rich thoughts and very productive ideas that the groups generated and reported on after working on the three tasks that they were assigned.

Progress

Despite international assessments or perceptions, many countries report that they have HRH strategic plans—with some in their second or third version. Lesotho, Rwanda, Uganda, Zambia, Malawi and even South Sudan have developed short-, medium- or long-term HRH strategic policies and plans to guide HRH investments for building the human infrastructure that is required to support their national health systems. For some countries, especially those facing chronic health worker shortages and a severe AIDS epidemic, HRH planning focuses on emergency measures to tackle the immediate workforce crisis.

The ability and willingness of the public health sector to engage other health sector actors such as faith-based providers, as is the case with the Christian Health Association in Lesotho and other key stakeholder groups, including in some cases even high-level political leaders, is considered essential in shaping the HRH agenda and coordinating country-level actions. For example, in Zambia, the president gave health sector leaders an ultimatum of two months to develop an HRH strategic plan and took personal interest in the whole process. The experiences from Uganda, Lesotho and South Sudan also show that adopting such a strategic and collaborative approach to workforce planning and management is both desirable and necessary.

Since HRH functions as well as decision-making authority and responsibility for HRH are fragmented across different levels of the ministry of health and the government itself, there is also a growing recognition that stakeholders need to go beyond the ministry of health to include the ministries of education, treasury and public service. However, the participants realized that moving these key players to a consensus on important HRH priorities requires sustained political commitment and national leadership, and without such support and cooperation, the health sector on its own would be powerless to plan and manage its workforce in a sustainable way. Both Namibia and Zambia reported some good progress on galvanizing this kind of high-level support for HRH.

There has been recent progress in strengthening HRH information systems in many countries, as well as a growing sense of the importance of having sound HRH data. Activities on this front involve mobilizing whatever data are currently available, working to improve the existing database to include information on location, gender, age structure, educational level, supply, demand, attrition and migration and using data to ask and answer some fundamental policy questions.

Different types of retention schemes are also being explored and implemented, and there is increasing openness to “creative” schemes. However, there are many lingering questions about what might constitute a sustainable retention scheme, and there do not yet appear to be conclusive evidence-based results.

There are also several promising HRH practices that have begun or are being planned, and they include: mobilizing auxiliary cadres of health workers and delegating to them a controlled set of tasks; innovative recruitment strategies that involve outsourcing mechanisms to private-sector organizations in Namibia and Kenya; and a mix of salary enhancements and non-financial incentives to retain and motivate health workers in Malawi.

Challenges

Although national HRH plans are considered essential for strengthening sustainable health systems, participants reported that there were problems in plan implementation. There were also issues around what was an appropriate timeframe for these plans and even how best to decide the timeframe. Reasons that are cited for lack of implementation included: inadequate financing, plans that were too ambitious and perhaps lack of HRH leadership, lack of political backing and inadequate core HRH specific technical capacity to take plans forward. Moreover, sufficient attention is not paid to the fact that such plans are organic documents that required revisions, modifications and new thinking to accommodate changes in policy, priorities and other emerging needs and trends.

Many countries are still struggling to overcome the impacts of some depressingly familiar HRH challenges that continue to plague their national health systems. The most pressing issues for nearly all the countries represented at the meeting include numeric inadequacy of skilled health workers; mal-distribution of existing staff, which is made worse by unplanned brain drain both regionally and internationally; low salaries and poor and often unsafe work environments; lack of career paths; education and training of questionable quality; macroeconomic public expenditure ceilings; a hiring freeze imposed by international lending agencies; and lack of a holistic approach at the country level to analyze and generate solutions that match the crisis.

In Rwanda, the salary bill for health workers and other civil servants is still considered unaffordable, resulting in new staff lay-offs and selling off government vehicles, among other drastic measures in the midst of worker shortages. At the same time, the government is pushing ahead with an aggressive health reform agenda involving decentralization of the health system, personnel and services to the district level where the management capacity is weak.

In most countries represented at the workshop, it appears that there was an absence of a succession plan to provide leadership and the much needed sense of continuity and stability for steady improvement. Nearly all the countries lamented that because key high-level policy planners and decision makers in the ministry of health are frequently transferred and replaced, since they are political appointees, it was difficult to devise policies and programs with a long-term perspective. For example, Kenya had three different permanent secretaries in a period of eight months.

Weak national capacity to absorb and use external funds remains an issue. A few countries cited corruption and poor governance and the lack of efficient and transparent administrative and financial procedures to disburse donor funds, including Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) resources. This resulted in multiple inefficiencies, including delayed implementation, resource diversions and even unaccountability. Absorption problems are also due to mismatches between internal country priorities and the conditions and preferences of external donors. Above all, chronic underinvestment in human resources means that fewer skilled people with program management and financial competencies are available to plan and use donor funds and grants efficiently and expeditiously.

Education and training of health workers continues to pose unique challenges including, unsatisfactory pre-service and in-service coordination, poor communication and even unhealthy relationships between different government ministries responsible for pre-service education. The experience of Uganda, where responsibility for pre-service education for health workers was shifted from the ministry of health to the ministry of education eight years ago, offers some lessons in this regard. Inadequate M&E technical capacity presents problems in establishing the quality of training and capturing lessons learned. There was a general feeling that lessons about better (or worse) practices and approaches are not being learned and fed into the loop of planning, implementation and continuous improvement of education and training.

HRH Areas of Future Interest

Many of the workforce challenges facing national HRH leaders and health sector leaders can be addressed only through collaborative in-country partnerships and working together across countries in the region to share knowledge, tools, promising practices and even health workers to strengthen national health workforces and promote regional health equity. As a basic principle, many countries will need to step up production of the right cadres of health providers and put in place effective ways of retaining them.

Similarly, the strategic management of human resources, particularly in the context of decentralization and increasing demand for services, is crucial and a growing area of interest. There is recognition that health workers, even if they were available in sufficient numbers, in the right composition and with adequate skills, would not produce the desired impact without a safe work environment and a strong system to manage and make them productive. For this to happen, adequate investments will be required to create professional HRH managers with skilled staff, workforce data, adequate budgets and authority to introduce and implement HRM policies, practices and procedures at all levels of the health system.

Other important areas of interest address work climate improvements, including workplace safety programs for health workers, retention, productivity, client-provider interactions, community engagement, innovative recruitment and deployment practices, as well as technical capacity to manage, monitor and evaluate programs.

Working Group Reports on HRH “Hot Topics”

During the workshop, participants were periodically put into working groups and asked to work on HRH topics of their interest. The eight topics were identified through a pre-workshop questionnaire sent to all the participants. Generally, in the working groups, participants were asked to discuss progress in this area in each country, identify challenges and agree on any conclusions that might cut across countries and could help in the future. This section provides a summary of the working group reports on each topic, and includes the working group topic descriptions that were given to guide each group. A more complete version of all the working group notes can be found in the appendix.

Human Resources for Health Strategic Planning

Working group topic description: “HRH strategic planning is the process of anticipating future staffing needs and HRH related actions (everything to do with human resources) to ensure that a sufficient pool of talented and motivated people with skills and the necessary experience (make sure people move up through the organization, gaining relevant experience) will be available to meet those needs in the long-term (and short/mid-terms).”

Many countries have either completed or are in the process of developing long-term HRH strategic plans to orient human resources investments for the health sector. This shows that the development of long-term HRH capacity is a priority for most countries. Lesotho, Zambia, Namibia and Malawi have developed comprehensive plans but, as is the case with other countries, there are considerable bottlenecks around a timely implementation of these plans.

There has been quite a bit learned about the HRH strategic planning process. Building effective alliances and actively engaging key stakeholders throughout the process was considered a critical success factor. In Zambia, short, regular meetings were held with the minister, who also kept the president regularly briefed on progress. Participants reported that flexibility, realistic timeframes and alignment with other existing plans and resources, both current and anticipated, are also important.

There is a need to regularly review the plans, taking into account changes in budgets, political infrastructure, priorities and other emerging needs to ensure they remain relevant, focused and not misdirected.

Workforce Planning and Assessment

Working group topic description: “Workforce Planning and Assessment is the dynamic process of gathering, analyzing, presenting and maintaining information on cadre profile, work site, qualifications, skills, vacancies and pre-service education graduate profiles. This process will inform policy decisions and HRH strategic planning.”

Most countries have conducted a health workforce needs assessment, several times, as a precursor or a complement to the national HRH plan. Failing to complete such an assessment before developing a long-term HRH plan or initiating a scale-up plan for health workers could ultimately undermine the effectiveness of such initiatives.

All countries have some workforce data—however, they are often paper-based and poorly kept, infrequently updated, not connected or linked, not distributed well and hard to retrieve. Timely and accurate information on the workforce will be essential to establish the existing stock, worker profiles, distribution and skills mix of providers and other support staff in the country. Further, when working with strengthening HRH information systems, it is important to start with addressing the kinds of stakeholder information needs that the system should aim to address.

Recruitment and Deployment Practices

Working group topic description: “Recruitment is the process of actively seeking participants to fill vacant positions using a variety of methods—internal job postings, advertising, search firms—and mechanisms to find and bring on those people in a timely, open, equitable and cost-efficient way. Deployment is the process and criteria used to determine assignment of place of work, composition and diversity of teams, work shifts, transfers and replacements.”

The countries cited many similar examples of cumbersome bureaucratic processes that slow down recruitment and hiring processes, and institute real barriers. For example, in Kenya, it takes between six and 12 months to fill a vacant funded position, and the same is true for other countries in the region.

But Uganda, Malawi and Zambia all reported some progress in decreasing the time it took to hire and deploy workers. Depending on the country, this was attributed to the creation of the Health Service Commission and de-linking the management of the health workforce from the wider public service.

Severe imbalances and geographic mal-distributions, especially rural-urban, still persist, resulting in unresolved and growing domestic coverage gaps in rural and marginal areas. For example, 80% of Rwanda’s physicians work in the capital city of Kigali, serving 10% of the country’s population. Locating training schools in rural areas and conducting district-based recruitment were suggested as good solutions to the problem of rural recruitment.

Hiring newly qualified health workers is also problematic. Some countries like Lesotho and Swaziland have tried bonding schemes but these are difficult to enforce. People get their education, mainly overseas or in neighboring South Africa, as part of bonding schemes but often ignore terms and conditions and just disappear. The system to track and hold them accountable is weak, and even when it exists, governments are unable or unwilling to enforce the bonding terms and conditions.

At the same time, there appear to be unemployed health workers in countries facing shortages, including Kenya, Uganda and South Africa. Participants thought that targeted and more efficient campaigns to mobilize these workers back into the health sector could generate immediate and noticeable benefits for the health sector in these countries. With donor support, Namibia and Kenya are implementing an innovative recruitment model that involves a nongovernmental outsourcing mechanism to rapidly hire and deploy providers in public-sector health facilities. Through this scheme, Namibia has recruited at least 100 nurses who were already employed within the Kenyan public health system, and the process was facilitated by both governments. It is important to point out that, although Kenya has reported a surplus of unemployed nurses, the Namibian scheme did not target this group, showing that decisions are not always driven by the reality on the ground, perceived or otherwise.

Provider Performance Improvement

Working group topic description: “Provider Performance Improvement examines provider performance issues at the specific health worker level (e.g., front-line supervisors, nurses) and includes desired performance, determining actual performance, identifying gaps, root cause analysis, intervention selection, implementation, monitoring and evaluation. Enabling factors that affect performance include feedback, incentives, clear expectations, supervision, training and tools.”

There are still huge problems around the types and quality of resources and systems that are in place to improve the performance of health providers. While performance parameters such as equitable

access, efficiency, effectiveness and quality are generally well understood and reflected in plans and approaches to strengthen health system performance, the systems and approaches that are being used, including performance measures and open appraisals, do not meet these goals.

Human Resources Management

Working group topic description: “Human Resources Management examines professional HRM capacity, personnel policy and practice, career path, promotions, HRH data and staff tracking systems.”

Deficiencies of HRM as a system pose significant problems for most countries, and it is an area that needs a lot of attention. Health providers work for months at a time without receiving their salaries or years before they receive written confirmation that they are permanent and pensionable. Several speakers mentioned that HRM was largely dysfunctional and there was little transparency within the system. A couple of participants described the system as being “fragmented” or “in complete shambles” and, as such, health workers did not feel supported, valued or even acknowledged for their work.

Nearly all countries are handicapped by poor work environments. Health providers, especially front-line staff, generally felt overworked, underpaid, ill-appreciated, poorly supervised and informed, and had limited career opportunities for personal and professional growth and development within the civil service.

A participant who was a physician recounted an interesting experience. Only 12 out of 100 of his classmates from different countries in Africa who graduated from a medical school in Nigeria in the mid-1980s are still living and working in Africa—and even those are not in direct practice, and none of them work for the public health sector. When they wanted to plan a reunion a couple of years ago, they learned that the most convenient location for all of them to meet together easily was either London or New York. They inquired about the reasons that pushed their colleagues out of their government jobs and countries, and the *main* reason for all of them was not poor pay or bad conditions but the perceived lack of a career path and opportunities to branch out and grow in their profession—in other words, they just did not feel they had a future in public service.

There was general agreement that a functional HRM system should answer at least the following basic questions that every employee brings to work each day:

1. Am I being valued and treated fairly (level of compensation, fair treatment by supervisor, attitude of colleagues, gender equity considerations and so on)?
2. Do I understand what I am supposed to do (job description, clear work plan and performance objectives)?
3. How do I know how well I am doing it (constructive and helpful feedback on performance, facilitative supervision)?
4. Who really cares about my role and contribution (whether or not the employer or supervisor cares, organizational ethos and how that matches with personal goals, values, principles, self-esteem, personal motivation)?
5. Do I have a future in this organization (career path, opportunities for growth, exciting assignments, feeling of job security)?

Retention Policies and Practices

Working group topic description: “Retention Policies and Practices include monetary and non-monetary incentives, policies and practices to manage migration.”

Countries are engaged in all sorts of schemes and plans to bolster retention of health workers. These range from salary top ups for selected cadres in Malawi to a “mountain” allowance for providers serving in hardship posts located in rugged mountainous locations in Lesotho. There are also quite a number of lessons learned—including learning about unexpected consequences of retention schemes, the difficulty of defining what constitutes a hardship post and then aligning a scheme for a particular hardship post, deciding what cadre(s) to focus on and the sensitivity and dangers of leaving cadres out, revising schemes regularly to ensure they remain attractive and purposeful, scheme sustainability issues and so on.

The Capacity Project has produced a resource paper and technical brief that review the evidence supporting retention strategies and examples of schemes used globally and synthesize lessons learned to date.

Health Care Worker Productivity

Working group topic description: “Health Care Worker Productivity includes setting productivity standards, estimating gaps, root cause analysis and intervention selection, implementation and monitoring and evaluation.”

Of all the topics, this is the one with the least amount of work going on at the country level. Perhaps there is insufficient understanding of productivity as a human resources management concept, and there may have been confusion among participants at the workshop around what productivity means and how it can actually be quantified or measured in their difficult organizational settings and unique socio-cultural contexts.

However, there appears to be a great deal of interest in and openness to examining productivity, especially in the light of chronic challenges around the issues of ghost workers, absenteeism, wastages and dual practice that are facing many countries. It appears that work related to productivity is underway in Lesotho and Zambia.

Performance Management

Working group topic description: “Performance Management ensures there is a system in place where supervisors provide clear performance expectations, monitor performance and conduct performance appraisals.”

This area is receiving a lot of attention lately. Several countries are doing something about performance appraisals or trying to introduce new ways to monitor performance more actively—or to develop a more open or transparent performance appraisal system.

Lesotho, Tanzania and Zambia have developed new performance appraisal systems. Senior civil servants in Kenya were recently required to sign performance contracts with set targets and deliverables. However, there are concerns about what happens with performance appraisals once they have been completed and doubts about their cost-effectiveness as a measure for managing the workforce.

Conclusion

This workshop revealed several compelling lessons as well as potential opportunities for further work on various aspects of the HRH situation. First, despite international perceptions and the many challenges facing countries, there are promising examples of progress in several areas, including HRH strategic plans, retention schemes, innovative hiring practices and country-level alliance building to engage key stakeholders and develop a united front for tackling this crisis.

Second, the essential process of stakeholder engagement and coordination that is necessary for building effective national alliances to champion HRH causes and implement interventions like human resources information systems, is a mechanism that is not well understood or managed in most countries. The participants mentioned that community representatives as well as educational and professional leaders were not always properly or sufficiently consulted on HRH or health reform priorities, and that will need to change.

Finally, training, recruitment, management, productivity and retention of health workers are all areas that need a lot of attention and support. Where feasible, health workers should be recruited from, supported and held accountable to the communities that they serve. Similarly, the skills mix, functions and even the type of training offered to health workers should be shaped according to health needs of local communities. For example, targeted policies and actions such as locating training schools in remote regions and recruiting both students and workers from underserved, marginalized communities are more likely to produce health workers with professional and personal ties as well as a commitment to serve in these communities.

—Ummuro Adano
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The Capacity Project
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Appendix

Topic Working Groups: Participant Notes

At the Capacity Project's HRH Action Workshop, HRH leaders from Kenya, Lesotho, Malawi, Rwanda, South Africa, Sudan, Swaziland, Tanzania, Uganda, Namibia, Zambia, the United Kingdom and the United States had the opportunity to form small working groups to address HRH issues related to strategic planning, workforce planning and assessment, recruitment and deployment practices, provider performance improvement, human resources management, retention policies and practices, health care worker productivity and performance management.

In this section, their work is presented largely as it developed in order to retain the language and contributions of individual participants. The contents have only been lightly copyedited and formatted. See the Summary of Highlights from Working Groups on page 13 for a synthesis of these participant notes.

Human Resources For Health Strategic Planning

Working Group Topic Description: HRH strategic planning is the process of anticipating future staffing needs and HRH related actions (everything to do with human resources) to ensure that a sufficient pool of talented and motivated people with skills and the necessary experience (make sure people move up through the organization, gaining relevant experience) will be available to meet those needs in the long-term (and short/mid-terms).

Notes:

1. Involve key stakeholders, including key political persons.

- a. Communication is very important: you must exchange views and define expectations with all stakeholders from the start. (Tanzania)
- b. Also, keep all stakeholders involved in strategic plan development process from the beginning. One strategy that worked in Zambia was holding short, regular meetings with the minister. In this way, the permanent secretary understood the background, process and goals thoroughly and was able to act as an HRH champion when presenting to the wider audience (e.g., President). (Zambia)

2. Strategic plans should be flexible to allow for unknowns and assumptions.

- a. One strategy for staying flexible that worked in Uganda was to start by identifying resource availability (present and future/projections). In this way it is possible to decide on a timeframe for resource allocation and use, while allowing for flexibility for other areas. (Uganda)
- b. Another strategy for this is using a longer term framework, while keeping strategic plans in the shorter term. For example, a ten-year framework and a five-year strategic plan. (Namibia and other countries)
- c. Strategic plans should leave room for revision; they should be reviewed regularly—preferably annually. (UK)

3. Timeframes should be in line with national plans and training production periods.

- a. It is important to have a clear long-term vision that is well-aligned with national plans. Uganda, as well as the five-year HSSP, has a long-range plan that extends to 2025. (Uganda)
- b. Millennium Development Goals (MDGs) can provide a good basis for timeframe development. (Malawi)
- c. Strategic plans don't necessarily have to be "aligned" with other national plans, but care should be taken to ensure that they are not "misaligned." (Uganda)
 - i. While it may sometimes be difficult to align strategic plans to (all) relevant national plans and training production periods, it is, however, critical that strategic plans are not misaligned with already established plans, their timelines and strategic goals.
- d. In addition to long- and short-term plans, strategic plans should be linked to mid-term national plans. (Zambia)
- e. There is no "rule of thumb" for developing a timeframe. (Uganda)

f. Staffing projections may be made for a longer period than the actual strategic plan, due to the time lag in training. (UK)

4. No one strategy can be successfully implemented on its own.

a. All strategies within the larger strategic plan are inextricably linked. You must therefore link them throughout planning and implementation processes to ensure success. (Zambia)

5. Strategic plan must be realistic.

a. Is it affordable? Is it do-able? (Tanzania)

6. Many countries still need assistance in developing HRH strategic plans.

a. This has not been fully addressed. (Swaziland and other countries)

7. Strategic plans should be reviewed regularly to accommodate changing assumptions.

a. For instance, the current famine in Kenya requires health care workers to work in feeding stations, which is resulting in a shortage of health workers in HIV/AIDS clinics. This shortage is being addressed through hiring of more workers. What will happen to these workers when the famine ends? (Kenya)

b. Changes in budgets. (multiple countries)

c. Change in political infrastructure. (multiple countries)

8. HRH situation analysis needed for development of HRH strategic plan (but level may depend on time and resources available).

a. Workforce assessment is an important basis for writing a strategic plan. However, if there is no time to undertake an assessment, this can be incorporated as a component of the strategic plan, and included in the next review. (United Kingdom)

b. Include workers outside the borders: for example, in South Sudan the Diaspora of workers should be included in the assessment as well as workers living in refugee camps and all other types of displaced workers. (South Sudan)

c. Assessment should also include qualitative data on service delivery satisfaction—attitude is important. (Tanzania)

9. Assumptions in strategic plans should be clear so that outcomes can be defended.

a. Funding, worker availability, etc., are a few of the assumptions that may be made in writing a short-, mid- or long-term strategic plan.

Workforce Planning and Assessment

Working Group Topic Description: Workforce Planning and Assessment is the dynamic process of gathering, analyzing, presenting and maintaining information on cadre profile, work site, qualifications, skills, vacancies and pre-service education graduate profiles. This process will inform policy decisions and HRH strategic planning.

Issues:

1. Establish integrated information systems.

- a. Ensure HR information systems are aligned and linked with other information systems, e.g., MOF, public service.
- b. Ensure that information is not retained at central level and that districts have access to information for HRH decision making and to stimulate workforce development in districts.

Lesotho:

- a. Decentralization—new, ongoing process.
- b. HRH data system links to districts for input. In the process of linking to MOF and MOPS information systems.
- c. HRH officers at district level are graduates and they collect data at that level, which includes CHAL health workers.
- d. Use UNIQUE system right now. May move to Oracle in order to generate more reports.

2. Developing and maintaining HR Information System (HRIS) requires building capacity to ensure reliable data. (HRIS needs to include information on pre-service and in-service training.)

Uganda:

- a. MOPS has an integrated personal system for all public service. HRD now working to collect its own HRH information and connect with MOP.
- b. Problem with inaccurate data; double counting. Some health workers are not employed and there is no system to capture info/data. Data collection happens but data quickly gets old.
- c. Need tools/computers at lower levels to capture data; Capacity Project helping with this.

(Government HRH planning needs to include private-sector health workers. These are often not included in government on payroll or personnel systems.)

Lesotho:

- a. Each program, district and hospital has a HRH officer; help capture and manage data.
- b. Has HRH assessment centers to determine if officer has right skills, attitude to work in HR.

3. **Need dynamic information/data systems—currently working on integrating the health database to that of Public Service and Ministry of Finance.** (All countries have HRH databases. Some have HR info systems.)

Lesotho:

- a. Putting in better systems at district level.

Zambia:

- a. Relies on MOHHRIS, which is not regularly updated. DFID supported payroll management and establishment of a control system. Setting up IFMIS in MOF—attempting to integrate HR information in HMIS.

4. **Before the development of an HR Information System it is useful to determine what information is needed/essential and for what purpose. [It is possible that we] could develop a good system, which is too complicated to use.**

Kenya: MOH (as in Uganda) at the audit stage.

- a. Disjointed in assessment, don't know number or cadres.
- b. Health workers recruited and deployed by public service committee.
- c. Have a payroll system but a problem of ghost workers.
- d. Have good pre-service nurses info from the Nursing Council of Kenya.
- e. Have weak in-service records—no tracking system; assumed that this HRH function happens at lower levels but doesn't happen.
- f. Weak linkages on HRH between centre, province and districts. (Capacity Project is helping.)

5. **Continuing professional development important for HRH workforce planning to anticipate and meet health needs.** (HIV/AIDS is a big driver in assessing continuing education.)

Zambia:

- a. Physician shortage—need to know how many trained, in what area.

Lesotho:

- a. Expanding MRIS system to include skills and link training to career development and succession plans.

Uganda:

- a. Has Continuing Professional Development (diaries) program in place but systems not in place to track and tie to performance.

6. Linking information to health sector strategic plans (between units).

(Minimum staffing number to meet objectives of strategic plan.)

(Who analyzes information? Must be done regularly.)

Lesotho: Has minimum staffing standards.

Rwanda:

- a. Reforms empower districts to recruit from lower cadres. MOH and Public Service working together to recruit.

(Donor influence in recruitment.)

7. Workload indicators still not working with the current country experience (flag for more discussion Friday).

(How to set minimum standards?)

8. Assessment of health workers outside the employment system.

Malawi and Rwanda: Announcements inviting them to register.

Recruitment and Deployment Practices

Working Group Topic Description: Recruitment is the process of actively seeking participants to fill vacant positions using a variety of methods—internal job postings, advertising, search firms—and mechanisms to find and bring on those people in a timely, open, equitable and cost-efficient way. Deployment is the process and criteria used to determine assignment of place of work, composition and diversity of teams, work shifts, transfers and replacements.

What issues are we facing?

1. Malawi (FBO perspective):

- a. The government has provided scholarships for college, and the students who accept these scholarships are then deployed to wherever the government chooses—often the students do not want to go where they are deployed, and they make many excuses as to why they shouldn't have to go. If they are forced to go, they often choose to leave for private sector. Although a legal bond is signed, compliance is very low because there is no method to ensure that they follow through on their agreement.
- b. The demand for health professionals is more than the supply. Because of this, it is very difficult to deploy—hospitals do not get the staff that they need.
- c. There is no collaboration with the Ministry of Education, and as a result many pre-nursing/pre-medical students do not take the required classes in secondary school that are necessary to enter nursing/medical schools.
- d. The supply is so low and the demand is so high that everyone who is trained is hired.

2. Lesotho (MOHSW perspective):

- a. The government has introduced a policy to take nursing graduates and other allied health workers directly from school straight into the work environment, which is helping to increase the numbers of people working in the country. Other medical profession positions have been more difficult to fill, as doctors are not trained in Lesotho (there are no medical schools in Lesotho) and instead go to South Africa (SA) to receive training. After training, most doctors decide to stay in South Africa or go elsewhere, and do not return to Lesotho.
- b. SA has a policy that if a doctor is trained in South Africa and wants to obtain a South African medical license, they have to stay at least one year in South Africa after school. After that year, many doctors are well situated in South Africa, well-paid, and not willing to return to Lesotho.
As a result, Lesotho has begun hiring doctors overseas, such as India.
- c. Nurses who received their nursing training for free (on scholarship) in Lesotho are required to work in Lesotho for two to three years in return; however, many do not follow through on those contracts and leave the country for higher paying jobs in other countries. There is a significant lack of infrastructure in the Lesotho government to follow up on and enforce these signed contracts.
- d. The Public Service Commission (PSC) appoints all positions within the government, even those positions in other Ministries. These Ministries, including the Ministry of Health, do not have a choice of who they hire (they are allowed to sit a representative on the hiring panel, however). The PSC tends to only look at a person's qualifications when considering them for employment/deployment, but does not necessarily look at the needs of the employing Ministry.

3. Swaziland (MOH perspective):

- a. While the Ministry of Health is represented in interviews for new employees, the Public Service Commission makes all final decisions. The process can take “ages.”
- b. Promotions can take 6–12 months to occur.

4. Kenya:

- a. Ministries are allowed to recruit and fill a position (temporarily) for up to one year, before the employee needs to be interviewed by the Public Service Commission to see if they are qualified. If the PSC determines they are qualified, they can be officially hired.

5. Rwanda (Capacity Project perspective):

- a. HRH reform is occurring at the national level with the creation of an HRH database.
- b. The country does not have enough professional health workers to recruit from. Many health workers were lost during the 1994 genocide. Many nursing schools that were developed after the genocide to address the nursing shortage were never officially credentialed. As a result, many Rwandan nurses who went to those schools cannot compete on the national/world level.
- c. Beginning this past week, decentralization has happened to the government of Rwanda, with reallocation of the central government to the district level.
- d. The government’s recruitment and retention strategy is to maintain an essential and qualified workforce with increased salaries. Some incentive strategies are to reduce unnecessary staff and consequently increase the salaries of essential staff, as well as re-examine and re-shape career paths.
- e. NGOs in Rwanda are not allowed to hire public-sector doctors; they must hire ex-pats instead. NGOs are allowed to hire all other health workers, however. Thirty to forty percent of health workers in Rwanda are employed by NGOs, as encouraged by the MOH. This is working for now, but it is not a sustainable option.

6. Tanzania/Zanzibar:

- a. The academic board approves all health training.
- b. There is a tendency of the MOH to absorb all health professional graduates.
- c. There is competition with the Ministry of Education, which offers professionals a teaching diploma after two years of school (nursing school is three years, medical school is four years), as well as higher salaries than those offered to health workers.
- d. The MOH reports all health professional graduates to the Civil Service Commission, and then the CSC must give their approval for the hiring of the graduate.
- e. Salary and working conditions in Zanzibar are not as good as on mainland Tanzania.

7. Tanzania:

- a. In 1994, the government was told by the World Bank/IMF to freeze employment hiring, In 1997 a health-sector reform allowed a partial waiver of the freeze, which continues today.
- b. Salary schemes are being revamped throughout the country.

- c. Strikes often happen in health clinics among professional health workers and general health workers.
- d. Only 30% of health care positions in Tanzania are filled.
- e. The nursing shortage has affected even the nursing schools, causing a decrease in the number of teachers available to lead the classes.

8. Zambia:

- a. The process for Zambians becoming health professionals is very much like the process in Malawi.
- b. For non-Zambians, however, the process is much more difficult. A non-Zambian hoping to fill a health position must be recommended to at least three different levels in the Ministry of Health before they can be hired. This process can take years. There is quite a lot of bureaucracy.
- c. For Zambians employed in the public sector, delay and bureaucracy are also major problems. People often work for three to four years without a formal appointment by the Public Service Commission, unless someone is working on their behalf within the PSC.

9. Kenya:

- a. The Public Service Commission hires all public-sector health workers, but has delegated lower-level professional recruitment to the Ministries (however, the PSC has the final say in who gets hired).
- b. There is a larger supply of health workers than a demand for them.
- c. Appointments are competitive; ads are placed in newspapers.
- d. However, before recruiting can begin for a certain position, an embargo has to be lifted (due to the ongoing hiring freeze) and to do that you need to get the permission of the DPM, located in the president's office. This process can take an average of two to three months.
- e. Advertisements are not always useful because Kenya is a big country and the mail is not very reliable, particularly when trying to advertise in a rural area. Kenya has not been decentralized—everything is done from Nairobi. When letters are being sent out to invite people for interviews, the mail can often get lost or misdirected. Therefore, the process can be a “bit long.”
- f. There are some rural areas in Kenya where health workers just refuse to work.
- g. Although Kenya has said that there is a surplus of nurses, they have discovered that there is a mismatch between what the MOH demands of nurses and the actual skill sets of the nurses graduating from the schools. The nursing schools do not pay attention to the secondary school grades of their entrants, but the MOH does, and that can sometimes lead to people not being hired after graduating from nursing school as a result of not having met the secondary school grade requirements of the MOH.

10. South Africa (USAID perspective):

- a. It takes a long time to hire health workers, due particularly to the long time it takes to train them (three years for paramedics, four years for nurses). Why can't we deploy students during training? Why can't we think of new ways of training health workers to include on-the-job training?

- b. There is a great deal of regional movement among the health worker cadres (particularly in Lesotho/Swaziland/South Africa). There needs to be increased recognition of that movement by the various countries affected.
- c. MOHSW is not adapting their job categories and skill categories for those jobs that address the TB, HIV/AIDS and other emergent needs of the communities served. They are training for a work environment that is extinct, or at the very least is focused on US/UK health needs (i.e., geriatrics), not African needs.

11. Zanzibar/Tanzania:

- a. Doctors go to the mainland for education, and some never return. Over the past two years, however, many have returned to Zanzibar. No reason for this change is known.

12. Zambia:

- a. Issues of deployment remain a problem. The government thinks the retention scheme should be rural-based—the MOH is slated to begin examining whether to give bonuses for working in rural areas. Other incentives for health workers to serve in rural areas include the installation of solar panels in homes, and the provision of motorbikes, bikes and other forms of transportation. Individual districts have also begun to come up with their own ways to motivate their staff, with salary increases, etc.
- b. Now the MOH is considering extending this retention plan to ALL health workers, not just those with the highest education (i.e., doctors, bachelors-prepared nurses).

13. Rwanda (Capacity Project perspective):

- a. There is a career ceiling in place—the lack of career paths stunts the growth of the health worker workforce.

14. Kenya:

- a. The MOE revised the ceiling so that teachers could reach the ultimate of the career ladder/salary level while still staying in the classroom setting. It is a hope that the MOH will follow in the footsteps of the MOE.

15. Rwanda (Capacity Project perspective):

- a. People are being recruited/re-assigned by the government and placed into positions that they are not suited for. Nurses are being put in charge of clinics and large scale projects, without the necessary training or support.

What is working?

1. Malawi (FBO perspective):

- a. Most nursing schools in Malawi are located in rural areas. There is a tutor incentive package to entice tutors to teach in these schools.
- b. Many nurse tutors are female and married and husbands do not want to relocate to rural areas, so the training colleges now offer great incentives, like free housing and subsidized utilities being paid for each nurse tutor.
- c. If doctors work in a Christian Health Association of Malawi (CHAM) hospital for two to three years, CHAM will pay for them to go back to school for a higher degree and/or for specialty training.

2. Kenya:

- a. A forum has been designed where stakeholders (i.e., MOE, MOH) will come together to develop a standard of education and recruitment so that there is increased harmony and decreased miscommunication and surprises.
- b. There is a planned collaboration between the universities and the public sector to monitor how long doctors spend going back to school (and consequently leave the health workforce) to receive specialization training (right now, there is no way to know how long a doctor will be back at school, receiving training for specialization).

3. Zambia:

- a. The MOH, under the Central Board of Health (CBOH), was working outside of the central government. CBOH has now been abolished and their functions have been transferred back to the MOH.

4. Tanzania:

- a. The government is looking for permission to employ registered nurses in higher-level positions, such as teachers in nursing schools, as heads of community clinics, etc.

5. Tanzania/Zanzibar:

- a. The competition between the MOE and the MOH has begun to be addressed, and will hopefully be minimized.
- b. An HRH plan is in place, and the MOH is looking forward to sending staff for training.

6. Rwanda (Capacity Project perspective):

- a. In an effort to stop donor poaching, NGOs cannot hire doctors from the public sector—the government is following through on enforcement of these rules.
- b. A detailed retention/recruitment strategy has been proposed to the MOH.

7. Kenya:

- a. The MOH is hoping to start localizing health worker recruitment so that job advertisements and recruitment can be more specific.

8. Lesotho (MOHSW perspective):

- a. The MOH has revived the nursing assistants program at Lachas'nek and Mafeteng. The students have been selected from those areas so that they can be deployed in those same districts after graduation.

9. Malawi (FBO perspective):

- a. The establishment of the Health Service Commission has been helpful, and has helped speed up the process of recruitment, employment and deployment.

South Africa (USAID perspective):

- a. The government is considering hiring private firms to recruit and hire health workers instead of relying on the MOH to do all the recruitment/deployment, which would ultimately speed up the employment process.

Provider Performance Improvement

Working Group Topic Description: Provider Performance Improvement examines provider performance issues at the specific health worker level (e.g., front-line supervisors, nurses) and includes desired performance, determining actual performance, identifying gaps, root cause analysis, intervention selection, implementation, monitoring and evaluation. Enabling factors that affect performance include feedback, incentives, clear expectations, supervision, training and tools.

Issues:

1. Training.

- a. Not coordinated (no national training strategies and vertical programs).
- b. Selection criteria not appropriate:
 - i. Per diems as motivator.
 - iii. Favoritism.
- c. Same staff attending workshops.
- d. Short courses not recognized as part of performance appraisals.

2. Negative attitudes of health workers in hiring, promotions and appraisals:

- a. Staff workload and environment

3. No info systems for tracking our HR—numbers, vacancies, training, etc.

4. No feedback of research—results and sharing new numbers. No feedback from those attending courses.

5. Lack of definition on measuring performance.

6. Job descriptions not clearly defined and expectations not clear.

7. Promotion due to seniority not performance and skills based.

8. HIV/AIDS affecting performance.

What is working?

1. Kenya:

- a. Continuing education program in the hospitals, upgrading nurses to diploma through on-site training.
- b. Tracking of the staff training and incentives used to improve performance.
- c. Distance learning program (self-directed learning manuals, mentors).
- d. Upgrading of certificate nursing—diploma nursing.
- e. Mentoring of the HIV/AIDS Clinical Officers coming in under the Clinton Foundation.
- f. Definition of the “Essential Service Package,” determining the functions and HRH standards. (Kenya, Lesotho and Uganda)

2. Uganda:

- a. Developed performance standards and placed under mentors at the districts for use in support supervision to health workers in lower-level health facilities.
- b. ICT: Palm Pilots used as monitoring tools and for transmitting data.
- c. Develop hospital policy and performance standards for all levels of health facility delivery.

3. Zambia and Lesotho:

- a. Accreditation system for FBOs.

What is not working?

1. Lesotho:

- a. Parallel Training Programs—degree level nursing v. diploma level nursing: Degree level nurses are paid more, but are not as hands-on as the diploma level nurses.

2. Upgrading the health workers but not remunerating them accordingly (several countries)

Conclusion:

1. Need for a strategic plan for performance improvement that includes:

- a. Clear standards
- b. Job descriptions
- c. Performance expectations
- d. Supervision

Human Resources Management

Working Group Topic Description: Human Resources Management examines professional HRM capacity, personnel policy and practice, career path, promotions, HRH data and staff tracking systems.

Issues:

1. General Issues

- a. HRM issues are the root cause of the poor performance in the health sectors of most of the countries.
- b. HRM and development units are fragmented within the Ministries and do not have the capacity to work with each other.
- c. If HRM issues are not addressed within the health sector, the rest will “all be noise”—retention plans will not work unless we sort out the HRM components first and foremost.
- d. In many countries there has been an increase in litigation cases within the MOH related to poor management of staff, especially regarding their benefits.
- e. Many countries’ HRM systems are “in shambles”—recently appointed HRM employees are finding themselves constantly “mopping up” problems. Country governments need guidelines for what the MOH needs to do to make sure that there is better communication and better efficiency at the HRM level.
- f. Many MOH staff are poorly managed and are not working at their full efficiency and capacity (leaving early, coming in late, etc.).
- g. There is a major difference between just a dedicated HRM department and a dedicated and supported HRM department.
- h. The various levels of government have changed and shifted over the years, and while the central level HRM may be working in some countries, the HRM at the various lower levels is often disconnected and sometimes non-existent.
- i. People are being put into positions that they are not qualified for. People who do the strategies are not working with the people who deal with personnel. There is a true disconnect. It is a structural issue—we should not be relying on a few motivated personalities to do the work, but we should instead structure it to automatically happen.

2. Country Strategies

- a. In Uganda, the HRM/HRD units are fragmented, the practice is to post people but not to follow up to see if the people they hired have received real training on HRM issues. Support of HRH is not a priority, and there is no concern about what the training is of those people that they place in positions. A doctor may be placed in the HR department who has no training or experience in HRH issues. There are only a few copies of HRH policies/protocol manuals in the MOH, and they are all located in the offices of top government officials. The people who would benefit from reading the manual do not have easy access to it. This is de-motivating. The information needs to be “brought down to the right people.” The people who produce the HRM documents keep the documents and do not circulate the information.

- b. While Uganda has an open appraisal system, it is very hard for supervisors to tell the truth. Appraisals are usually done on paper and pushed through the system where they get lost until many months later when the employee is finally able to see it.
- c. In Uganda, promotions occur as a result of one interview with someone off-site that you don't know or work with—if you have a bad interview, you may not be promoted, even though you are doing an excellent job. People are not receiving the opportunities for the training that would/should eventually lead to them getting a raise.
- d. In Zanzibar, there is no transparency within the HRH system—most health employees do not know what their career paths consist of. WHO assisted in producing an HRH document for the region, but it has not been updated since 2003.
- e. In Rwanda, when working for an NGO an employee normally receives the policies and protocols of the organization. This is not true for employees within the MOH. In the private sector, employees receive appraisals. Appraisals are rare in the MOH—if they are done, they are not done truthfully. Employees are instead always given the highest marks on appraisals (even if they do not deserve it) because the MOH fears that a negative appraisal will cause people to quit.
- f. Malawi recently completed a study of retention of workers in the rural system in which issues of career path and promotion were clearly shown to be very important.
- g. Malawi wants to begin to track health workers within the country—but there is no current “living” system in place to track these workers.
- h. Lesotho is now beginning to examine the labor law and how it relates to the current HRM issues within the country.
- i. In Lesotho, for those departments in the public service system that have been restructured, there is an open appraisal system where people do get feedback. You first assess yourself, and then your supervisor assesses you. A third party can be called in to address any conflicts. An HRH database has also been completed, and the payrolls from the different levels of the health sector are used to monitor that database.
- j. It is very difficult to retrieve appraisals that are done on paper.
- k. In Kenya, there are not enough qualified staff to address HRM issues for the MOH. There are currently more than 6,000 promotions that are pending within the public sector due to the lack of HRM capacity to handle the paperwork/evaluations. There is a serious issue of facilitation. There isn't the capacity to implement the basic things that easily motivate people. Health workers have to worry about so many things, including how they will achieve a promotion in a timely manner. It doesn't matter how well an employee is trained or how well they are supervised—it is hugely discouraging if they have to travel 200 miles to sign a piece of paper (an evaluation/appraisal) or follow up on a lost paycheck.
- l. The biggest cause of HRM problems is the lack of computerization for HRM issues. Because of the lack of tracking, employees feel lost in the system and feel insecure. They know that as soon as their papers go into the system they are lost—some people received promotions many years after they left.
- m. Swaziland has just started a new tracking system, but it is making everything more confusing because there has not been adequate training.

3. Potential Solutions

- a. A computerized HRM data tracking system to see where health sector employees are, their skills and all other pertinent information.
- b. Everyone who works for HR should be required to have some sort of HRH background, training and/or an understanding of working with people.
- c. Develop a “shadow system” for monitoring HRM at the different government levels, not just at the one central level.
- d. Career paths: In many countries, you have people coming into a position and just stagnating. This is very demoralizing. People leave because they are frustrated. Some cadres, such as nursing assistants, have no movement. This needs to be changed.
- e. In Lesotho, quite a number of in-service trainings are offered so that, while there may not be a career ladder within certain cadres, workers can receive the training they need to trade cadres.
- f. There is no credit given for amount of work experience (a nursing assistant who works for ten years cannot move into a nursing position). Even those that receive a higher degree (i.e., MPH) do not have any positions to move into. In Zambia, the MOH has realized this and is trying to figure out where to put people who have received higher degrees.
- g. In Uganda, the MOH is beginning to expand the structure of district work places to address those doctors who have achieved specializations. There is still not enough space for them, though. They have to wait for a position, which is very frustrating. The more educated, more experienced people are leaving Uganda.
- h. A successful HRM system should be able to answer these five questions (regardless of sector, type of job, etc.)—if it cannot, it is not working effectively.
 - i. **Am I (the employee) being treated fairly in terms of compensation and in terms of the environment in which I am working?**
 - ii. **Do I know what I am supposed to do?** (There is nothing as bad as lack of clarity—job descriptions and performance expectations are necessary.)
 - iii. **Do I know how well I am doing my job?** (Is there a system of feedback? Is the feedback reliable?)
 - iv. **Who cares?** (Would anyone miss me if I didn’t come to work?)
 - v. **Do I have a future in this organization?** (Is there a career path? Are there opportunities for personal and professional development?)
 - (1) Thoughts/comments on these five questions:
 - (a) In Uganda health workers are taught about how to address HIV, TB, malaria, etc., with their patients, but they are not taught how to take care of themselves—this falls within the issue raised by the question “Who cares?”
 - (b) In Kenya, the MOH has not examined the impact of HIV upon health workers, and is not addressing the support these people need. Perhaps the MOH should begin to provide counseling services for those health workers affected/infected with HIV/AIDS and establish a psycho-social support system as well.

Retention Policies and Practices

Working Group Topic Description: Retention Policies and Practices include monetary and non-monetary incentives, policies and practices to manage migration.

Key Issues and Questions:

1. How to decide on the content of a retention package:

- a. Monetary incentives
 - i. Government can choose to offer monetary incentives across all sectors, with specifics of package to be determined by each sector independently. It has proven effective for the health sector to offer salary increases across all cadres, and has eliminated much abuse of monetary incentive system. (Kenya)
 - ii. It is important to note that many times monetary government incentives originally planned to be awarded across cadres are, in reality, given only to workers at the managerial level and not to the front-line/hands-on health workers. (Tanzania)
- b. Non-monetary incentives
 - i. Can include no/low-interest loans. (Zambia)
 - ii. Can include housing and vehicle loans. (Zambia)
 - iii. How do you choose which cadres will receive incentive packages, if funding is not available to provide for all cadres? Cadres not included in incentive packages may lose morale or even quit. What non-monetary incentives can be used to combat this issue (Zambia)? This problem also occurred in Malawi, and proved very de-motivating for health workers not included in incentives packages.
- c. Timeframe for incentives should be considered changeable in accordance to changes in the labor market
- d. It is important to understand the down-side of some incentive packages:
 - i. Some incentives can cause unforeseen problems in other areas, thereby exacerbating the problem instead of helping to fix it. (Tanzania)
- e. What advice is available on convincing governments to allocate incentive packages for health workers?
- f. It is important not only to retain people but also to provide incentive packages that will attract new health workers. (Uganda)

2. How to define “hardship posts”? (Uganda)

- a. Hardship posts can be positions:
 - i. Anesthesiologists
 - ii. Pathologists
 - iii. Doctors are sometimes reluctant to study for hardship positions because they are not as marketable as hands-on public health positions. (Tanzania)

b. Hardship posts can be locations:

- i. Rural areas
- ii. Hard-to-reach urban areas
- iii. Often, hardship-based incentive packages do not provide enough salary increase to cover actual living costs (transport, communication, education, etc.) in hardship post (Lesotho)

c. A system of review must be in place as hardship posts change.

d. What advice is available on strategies that can be used to attract health workers to hardship posts? (Uganda)

e. Many workers simply do not want to work for government, regardless of the location/ position available. (Rwanda)

- i. To address this problem, incentive packages in Rwanda include greater increases for workers in rural posts, performance-based incentives (regardless of post) and training selection preference is given to rural workers.

3. Managing staff absence.

a. Information system to track staff.

- i. This information system can also be used to identify what groups of health workers are leaving (age, sex, etc.) and design incentive packages to target these specific groups. (UK)

b. Must attract people who have ability to do the work once employed. Workers who do not have required abilities often do not work the full number of hours required for the job. (Tanzania)

c. Supervision.

d. Incentives targeted to getting people to fill out proper paperwork when terminating:

- i. Health workers will leave with no notification, causing “ghost workers.” (Swaziland)
- ii. Often, managers do not want to take responsibility to enforce policies on absconding workers. (Swaziland)
- iii. To combat this problem, it has proven effective to terminate all benefits (including job and Social Security) simultaneously when staff members disappear for more than thirty days. This increases personal responsibility to follow proper channels. (Namibia)

e. Better coordination between Government and donors.

- i. Many health workers are lost to the private/NGO sectors. (Namibia)

4. Special incentives packages to be performance-based.

a. Tried this in Malawi, but no performance measurement standards were defined. Therefore, in reality incentives were not performance-based. (Malawi).

5. Site-specific recruitment. (Kenya)

- a. Post location is included in advertisement for position. (Kenya)
- b. This increases likelihood of retaining workers, especially in hardship posts. (Kenya)

6. Targeting retention policies toward at-risk groups.

- a. Must identify at-risk groups.
 - i. In Lesotho, they have an Information System that allows human resources to identify workers who are migrating by age, sex, etc. (Lesotho)
- b. Should include health workers being seconded out to donor organizations.

7. Try to deal with the underlying problem—don't just go for the "easy option." (e.g., incentives) (UK)

- a. Pay reform. (UK)

8. Sustainability of incentives.

- a. Policy must be clearly articulated from the outset, or you can get "locked-in" to providing incentives on a longer-term basis than planned. (Lesotho)

Health Care Worker Productivity

Working Group Topic Description: Health Care Worker Productivity includes setting productivity standards, estimating gaps, root cause analysis and intervention selection, implementation and monitoring and evaluation.

1. Key Issues:

- a. How to measure it? What to measure?
- b. Need for enabling environment
 - i. Infrastructure
 - ii. Support Staff
 - iii. Supplies
- c. Attitude/Motivation
- d. Supervision

2. What Is Working?

- a. Selecting trainees based on motivation (Lesotho)
- b. "Ownership" of departments clearly defined (Kenya)
- c. Clear job descriptions (Lesotho)
- d. Time studies to identify activity standard (Zambia)

3. Ideas to Increase Productivity

- a. Clear public-private partnership policies on part-time practice
- b. Clear selection for staff motivation
- c. Pre-service level: teach empathy/have empathy mentors
- d. Set policy guidelines and standards for:
 - i. Equipment, workload and staff; Include numbers, quality and outcomes
 - ii. By level
 - iii. By local context
- e. Be able to measure and report
 - i. Include appraisals
 - ii. Include client satisfaction

Performance Management

(Lesotho, Kenya, Zambia, Rwanda and Tanzania)

Working Group Topic Description: Performance Management ensures there is a system in place where supervisors provide clear performance expectations, monitor performance and conduct performance appraisals.

1. Issues:

- a. Rwanda—pockets of performance management in different districts but no clear PMS in MOH.
- b. All countries have PMS systems, but they are not operational in most countries other than Lesotho and Uganda (but there are some issues in those two countries as well). Tanzania has an Open Appraisal System, but for higher levels.
- c. Most countries have appraisal systems developed, but they are complicated and people don't know how to develop workplans.
- d. All countries have sector plans rolled up to departmental and district levels—not yet rolled down to individual workplanning other than in Lesotho and Uganda.
- e. Kenya—workplans are related to budget but delayed releases of funds/budgetary constraints have affected achievement of targets.
- f. Closed Performance Appraisal Systems (PAS) in place in some countries and now moving to an open PAS. (Zambia, Uganda and Tanzania)
- g. In most cases, supervisors are particularly not knowledgeable about jobs of employees, are not empowered to monitor performance, are absent for trainings and are not giving the necessary support to their employees.
- h. Introduction of PMS has been linked to restructuring to ensure that there are clearly defined jobs. (e.g., Zambia—however, other strategies are in place to monitor performance at the department and individual levels)

2. What has been tried/what has worked:

- a. Kenya—performance contracts have been introduced for higher levels and will be tested in 2006.
- b. Uganda, Zambia—moving from a closed to an open system of appraisal.
- c. Lesotho—mentoring has been implemented, but has failed due to high attrition.
- d. Job profiling done in Lesotho but is a problem when it comes to nurses.
- e. Zambia—monitoring performance and doing target setting through weekly meetings.
- f. Rwanda—undertaking radical restructuring exercise and transfer of workers to local government where districts will have operational budgets and autonomy to recruit. The MOH will establish targets with indicators for services and facilities, will be responsible for meeting targets and will be remunerated according to performance.

- g. **Uganda**—has area team strategy that is working well to monitor performance—also uses General Assembly/Joint Review meetings to monitor performance. Zambia and Tanzania also have Joint Review Meetings working well.
- h. **Tanzania**—Open Appraisal System has been introduced and is working for higher levels of government.
- i. **TEHIP Project**—good example of what is working in Tanzania in that they empower districts (two districts) to manage health packages—very successful, and there are plans to scale it up to other districts.



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