# HUMAN RESOURCES FOR HEALTH COUNTRY COMMITMENTS: CASE STUDIES FROM THE DOMINICAN REPUBLIC, KENYA, MALI, AND UGANDA

IntraHealth
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Because Health Workers Save Lives.

# TABLE OF CONTENTS

# FOREWORD

## Two Years Later: Did the Recife Human Resources for Health Commitments Make a Difference?

As we reach the second anniversary of the World Health Organization's Third Global Forum on Human Resources in Health (HRH) in November 2013 in Recife, Brazil, we look back and consider the differences made as a result of the Forum. Have we, the global community, kept our promise to extend quality health care to all populations everywhere? Have we extended services that are affordable and accessible to those most in need?

Health workers are the face of the health care system, whether they work in the public sector, the private sector, or as part of a community organization. IntraHealth International is committed to making sure that health workers around the globe are present, ready, connected, and safe so they can provide quality care to all communities, and that they are working in high-functioning supportive health systems. Over the past two years IntraHealth has partnered with national governments and their stakeholders in Africa, Asia, and the Americas to help honor and take action on the HRH commitments they presented in Recife.

Four countries have shared their experiences over the last two years in defining, implementing, and measuring their HRH commitments. In the case studies presented here, the experiences of the Dominican Republic, Kenya, Mali, and Uganda provide insights on how global accountability, such as commitments made to international stakeholders, can catalyze action and advance national health objectives. The experiences described in the studies may inform other countries as they assess their own progress over the last two years and plan future strategies to reach universal health coverage and achieve the post-2015 Sustainable Development Goals.

In these four countries, progress has been made through stakeholder engagement, harmonization of strategies, devolution of management, and improved monitoring practices. The global attention and energy behind the HRH commitments allowed governments to bring stakeholders together to support, implement, and demonstrate progress. Much is yet to be done. Community systems can be further developed and better managed and nurses adequately equipped to lead frontline teams. In addition, community health workers can be counted and recognized to maximize their contributions. In general, greater investments can be made to maximize efficiencies and create stronger health systems.

Through an improved global health workforce, many countries reached, and some even exceeded their targets for the health-related Millennium Development Goals. Other countries did not reach their goals, but made progress. Even so, the global community has not met the health care needs of hundreds of millions of individuals. Lack of access to trained and supported health workers still leads to preventable maternal, newborn, and child deaths. Women's health is

compromised due to lack of reproductive services and unmet contraceptive need. Many people, especially those in marginalized groups, do not receive HIV prevention services, care, and treatment.

As we enter the post-2015 era in global health, we look back with satisfaction at the progress made to date, but also are challenged by the work we have left to do. We have come a long way, but the journey continues. It is our hope that the experiences shared here will help guide us all in leveraging global commitments to further develop the health workforce and equip them to advance national health objectives and contribute to achieving the Sustainable Development Goals and helping the world reach universal health coverage.

–Pape Gaye,
President and CEO, IntraHealth International

# TRACKING HUMAN RESOURCES FOR HEALTH COMMITMENTS: PROGRESS IN THE DOMINICAN REPUBLIC

# BACKGROUND

The government of the Dominican Republic is steadfast in its commitment to improve the health and well-being of its population. Concentrated efforts over the past few decades to strengthen the implementation of national policies, health sector reform, integrated service delivery models, and a cross-sectoral approach have contributed to significant improvements in health indicators. The HIV incidence rate (the number of new HIV infections per year per 100 people aged 15-49) has witnessed a 92% decline in the last decade (from 0.12 in 2001 to 0.01 in 2012) (United Nations [UN] Statistics Division 2014). Universal access to reproductive health care is increasing: contraceptive prevalence among married women aged 15-49 rose from 56.4% in 1991 to 71.9% in 2013 while unmet need for family planning declined from 19.4% to 10.8% during the same period (CESDEM and ICF International 2014; UN Statistics Division 2014). The under-five mortality rate and maternal mortality ratio decreased by about half from 1990–2013 (UN Statistics Division 2014).

While these trends point in a positive direction, the government recognizes that much more must be done to overcome challenges within service delivery. For example, despite the fact that 95% of pregnant women attend four or more antenatal visits and 99% have institutional deliveries, the country's maternal mortality ratio (100 maternal deaths per 100,000 live births) is well above the regional average of 85 maternal deaths per 100,000 live births (UN Statistics Division 2014). One of the government's critical pathways to pursue the nation's health goals is, therefore, to improve the quality of the health service delivery system (Ministerio de Salud Pública 2013a). Central to the national policy on quality in health is a focus on strengthening the systems that govern human resources for health (HRH) to address health workforce challenges such as weak supervision, poor provider performance, inadequate clinical capacity, health worker absenteeism, and health worker maldistribution (Ministerio de Salud Pública 2010, 2013a; Rathe and Moliné 2011). To this end, the Ministry of Health is aggressively implementing its 2013–2017 HRH Strategic Plan, which emphasizes strengthening human resources management policies, systems, and practices. The purpose is to ensure availability of a workforce with the professional and ethical competence needed to carry out its responsibilities and create an enabling environment for health workers to perform effectively (Ministerio de Salud Pública 2013b). Given the critical linkages between a strong health workforce, quality of care, and service utilization for health impact, donors and partners such as the Pan American Health Organization (PAHO), World Bank, and the United States Agency for International Development (USAID) through its global Capacity*Plus* project (led by IntraHealth International) have assisted the Ministry in its comprehensive efforts to improve how HRH are planned, produced, deployed, supported, and retained.

It is against this backdrop and guided by a firm belief that "there is no health without a workforce" (Campbell et al. 2013) that the government, as represented by the three ministries that oversee and manage the health workforce (the Ministries of Health, Public Administration, and Higher Education), declared its country's five HRH commitments to the global community at the World Health Organization/Global Health Workforce Alliance (WHO/GHWA) Third Global Forum on Human Resources for Health held in Recife, Brazil in November 2013 (see Table 1). This paper describes the political environment that enabled

the HRH commitments to be developed with stakeholder support, the actions taken to implement said commitments, and the progress achieved to date.

## Table 1. Dominican Republic's HRH Commitments, by Indicator and Timeline[1]

| No. | Commitment | Indicator | Estimated Completion |
|---|---|---|---|
| 1 | Support measurement and monitoring of regional HRH goals 2007–2015 and study in-depth the areas where the country has achieved the most progress | Application of PAHO system to monitor regional HRH goals (PAHO 2013) | September 2014 |
| 2 | Develop processes for application of an effective HRH management model with emphasis on: <br> • Promoting the Health Career Law <br> • Institutionalizing an HRH management policy that impacts productivity, service quality, and universal coverage, such as policies for performance management, recruitment, and incentives | Reintroduction of the Health Career Law | June 2014 |
| 2 | | No. working groups to develop the bylaws in the Health Career Law | September 2014 |
| 2 | | Mapping of the HRH management processes | March 2014 |
| 2 | | Existence of a policies and procedures manual for HRH management | December 2014 |
| 3 | Identify mechanisms to elevate the skills and professional level of the health workforce by 2015 | Mapping of stakeholders involved in HRH training | December 2014 |
| 3 | | Situational analysis of HRH training | March 2015 |
| 4 | Form a critical mass of leaders with specialized skills in HRH policy, planning, and management at the central, regional, and local levels | Numbers trained in HRH policy, planning, and management at the central, regional, and local levels | March 2015 |
| 5 | Strengthen the Ministry of Health's strategic oversight over the health workforce through the advancement and convergence of policies related to health systems, services, and cross-sectoral coordination to revitalize primary health care and achieve universal health coverage | Existence of strategic plan for the Ministry of Health HR Directorate in its new oversight role | December 2015[2] |
| 5 | | Availability of HRH policies and procedures manuals for the central, regional, and local levels | |
| 5 | | Establishment of cross-sectoral coordination working group | |

[1]Translated from the original (Ministerio de Salud Pública 2013c).
[2]Due to a typographical error in the submitted commitments template, the date for completion was incorrectly listed as 2013.

# METHODOLOGY

The methodology employed to review progress made on the country's five HRH commitments was descriptive and qualitative in nature. Of great utility was the first-hand experience of many of the co-authors as key leaders, implementers, or contributing members to the processes and approaches involved in meeting the declared commitments. Key informant interviews and informal discussions with HRH stakeholders provided deeper understanding and description of the background, processes, and actions undertaken to implement the commitments. Although no formal desk review was written, the case study description was supported by the collection, review, and analysis of available documentation—including government and project plans, documents, and reports. The information presented in this article was also validated with national stakeholders in the relevant ministries or institutions.

# CASE DESCRIPTION

The Ministry of Health has made substantial progress in meeting the country's HRH commitments. Specific details on the policy processes, actions, stakeholders involved, and results of each of the HRH commitments are provided below.

## Political Environment

In 2007, the government, along with other countries in the Latin American region, adopted a regional initiative in partnership with PAHO/WHO (2007) to strengthen human resources for health across the Americas for the period from 2007–2015. As part of that initiative, 20 goals were defined, which are organized according to five critical challenges identified in the Health Agenda for the Americas and the Toronto Call to Action (PAHO 2005). The goals encompass actions for long-range HRH policies and planning for the effective education, equitable distribution, retention, and motivation of the health workforce to meet the population's health needs. The orientation around these goals and the political will behind this HRH initiative established an environment within the Dominican Republic that was favorable to human resources investment and poised to articulate commitments that would align existing goals and activities to specific commitments articulated toward the achievement of universal health coverage (UHC).

The systems needs and HRH gaps within the country were well understood, and the mechanisms were in place, resulting from government engagement in the Toronto Call to Action, for national and local leadership and stakeholder support, as well as for implementation of the Recife commitments. When the GHWA invited the government to submit commitments as part of the 2013 Global Forum, the country was able to join many others in committing to specific HRH accomplishments for which it was willing to be accountable. With the broader support of RESSCAD (Health Sector of Central America and the Dominican Republic) and COMISCA

(Council of Central American Ministers of Health) behind HRH development, and a regional structure in place, the government was able not only to define commitments for Recife, but also to enter into those commitments with confidence that it would be able to sustain support and follow-through.

## RESULTS

### Commitment 1: Support measurement and monitoring of regional HRH goals

Despite advances in other areas of commitments made in Recife, a comprehensive process for monitoring and evaluation (M&E) of the health workforce has not been developed due to the lack of an effective process and national electronic information management system. PAHO is supporting the Ministry of Health's Directorate of Human Resources to measure and monitor 20 regional goals for HRH, defining the national baseline in 2011, and completing an intermediate assessment in 2013. The Ministry is conducting the final evaluation of the regional HRH goals in 2015, with PAHO support (Dal Poz et al. 2015). The final evaluation will include key informant interviews and utilize the same instruments and methodology as used in the baseline and intermediate assessments.

The intermediate measurement of HRH indicators and progress toward achievement of the regional HRH goals, conducted in May 2013, identified critical challenges and goals to address them. It was this mid-term measurement that directly informed the development of the Recife HRH commitments. The Ministry of Health then developed a framework prioritizing the challenges, assigning responsible parties, and defining the deliverables needed to advance each goal. Achievements to date toward regional HRH goals 6, 7, and 8 include:

- Establishing, equipping, and deploying health workers in primary health care facilities
- Training teams of providers from primary health care facilities
- Obtaining participation of key individuals in PAHO's virtual diploma course on health services management, although the Ministry of Health has not documented the specific number of health workers or teams who have completed training.

*Outcome:* To date, despite Ministry of Health dedication to strengthening the health workforce, the only established process in place to track health workforce developments and improvements is the M&E framework developed for the 20 regional goals for HRH (PAHO/WHO 2007). This process is not an institutionalized information management system, but rather a process of interviewing key actors according to the M&E guidelines for measuring the 20 regional goals. However, to support progress toward reaching its HRH commitments, the Ministry's HRH Management Unit developed a framework for measuring progress toward achieving the HRH commitments (Table 1), and aligned those indicators with the measurement

activities of the 20 regional goals.

## Commitment 2: Develop processes for application of an effective HRH management model

A pivotal component of the Ministry of Health's vision for strengthened HRH management was the ratification of the Health Career Law by Congress in June 2014 (Comisión Permanente de Salud 2014). The Health Career Law serves as a legal, regulatory, and administrative framework detailing the employment relationship between the government and health workers, and classifying and ranking salary and wage structure and job functions. As such, the Law provides a solid foundation and increased authority for the Ministry to press for needed policy changes and resource allocations to enable a more effective management system. This commitment aligned closely with the regional HRH goals under Challenge 4 of the Toronto Call to Action, "Create healthy work environments and encourage commitment to the mission to ensure the provision of quality services for all population." The commitment leveraged additional support to a specific legal mechanism that the national government had designed to meet Challenge 4. Likewise, the political pressure to demonstrate progress toward Challenge 4 as well as resolve conflicts between the health care unions and the Ministry of Health enabled the national government to move the proposed legislation through the approval process.

To move the draft Health Career Law forward, the Minister of Health made an official request to Congress to expedite the process of enactment and public hearings on the bill. The Minister presented the bill for discussion at public hearings and later to the congressional committee for review (PAHO, Ministerio de Administración Pública, and Ministerio de Salud 2014). The bill was passed by the Executive Branch in November 2014, thus achieving the first indicator toward the second HRH commitment.

With support from PAHO and Capacity*Plus*, the Ministries of Health and Public Administration also spearheaded the development of bylaws to ensure successful implementation of the Health Career Law. The process included drafting a detailed action plan with roles and responsibilities for various stakeholders (such as training institutions, the Ministry of Higher Education, and health professional bodies), divided among seven working groups that meet regularly to continue development of the bylaws. Once fully implemented, the Health Career Law should result in greater job stability and improved working conditions for public sector health workers in the country.

A second component for developing and institutionalizing an effective HRH management model was the December 2014 launch of a policy and procedures manual for HRH managers, which clearly maps out the various HRH management processes to be followed. All departments within the central Ministry of Health have been implementing the manual. The Ministry's HRH Directorate has applied the manual to guide recruitment, selection, and hiring processes, which has resulted in more transparency and fairness in HRH management practices at the national level.

**Outcome:** Fostering leadership in middle management has been key to creating demand for transparency and implementation that will lead to lasting change. With support from Capacity*Plus*, the HRH Directorate strove to create a cadre of trained and empowered human resources (HR) managers. This commitment has resulted in a critical mass of advocates for increased transparency, developers of HR management tools, and implementers of new or improved management processes. Implementation of these tools and processes is conducted with more ease and fewer obstacles as these managers will remain in their posts longer than high-level managers who are more likely to be reappointed or moved elsewhere.

## Commitment 3: Identify mechanisms to elevate the skills and professional level of the health workforce by 2015

As part of this third commitment, the Ministry of Health is leading a continuing education program aimed at increasing the competencies of general practitioners and nurses. This online course, developed with financing from the International Development Bank (IDB) in partnership with the Autonomous University of Santo Domingo, is part of a regional continuing education plan.

With the continuing education effort, the Ministry has planned a mapping of stakeholders involved in HRH training. The proposed mapping of stakeholders and a situational analysis to identify HRH training opportunities and gaps across the nation are planned for late 2015 but have not yet been carried out, as the needed resource allocation has yet to be confirmed. The HRH Directorate is actively identifying the resources needed for the mapping and training needs assessment.

**Outcome:** More than 900 health workers have enrolled in the inaugural two-year course to specialize in primary health care, which began in April 2014. A group of 25 facilitators were formed to teach the continuing education program.

## Commitment 4: Form critical mass of leaders with specialized skills in HRH policy, planning, and management at the central, regional, and local levels

As part of its commitment to form a critical mass of leaders with specialized skills in HRH at all levels, the Ministry of Health added a management course to its ongoing training initiatives in HRH policy, planning, and management for HR managers. The government established a diploma course in HRH management, provided through the National Institute of Public Administration, to professionalize the cadre of regional HR managers. The program empowers HR managers to change their role from administrators of personnel and paperwork to proactive managers who plan, deploy, support, and manage an effective workforce. Currently, the HRH management course is available to HRH managers from all hospitals in the country. The HRH

management training has become institutionalized and sustainable through the National Institute of Public Administration's assignation of a budget of $16,000 per year and training of a government-supported team of facilitators to conduct training.

Through a partnership between the Ministry of Health and PAHO, a second course has been developed, which trains HRH managers in the Ministry to improve their competencies in primary health care planning. This online course is offered through the PAHO Virtual Campus for Public Health.

Additional data on the number and types of other HRH training courses and workshops being conducted at the national and local levels will be collected by the Ministry of Health as part of the training situational analysis planned for late 2015 (see Commitment 3).

*Outcome:* In less than two years since the HRH commitments were announced in Recife, the government has seen measurable achievements with regard to Commitment 4. Since the inception of the HRH management course in 2014, 69 regional HR managers have graduated from the National Institute of Public Administration program, thus building country capacity through a critical mass of leaders with specialized HRH management skills. The government has recently begun to enroll managers within the Ministry in PAHO's Virtual Campus management course, with six managers having completed the training since 2014.

## Commitment 5: Strengthen strategic oversight of health workforce through policies for health systems, services, and cross-sectoral coordination

The government has invested in strengthening the leadership role of the Ministry of Health in oversight of the health workforce through the development of a strategic HRH plan, dissemination of the newly finalized policies and procedures manual for HRH management to the regional and local levels, and establishment of a cross-sectoral coordination working group.

Immediately following the Global Forum in November 2013, the Ministry of Health and its HRH Directorate moved quickly in December 2013 to initiate development of a new strategic HRH plan, updating the previous 10-year-old strategic plan. The result—the Institutional Strategic Plan of the General Directorate for Human Resources (DGRH 2013–2017)—is a regulatory instrument intended to inform all actions and processes related to human resources management under the Ministry of Health. Upon return from Recife, the director of the HRH Directorate, who was designated by the Minister of Health to sign the country's HRH commitments declaration, streamlined the process of finalizing the strategic plan by hosting a variety of planning workshops. The workshops included representatives from the nine regional health directorates, HR managers from the national hospitals, and technical staff from the national HRH Directorate and the General Directorate for Coordination of Public Health Care Services. The participants worked together to review and finalize the plan's objectives and activities, which include HRH planning, financing, development, performance management, and

evaluation. The finalized strategic plan began to be implemented in January 2014. An annual operational plan, which is used as a tool to guide the day-to-day work of the HRH Directorate, was developed alongside the strategic plan and updated in January 2015.

The HRH management manual described under Commitment 2 is being used to align and coordinate health systems and service policies between the central Ministry of Health and the decentralized service delivery arms through the General Directorate for Coordination of Public Health Care Services. To support application of the manual at the regional and facility levels, a dissemination workshop was held in April 2015 for 35 regional HRH managers and HRH analysts and assistants from the country's largest hospitals.

The Ministry of Public Administration has formed a cross-sectoral, coordinating working group to spur action, negotiation, and discussions related to HR planning. The working group has 20 members, including the Vice Minister of Planning and Development from the Ministry of Health, the Vice Minister of Quality from the Ministry of Public Administration, as well as other representatives from the respective HRH Directorates of the Ministries of Health and Public Administration, and the General Directorate for Coordination of Public Health Care Services. The group meets monthly to discuss all HRH initiatives and processes being undertaken by these agencies. A work plan developed to guide these discussions is reviewed and updated at each meeting. For example, the interagency working group is promoting the process for development of the bylaws guiding implementation of the Health Career Law and the definition of the organizational structure for the Ministry of Health and the national hospitals.

**Outcome:** The government was able to achieve a new strategic plan that for the first time has clearly delineated the roles and responsibilities of the two HRH regulatory bodies (of the national Ministry of Health and the service delivery arm). The HRH management manual advanced the application of the Law 123-15, which created the National Health System and established the separation of functions, conferring on the Ministry of Health regulatory oversight over HRH and defining the Ministry's management processes.

## DISCUSSION

Given the multisectoral nature of health systems and HRH, the government's decision to send representatives from each of the three ministries (health, education, and public administration) that have oversight and management responsibilities over the health workforce to the Third Global Forum on HRH represented an impressive start to the country's HRH commitment process. The three government representatives, already having a strong commitment to HRH development following the Toronto Call to Action, were highly motivated by their participation and the sharing of experiences and lessons learned at the Global Forum. Upon their return, each representative oriented other leaders within their respective ministries to the Recife Political Declaration on Human Resources for Health and the specific commitments presented by their government at the Forum. They aligned the commitments with ongoing strategies, leveraged

the influence of the commitments to move objectives forward, and successfully coordinated roles and activities, as demonstrated by the application of the various initiatives across more than one commitment.

Overall, the Ministry of Health has made great progress toward its five declared HRH commitments, achieving many of the targets by the estimated completion date. These commitments energized ongoing system strengthening efforts, and helped build a strong foundation for a human resources management system that more effectively plans, recruits, deploys, and supports the health workforce to ensure equitable primary health services for the population.

One key example of how a stronger management system coupled with empowered HRH managers and leaders and renewed regulatory frameworks, policies, and procedures can make a difference is the Ministry of Health's payroll cleaning process. To increase transparency in the health sector and productivity of the health workforce, the Ministry of Health, in collaboration with the Ministry of Public Administration, has continued to lead a payroll cleaning process to identify and eliminate "ghost workers"—individuals who receive a salary but are not actually working—to free up financing that can be better invested to hire and deploy health workers to provide services where they are needed. Analysis of the payroll system by the Ministry of Health revealed nearly 10,000 ghost workers (out of approximately 59,000 employees) along with over 2,200 workers who had been "in the process of retirement" for over three years. These inactive workers were preventing the Ministry from being able to fill service delivery positions with qualified candidates. Through January 2015, the Ministry eliminated 3,913 ghost workers, resulting in savings equivalent to $9.1 million per year. The Ministry also fully retired 2,241 staff, thus opening their posts to new hires. The Ministry of Health is reinvesting the savings to hire new health workers for primary care facilities, purchase medicines and supplies, and repair health facilities. These changes, coupled with the elimination of user fees and a rise in the number of subsidized members in the national health insurance plan, will be able to contribute to expanded coverage of primary health services.

This case study highlights three aspects that have been central to the Dominican Republic's successful achievement of its HRH commitments. These features of success, which will help to ensure sustainability, include establishment of regulatory frameworks, HRH capacity building, and multisectoral coordination. With regard to the first element focusing on regulatory frameworks, ratification of the Health Career Law is a positive step but demands that the mandate to regulate and support the health workforce continue into the future. Second, the clear definition and institutionalization of policies and procedures and the training of HRH managers with necessary HR management skills and capacity establishes a sound environment in which the health workforce can perform its service delivery responsibilities. Finally, leveraging the momentum gained to date and taking the achievements even further will depend on the continued close involvement and dedication of the multisectoral actors who are directly and indirectly responsible for the health workforce.

# CONCLUSION

The government is striving to improve the health and well-being of its population through a focus on improved primary health care services and universal health coverage. Paramount to this initiative is the strengthening of the health workforce and the management systems needed to create an enabling environment for effective performance and high-quality service provision. Recognizing the importance of HRH systems strengthening and having already laid the fundamental groundwork, the government was eager to declare its HRH commitments at the Third Global Forum on HRH in Recife.

To maximize the momentum gained from the Global Forum, the government immediately set to work on implementing its stated commitments. Through a clear focus on policies, processes, actions, and needed stakeholders, the government has remained relatively on-target to achieve its commitments by the estimated dates of completion. A critical component for countries to achieve their HRH commitments is to either develop a results framework that defines progress and results indicators associated with completion dates, or capitalize on existing HRH frameworks. Other countries may benefit from examining the successful experience of the Dominican Republic, which linked its HRH commitments to the existing framework for the 20 regional goals for HRH, using that framework to guide and facilitate its advancement toward the Recife commitments.

For future "lessons learned," it should be noted that because the government used indicators derived from the 20 PAHO regional goals for HRH, the indicators did not specifically measure the achievement of the Recife commitments but rather have measured progress toward the PAHO goals. Some were process indicators and some were results indicators, and both types of indicators had varying degrees of clarity. It may be helpful for other countries to review indicators for clarity, specificity, and redundancy. It is also recommended that the Dominican Republic, and all countries pursuing HRH development and service delivery improvements, establish an M&E framework that tracks the impact of HRH improvements on service delivery quality and health outcomes. The ability to link investments in HRH to measurable improvements in quality services will advance the government's intentions as outlined in the national policy for quality and will support negotiations for resources with evidence of return on investment. Overall, the progress demonstrated by the Dominican Republic in developing and implementing HRH policies, systems, and regulatory frameworks, building HRH capacity, and more broadly engaging other sectors has laid a solid foundation for the country to continue to advance its health goals through a well-placed, motivated, and skilled health workforce.

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# KENYA MAKES PROGRESS TOWARD HRH COMMITMENTS IN A DEVOLVED HEALTH SYSTEM

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# INTRODUCTION

The Third Global Forum on Human Resources for Health (HRH) (Global Forum) sponsored by the Global Health Workforce Alliance (GHWA) and the World Health Organization (WHO) was held in Recife, Brazil in November 2013. Kenya made five HRH commitments to the global community during the Global Forum. The commitments stipulated HRH interventions that Kenya would undertake toward achieving the health sector strategic goals included in Kenya's Vision 2030 (Government of the Republic of Kenya 2007), the Constitution of Kenya 2010 (Republic of Kenya 2010), and the Kenya Health Policy 2012–2030 (Ministry of Medical Services and Ministry of Public Health and Sanitation n.d.). By aligning and integrating HRH strategies into its broader country health vision, Kenya hopes to attain the highest possible standards of health in a manner responsive to the needs of the population.

## Background

Many challenges face the development of Kenya's health workforce, including severe shortages of essential cadres, unequal distribution of health workers, low and uneven remuneration across cadres, and poor working conditions. Key cadres that face severe shortages include physicians, nurses, clinical officers, laboratory technologists, nutritionists, health records officers, and radiologists. Whereas the WHO recommends a minimum of 2.3 physicians, nurses, and midwives per 1,000 people, Kenya—with a population (in 2014) of 44 million people—has a ratio of only .1 physician and 1.2 nurses and midwives per 1,000 persons.

Within the context of the national shortage, the unequal distribution of health workers creates further inequities. Health worker shortages are most severe in rural and remote areas. For example, as of 2012, Mandera County (a hardship area in northern Kenya) has .9 public sector nurses per 10,000 population and Kwale County (a rural coastal area) has 3.7 nurses per 10,000 population (Barker et al. 2014). In comparison, Kisumu County (an urban area) has 7.3 public sector nurses per 10,000 population (Barker et al. 2014). These distribution inequities are most acutely felt in Kenya's arid and semi-arid (ASAL) region. While health workforce issues affect the quality of service delivery countrywide, service coverage across the ASAL counties of Northern Kenya (Garissa, Isiolo, Lamu, Mandera, Marsabit, Samburu, Tana River, Turkana, Wajir, and West Pokot) is notably worse, with the lowest ratio of health workers to population in the nation. The ASAL counties make up approximately 35% of the Kenyan population (REGLAP 2012), but only 2% of physicians, 2% of nurses, and 5% of clinical officers serve in these counties. With its unique and primarily rural geography, low population density, nomadic peoples, inadequate infrastructure, weak telecommunications, and insecurity, there are many factors in the ASAL region that constrain access to quality services and contribute to extremely poor health outcomes. These conditions also discourage recruitment and retention of potential and existing health workers.

Low and uneven remuneration across cadres is another factor exacerbating health worker shortages. Physicians in Kenya have long complained of inadequate remuneration, and Kenya has battled recurrent physician strikes, resignations, and emigration of health professionals to other African countries. These same remuneration complaints also come from nurses, clinical officers, and other health workers, with similar consequences.

Finally, unsatisfactory working conditions have led to diminishing health worker productivity and retention. The poor working conditions include long working hours, inadequate medical equipment, and limited occupational health and safety measures at the facility level.

To address these HRH challenges, Kenya's Ministry of Health presented five commitments at the Global Forum in Recife (listed below).

**Commitment 1: Devolve the Human Resources for Health Interagency Coordinating Committee (HRH-ICC) to 47 counties to oversee the implementation of HRH strategies in the counties with linkage to the existing national coordinating mechanism, by 2015.**

The rationale behind devolving the national HRH-ICC to the counties is to strengthen county governments under the Constitution of Kenya 2010 and provide a forum at the county level in which HRH discussions are held and through which national policies are disseminated and domesticated toward county implementation. The devolution is expected to lead to better uptake of best practices in health workforce management across the counties and the adoption of a more conducive and motivating environment for health workers, resulting in improved service delivery and better health outcomes.

**Commitment 2: Recruit at least 12,000 facility-based new health workers per year by 2017, thus a total of 48,000 health workers, to support facility and community-level health service delivery.**

This commitment is geared to address shortages of health workers with respect to need and to address maldistribution. The health worker numbers are disaggregated across counties by cadre.

**Commitment 3: Recruit at least 40,000 new community health extension workers (CHEWs) by 2017 to support community-level health services and the One Million Community Health Worker (CHW) Campaign, to which the Government of Kenya has signed on.**

In 2006, Kenya developed a community health strategy to ensure that health promotion and disease prevention services would be undertaken at the community level to promote better health outcomes for Kenyans. The strategy was revised in 2013 (Ministry of Health 2013a), but rollout of the updated strategy has been hindered by inadequate numbers of CHWs. In 2013, the country developed a scheme of service for community health personnel, which recognized CHEWs as an official health worker cadre. The third HRH commitment is expected to boost the number of CHEWs as part of the health system and to support services at the lowest level of care. The Kenya Scheme of Services for Community Health Services Personnel (Directorate of

Public Service Management 2013) supports recruitment, career progression, and remuneration of this cadre by the counties.

**Commitment 4: Increase spending in the health sector on HRH, beyond staff salaries and allowances, by 2017.**

The Government of Kenya, following devolution, undertook an assets assessment that included the workforce, and plans are underway to utilize the findings to guide health sector staff rationalization for more efficient and effective service delivery. The Ministry of Health, with the support of partners, has helped select counties to undertake a baseline budget analysis. This analysis has been instrumental in the development of HRH budgeting tools that will provide guidelines to the counties so that they can budget their health workforce costs beyond remuneration alone to include costs involved in employee welfare, employee relations, reward and recognition strategies, work climate improvements, and management of personnel records, including eRecords and bulk filing systems. This fourth commitment aims to put more resources toward addressing the non-salary-related barriers to recruitment, retention, and performance, such as staff welfare issues, occupational health and safety improvements, and performance incentives.

**Commitment 5: Promote public-private partnerships for health financing and establish mechanisms for mutual benefits for a better health workforce and quality service delivery.**

This commitment strives for engagement among government entities and private-for-profit, faith-based, and nongovernmental organizations to partner and provide financial support on key HRH issues at both the national and county levels.

# METHODOLOGY

To document Kenya's experience and progress to date toward reaching its HRH commitments, the authors carried out an initial desk-based analysis of the national HRH commitments as well as an informal review of complementary grey literature and national policy documents. Authors also had first-hand involvement in activities to advance Kenya toward its commitments, and they gathered and validated qualitative information from interviews and informal discussions with HRH stakeholders and relevant actors.

# CASE DESCRIPTION

## Political Environment

In recent years, the government of Kenya has been shaping its national policy direction to move toward universal health coverage, including measures outlined in the Kenya Essential Package for Health (Ministry of Health 2006) and the National Hospital Insurance Fund (NHIF 2015).

However, Kenya's health system has continued to face critical HRH weaknesses, and global evidence points to a direct correlation between the size of a country's health workforce and its health outcomes (WHO 2010).

Recognizing that strengthening HRH needed to be a central component of efforts to strengthen the national health system, in 2008 the government developed its First National Human Resources for Health (HRH) Strategic Plan (2008–2012). This plan was followed by the current Kenya Health Sector Human Resources Strategy (2014–2018) (Ministry of Health 2014). These two strategies, developed in collaboration with global partners, mark the first steps taken by the government to strengthen the health workforce to deliver services more effectively and efficiently.

The HRH commitments announced at the Global Forum were developed by a technical working group comprising the Ministry of Health, development partners, faith-based organizations (FBOs), medical training institutions, and regulatory bodies. The commitments were validated at a meeting of the national HRH-ICC in October 2013. To advance the commitments, the government carried out a number of steps to orient and engage country stakeholders, define benchmarks toward progress, establish a monitoring and evaluation (M&E) framework, and begin to track progress.

## Stakeholder Orientation and Engagement

Kenya is undergoing devolution of its health sector as part of the new Constitutional Order (Republic of Kenya 2010). In 2013, the government held its first general elections under the new constitution, which set up national and devolved governments, including 47 new county governments. During the formulation of the HRH commitments in 2013, the 47 county governments were in their formative stages, and a number of them lacked the county health departments, health ministers, and other key staff necessary for the national government to actively engage them in development of the commitments. Subsequent to the Global Forum, it was necessary to appropriately market and widely disseminate the HRH commitments to sensitize key county actors and achieve their buy-in, adoption, and participation in the implementation of the commitments. The national government was able to engage with the county governments and other stakeholders during this dissemination process, packaging the HRH commitments in easy-to-read brochures targeted to various audiences and circulated to the Ministry of Health leadership and wider stakeholders at both the national and county levels (Ministry of Health 2013b).

## Political Support

After announcing the HRH commitments at the Global Forum, the government took the following steps to expand and sustain political support.

1. Incorporation of the commitments in the Kenya Health Sector Human Resources Strategy (KHSHRS) 2014–2018 (Ministry of Health 2014): The signed commitments were incorporated into the KHSHRS 2014–2018, with inputs articulated into the Strategy's M&E framework. The signature page of the commitments, as signed by the Cabinet Secretary for Health, was attached as an appendix to the KHSHRS 2014–2018.

2. Dissemination of the commitments at the national HRH-ICC meeting: Following the commitments' dissemination at the national level, the HRH-ICC formed a technical working group (TWG) to develop an action plan for implementation of the commitments. The TWG is chaired by the Human Resources Management (HRM) Director at the Ministry of Health and includes various national-level implementing partners.

3. Dissemination of the commitments at subnational inter-county HRH–ICC fora: At the subnational level, the commitments were disseminated through nine inter-county HRH-ICC fora, where the commitments were discussed and the HRH brochures were disseminated. Each of these fora was attended by a broad range of subnational stakeholders, including County Executive Committee members for health (a.k.a. county health ministers) and chief officers of health.

4. Website dissemination: The HRH commitments brochure was posted on the Ministry of Health website and on the HRH Repository hosted by the Kenya iHRIS website (Ministry of Health 2013b).

## M&E Reporting Process

The Ministry's HRM Department developed a reporting process to monitor and evaluate the commitments' implementation countrywide, which is used at the national and county levels. With technical support from the IntraHealth-led and USAID-funded Capacity Kenya and HRH Capacity Bridge projects, county health teams—including County Executive Committees, chief officers of health, and county HRH officers—were trained to use a reporting framework and a monitoring and evaluation tool.

The 47 counties are grouped into nine county clusters, each of which is guided by a county cluster HR manager. Through the M&E reporting process, data collection is carried out at the county level, facilitated by the county cluster HR managers in collaboration with county HRH officers. Quarterly reports are generated by county payroll managers and chief officers of health, approved through the inter-county HRH stakeholder fora, and channeled to the national HRH-ICC Secretariat and the Ministry's HRM Director. Moving forward, data will also be sourced from the Ministry of Health Community Health Unit and various other Ministry departments as necessary, and will flow through the National HRH-ICC Secretariat to the HRM Director.

## Implementation

To facilitate the implementation of the commitments, the interventions were incorporated into the Kenya Health Sector Human Resources Strategy. The strategy and the commitments were

subsequently disseminated to stakeholders and county governments. Devolving the HRH-ICC to 47 counties was a priority. The 47 counties were clustered into nine geographical areas and former administrative structures, and the nine clusters were supported to develop cluster-level terms of reference as well as a schedule for hosting cluster meetings.

The county governments also filled staffing gaps by recruiting health workers through the county public service boards in addition to transitioning into their county payroll contract health workers supported by partners as per government schemes of services. Further, the national Ministry of Health disseminated the recently approved scheme of service for community health personnel to county governments toward recruitment of CHEWs and lobbied them to support setting up more community health units to operationalize community health services.

Efforts have been made to increase health sector spending on HRH beyond staff salaries and allowances by 2017 through development and dissemination of the Kenya HRH Staffing Norms and Standards, which aid in rational staffing at the facility level. In addition, a county HRH unit and job profile for county HRH officers was developed to guide counties in staffing of the health department for better health workforce management, including HR supervision. Budget analyses were undertaken to guide the development of HRH budget tools, including budgeting flow charts and checklists to assist health departments with budgeting. To improve records management, the Ministry of Health approached partners to support review and preparation of health worker files for transfer to the counties as well as to digitize files into eRecords. Policy guidelines to support use of ePersonnel records are under development by the national Ministry of Health. Infrastructure norms and standards are also under development to establish expectations for the appropriate health worker work environment for service delivery.

The government has launched initiatives to promote public-private partnerships for health financing, encouraging development partners and the private sector to invest in HRH development and service delivery by establishing mechanisms that could be used to mobilize resources. Possible mechanisms include revolving loan funds; initiatives geared toward restructuring Kenya's national health insurance fund (NHIF); centralized procurement of medical equipment for critical services; and free maternal, neonatal, and child health services (e.g., the First Lady's Beyond Zero Campaign).

## Implementation Monitoring

Kenya's HRH commitment progress reports will serve to show progress against each of the commitments at the national, county cluster, and individual county levels (see Figure 1). The reports will also be used to guide health sector decision-makers on additional investments and supportive or corrective actions required to further advance the country's commitment objectives. This information will be aggregated and shared through the national HRH-ICC and inter-county HRH-ICC meetings. The aggregated progress reports will also be shared globally, as part of Kenya's commitment to accountability, at the next GHWA/WHO Global Forum on Human Resources for Health. In the interim, progress updates will be shared with the WHO upon request. Ultimately, the tracking of progress will help the government understand how

achievements toward the HRH commitments contribute to improved service coverage, quality, and use, as well as longer-term improvements in health outcomes.
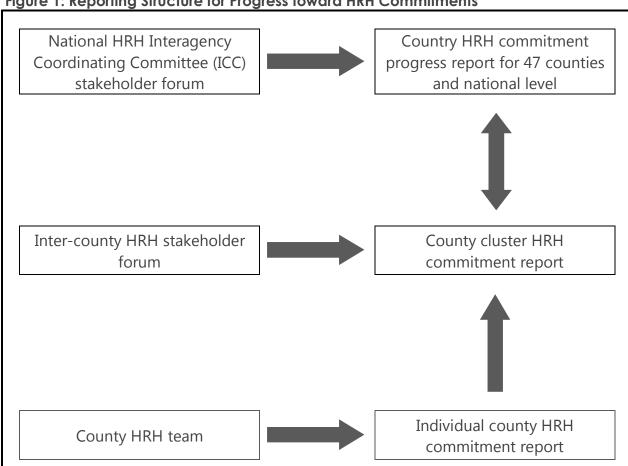
**Figure 1: Reporting Structure for Progress toward HRH Commitments**

| National HRH Interagency Coordinating Committee (ICC) stakeholder forum | → | Country HRH commitment progress report for 47 counties and national level |
|---|---|---|
| Inter-county HRH stakeholder forum | → | County cluster HRH commitment report |
| County HRH team | → | Individual county HRH commitment report |

## RESULTS

For the period from November 2013 to December 2014, four significant achievements were attained. First, the Ministry of Health successfully sensitized stakeholders in all 47 counties, fostering their buy-in and recruiting their engagement in the implementation of the commitments.

Second, the Ministry created a TWG specifically dedicated to supporting the counties to implement the commitments, resulting in the development of implementation plans in each county. Due to the time and resources that the government invested in tailoring its messaging about the commitments, sharing information at national and subnational meetings, and providing support through the TWG, all 47 counties now are collecting data and monitoring progress toward reaching the commitments.

Third, the Ministry aligned the HRH commitments with existing policies and Constitutional directives, thereby positioning the commitments to be integrated into the country's health strategies. By linking the commitments to existing health workforce strategies, Kenya has been able to harmonize development initiatives, avoid multiple parallel initiatives, target resources, and leverage the accountability mechanism of the HRH commitments to catalyze progress toward national workforce objectives.

Finally, the Ministry of Health developed an M&E framework that will mark progress toward each achievement with measurable indicators. The Ministry also trained county leadership on how and when to collect data, document the indicators, and track and report progress. The first reports were generated in the summer of 2015, but a longer period of tracking and recording will be required before meaningful progress can be demonstrated. Because each county government is an independent entity, progress toward achievement of the commitments will vary from one county to another, and the national government may have little influence on their progress or timeline. Nonetheless, the national government will continue to provide strategic guidance on the HRH commitments as well as on the Kenya Health Sector HR Strategy.

With political support secured through sustainable mechanisms for prolonged engagement, and with an accountability structure in place to monitor progress and highlight areas needing attention, it is anticipated that the commitments will be implemented with widespread participation and optimum expectation for their achievement. Since 2013, progress has been made toward all five commitments. Key achievements from the July 2015 report are summarized below in Table 1.

## Table 1: Progress toward Achieving Kenya's HRH Commitments (as of July 2015)

| Commitment | Target | Implementation Level |
|---|---|---|
| 1. **Devolve the Human Resource for Health Interagency Coordinating Committee (HRH-ICC) to 47 counties by 2015**. | a. Devolve HRH-ICC to counties. | • Devolved into nine county clusters that ensure participation by all 47 counties. |
| | b. Establish a mechanism for linking the national HRH–ICC and county HRH–ICCs by 2015. | • Linkage established through participation and sharing reports of national members in the county cluster HRH–ICCs and vice versa.<br>• Key outputs of the HRH-ICCs include handling HRH transitional challenges, discussing common HRH county issues (e.g., promotion of seconded staff, vertical and horizontal staff transfers), sharing specialists, and sharing HRH best practices. |
| 2. **Recruit at least 12,000 health workers per year by 2017 to support facility- and community-level health services.** | a. Recruit 12,000 health workers per year (comprising at least nurses, clinical officers, physicians, laboratory technologists, health records officers, nutritionists, and radiologists) to 2017. | • A total of 7,484 health workers recruited since November 2013. This translates to 38% of the 22-month target from November 2013 (based on the 44 counties that submitted progress reports by July 31, 2015). |
| 3. **Recruit at least 40,000 community health extension workers (CHEWs) by 2017 to support community-level health services and the One Million Community Health Worker campaign.** | a. Recruit 40,000 CHEWs by 2017. | • A total of 1,558 CHEWs recruited by July 31, 2015.<br>• Scheme of service for community health services personnel approved in November 2013.<br>• CHEW cadre created in the health sector. |
| | b. Advocate to counties to establish community health services within each county by 2017. | • Counties running community health services under public health.<br>• Some support obtained from different partners.<br>• Ministry of Health Community Health Services Unit continuing to sensitize and advocate to counties to strengthen community health services at the county level. |
| | c. Establish and ensure functioning of community health units (from 2,511 in June 2012 to 9,294 by 2017). | • A total of 950 new community health units recorded as established since November 2013, most through partner support.<br>• As of July 2015, there were 3,461 units in all (37% of target). |
| | d. Establish mechanism for community health insurance through NHIF by 2015. | • Social health insurance through NHIF initiated for all Kenyans.<br>• Concept note for Community National Hospital Insurance Fund developed and pilot undertaken. |

| Commitment | Target | Implementation Level |
|---|---|---|
| **4. Increase spending in the health sector on HRH beyond staff salaries and allowances by 2017.** | a. Increase efficient and effective use of available resources in health care delivery, including HRH, by 2017. | • Nationwide staff rationalization undertaken through a Capacity Assessment and Rationalization of the Public Service (CARPS) exercise for the public service workforce, including the public sector health workforce.<br>• Report shared with national and county governments for their implementation.<br>• HRH audits conducted to establish head count of health workers in each county to eliminate ghost workers and determine staffing gaps.<br>• Kenya HRH Staffing Norms and Standards launched and disseminated to all 47 counties to aid in facility staffing.<br>• HR units established in 24 (51%) of county government health departments.<br>• HR service supportive supervision undertaken in all counties and nationally.<br>• Training needs assessments (TNAs) conducted in all 47 counties. |
| | b. Allocate HRH budgets beyond employees' emoluments toward employee welfare, employee relations, reward and recognition, work climate improvement, and occupational health and safety by 2017. | • Gradual increase in health department recurrent allocation of 48.6% between 2013/14 and 2014/15 and subsequently HRH budget allocations at the county level.<br>• Allocations beyond emoluments commenced for health worker welfare, occupational safety and health, attraction and retention incentives, reward and recognition, etc.<br>• Sub-county and county health management team participation in budgeting. |
| | c. Prepare guidelines and tools to help county governments budget and plan for health service delivery and commensurate HRH establishment by 2015. | • Budget analysis undertaken to guide on HRH budget tools development.<br>• Budgeting flow chart and checklist prepared to aid county government health departments in budgeting.<br>• Flow charts and checklists shared through inter-county HRH-ICCs. |
| | d. Improve efficiency in HR processes (e.g., recruitment, HR records management) by reducing recruitment turnaround time and increasing utilization of information and communication technology (ICT) for cost-effectiveness by 2017. | • HR records reviewed, scanned, and digitally stored for 43,000 health workers.<br>• Devolution of HR records to counties carried out.<br>• Personnel files devolved to 40 counties thus far; all 47 counties have access to eRecords through the integrated Human Resources Information System (iHRIS).<br>• Recruitment turnaround time reduced to under three months at county level. |

| Commitment | Target | Implementation Level |
|---|---|---|
| | e. Take stock of the assets available in each county, including HRH, as a critical step in resource rationalization for efficient and effective service delivery by 2014. | • Capacity Assessment and Rationalization of the Public Service (CARPS) registration exercise conducted, including for the health sector.<br>• Head count and biometric data for each staff member available through CARPS.<br>• Report released for implementation. |
| 5. Promote public-private partnerships for health financing and establish mechanism for mutual benefits for a better health workforce and quality service delivery. | a. Promote private-sector investment in health care with counties for infrastructure, ICT solutions, and financing of HRH development; for example, through the Afya Elimu Fund (revolving education fund) and other initiatives, by 2017. | • International Finance Corporation (IFC) to provide central funding mechanism for HRH training institution; seed capital of 10M USD committed.<br>• Private-sector companies and foundations (Ratansii Education Trust, Family Group Foundation, I&M Bank, Chase Bank) providing financial resources toward health worker education by providing seed capital in Afya Elimu Fund with 6,000 beneficiaries (341 scholarship recipients, 423 graduates).<br>• Five counties (Mombasa, Kiambu, Kwale, Turkana, and Laikipia) have established public-private partnerships with the private sector. |
| | b. Adopt multisectoral participatory approach for delivery of health interventions in attaining the best possible health outcomes between the public sector (beyond the health sector), private and private-not-for-profit sector, and faith-based organizations at the county and national levels by 2016. | • Interagency Coordinating Committees adopting multisectoral participatory approach at the national level.<br>• All 47 counties working across sectors to promote health care delivery, but multisectoral participatory interventions still in their infancy. |
| | c. Strengthen linkages with development partners in supporting government efforts toward funding initiatives to improve service delivery, availability of health workers at the facility level, and ongoing reforms in the health sector by 2017. | • Ministry of Health, counties, and development partners supporting service delivery, HRH, and contract workers at the facility level for improved service delivery. |
| | d. Promote national health insurance through increased effectiveness of the National Hospital Insurance Fund (NHIF) as a social health financing mechanism by 2015. | • Government-led initiative carried out to restructure NHIF as well as use it to channel funds for free maternal, neonatal, and child health services; the mechanism boosted by increased workers' contributions; gaining ground in provision of social health financing.<br>• Managed medical equipment meant to improve quality service delivery adopted by counties.<br>• All health workers enrolled in NHIF social health insurance. |

| Commitment | Target | Implementation Level |
|---|---|---|
| | e. Develop innovative and equitable financing strategies that enhance universal health coverage and access to health care by 2017. | • NHIF partnership with Safaricom Limited to launch mobile money platform (Linda Jamii) to expand health insurance to informal workers by allowing monthly premium payments through M-Pesa payment platform used with mobile phones.<br>• Government offering free maternity treatment and neonatal and child health services to children under 5 years (First Lady's Beyond Zero Campaign). |

# DISCUSSION

Countries can learn important lessons from Kenya's experience about how to build national consensus in support of HRH commitments, particularly in a context of decentralized implementation. Before pursuing implementation of the commitments, Kenya invested the time and attention required to build stakeholder agreement to ensure that the commitments addressed all stakeholders' interests, were integrated with the country's health strategies, and aligned with national policies. Through various fora at the national and subnational levels, the Ministry of Health allowed relevant stakeholders—including civil society entities that support HRH issues—to discuss the commitments, voice their inputs and recommendations, and link the commitments to their own plans and agendas. This initial investment in consensus-building has paid off through strong stakeholder coordination, harmonization, and cooperation in support of commitment objectives.

Although consensus and engagement among stakeholders have been critical to the advancement of the HRH commitments, the government must continue to cultivate stakeholder support to sustain the buy-in achieved at the outset of the initiative. Because county government elections had just been held when the commitments were formulated in late 2013 and county governance mechanisms were in their infancy, it was far from clear at the time whether the process would move forward smoothly and whether the subnational implementation and management of the commitments would be realized. Through the quarterly inter-county HRH stakeholder fora, however, the county governments have remained engaged not just during dissemination of the commitments but also during their subsequent implementation.

Alignment between the Ministry of Finance and the Ministry of Health is another essential component for the successful implementation of the HRH commitments, as well as for other HRH and health systems development strategies. In Kenya, the government has established a process through which the National Treasury coordinates fund allocation with the county governments. The National Treasury also disseminates budget guidelines to the central and county governments to inform their resource planning. The counties and the central government submit their budgets based on those criteria, which are established by the Commission for Revenue Allocation and are based on population demographics, disease burden, prior year's spending, and other factors. To support this process, IntraHealth, with USAID funding, partnered with the government to undertake a baseline survey on HRH budget allocations in select counties and also developed HRH budgeting tools for county use to ensure that resource allocations and budget lines cover key HRH needs beyond personnel emoluments.

An M&E framework is essential for transparency and accountability in working toward achievement of the HRH commitments. Understanding these principles' importance as critical components of good governance, Kenya's process has not only been inclusive and participatory but also measurable. There are some areas where the M&E framework can be improved, however. For example, when developing an M&E framework and indicators, it is critical to craft a

manual or guide to standardize and explain what data are to be collected and from which sources, as well as how the data are to be calculated, presented, and interpreted. The guide should also clarify any indicators that might be overly broadly interpreted. This type of guidance structure can help ensure that the data are valid and that the information is collected consistently and compared accurately with each measurement. In Kenya's M&E framework, for example, indicator 3.4 ("Advocacy to counties to establish community health services within each county by 2017") lacks a clear explanation of how "advocacy" is being defined or measured.

As soon as the first progress reports on the HRH commitments were generated through the inter-county HRH-ICC and national HRH-ICC, the Ministry of Health began to share the reports with stakeholders and constituencies for their input and comments. The Ministry is also reviewing the reports to identify ways to improve and expedite implementation of the commitments for better results by 2017, and may consider hosting the HRH commitment progress reports on its website. Dissemination of progress will help to increase and reinforce confidence and trust, allow the Ministry to assess constituents' interest in the commitments, and inform future communication campaigns in support of HRH budget allocations. As the government and its partners continue to document Kenya's progress in achieving its HRH commitments as part of the overarching strategy in pursuit of universal health coverage, Kenya will be able to more widely share its experience and help other countries strengthen their health workforce so that they, too, may make progress.

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# HUMAN RESOURCES FOR HEALTH COMMITMENTS: MALI ADDRESSES WORKFORCE SHORTAGES AND DISTRIBUTION

**November 2015**

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# INTRODUCTION

Over the past ten years, Mali has overcome challenges to strengthen its health system and improve the health status of its people. For example, the maternal mortality rate decreased from 1,100 to 550 deaths per 100,000 live births between 1990 and 2013 (World Health Organization [WHO] 2015). However, the political crisis of 2012 caused a number of setbacks, weakening a vulnerable economy, prompting health workers to emigrate out of the already disadvantaged northern provinces, creating populations of refugees, and placing additional demands on the health system. In addition, global partners who were providing technical and financial support to improve Mali's health system—including the US government, Canada, and the European Union—suspended their work in Mali until the severity of the crisis subsided. As of 2013, therefore, many of the gains toward achieving the Millennium Development Goals (MDGs) had been reversed, and average life expectancy was only 55 years of age (World Bank 2015a).

Mali's government is determined to continue to strengthen its health services in order to regain its losses, improve maternal and child health, and make progress toward eradicating preventable deaths from disease and malnutrition. The government is well aware that broader access to quality health services is one of the main challenges it must address. With a wide disparity in health service availability, the country's rural and remote areas pose the greatest need. For example, the Mali Demographic and Health Survey (DHS) of 2012–2013 reports that while most women in urban areas are attended by skilled professionals during childbirth (73% by nurses or midwives, and 13% by physicians), only 25% of rural women give birth in the presence of a nurse/midwife, and just 2% are attended by a physician (CPS/SSDSPF et al. 2014). An adequate number and equitable distribution of skilled health workers is vital for meeting the country's health needs and moving toward universal health coverage. The WHO estimates that 2.3 health professionals per 1,000 people are needed to provide basic health services, but according to 2012 government reports, Mali's national physician-to-population ratio was .08 per 1,000, with a ratio of .43 per 1,000 for nurses and midwives (WHO 2013).

Facing these critical shortages and wide disparities in health workforce coverage and access, the government of Mali announced four human resources for health (HRH) commitments at the WHO/Global Health Workforce Alliance (GHWA) Third Global Forum on Human Resources for Health (Global Forum) held in Recife, Brazil in November 2013. Mali's Recife commitments are intended to address the health workforce shortage and the inequitable coverage by establishing infrastructure, practices, and processes to produce more health workers and deploy them where they are most needed. The four commitments are listed below.[1]

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[1] Mali HRH commitments in original French language: (1) *Développer le système d'information et de gestion des Ressources Humaines en Santé à tous les niveaux de la pyramide sanitaire d'ici à l'an 2015; (2) Rendre disponibles les Ressources Humaines en Santé qualifiées (Médecins, Sages-femmes et Infirmiers) dans 60% des Districts Sanitaires d'ici à l'an 2018; (3) Renforcer les compétences des Ressources Humaines en Santé (Médecins, Sages-femmes et Infirmiers) au moins 1 fois par an; (4) Promouvoir un environnement institutionnel favorable à l'engagement des Ressources Humaines Human Resources for Health Country Commitments:*

**Commitment 1: Develop and decentralize a computerized human resources information system (HRIS) to better manage the health workforce by 2015.**

This commitment aims to increase and improve the information available to decision-makers through computerized HRH information systems to allow evidence-based HRH policies and strategies.

**Commitment 2: Ensure that 60% of health districts are fully staffed by qualified health providers (including physicians, midwives, and nurses) by 2018.**

Because of the political crisis of 2012, the Ministry of Health's ability to recruit health workers into the northern regions of the country where the conflict was concentrated was greatly compromised. For example, in 2008, 565 contracted health agents were recruited to the northern regions; after 2009, however, no further health workers in this personnel category were recruited (Ministry of Public Health and Hygiene 2013). Since 2012, the overall level of HRH recruitment in the north has continued to decline each year.

**Commitment 3: Offer capacity-building opportunities to the health workforce (physicians, midwives, and nurses) at least once a year.**

In Mali, continuing professional development (CPD) is not required by law and is generally considered to be the responsibility of professional associations and/or individual health workers. Medical associations and other professional organizations initiate, provide, and promote CPD, and global partners provide in-service training in clinical skills and non-clinical competencies. However, because there are no standard national CPD requirements or regulatory oversight across each cadre, training to refresh skills or update knowledge is inconsistent and inadequate. Moreover, trainings are often held away from health facilities, requiring health workers to travel (incurring a cost for the training partner) and to be absent from already stretched service delivery teams. It is common for the same health workers to repeatedly attend capacity-building workshops on the same topic.

**Commitment 4: Promote an institutional environment that enables health worker retention in underserved and difficult areas.**

To achieve Mali's national goal of reaching one doctor, one nurse, and one midwife per 1,000 inhabitants, Mali needed to add 14,205 physicians and 15,525 nurses and midwives in 2013. However, its production between 2011 and 2012 fell far below these targets, averaging 274 physicians, 459 midwives, and 1,562 nurses (Ministry of Public Health and Hygiene 2013). In addition to increasing recruitment, training, and deployment of health workers, the Ministry of Public Health and Hygiene understands that is critical to retain existing staff as well as increase the number of health workers. This commitment was intended to ensure that resources and strategic planning would coincide with recruitment and deployment efforts.

This case study shares Mali's experiences in developing, implementing, and tracking its HRH commitments, focusing on the political environment in which the HRH commitments were

*en Santé à servir dans les zones difficiles.*
*Human Resources for Health Country Commitments:*
*Case Studies from the Dominican Republic, Kenya, Mali, and Uganda*                                    37

made, the interventions that were implemented to meet said commitments, and the progress that has been achieved to date. The case description also seeks to shed light on the enabling and inhibiting factors toward leveraging the HRH commitments to advance health workforce improvements.

# METHODOLOGY

Case study authors included a representative from the Ministry of Public Health and Hygiene and advisors from IntraHealth International, who worked closely with the Ministry in achieving its goals. An initial desktop review of relevant documents focused on policy papers and grey literature, with informal review of related publications. Authors also referenced World Bank and WHO databases as well as Mali's DHS reports. Finally, interviews with key actors at the national and local levels illuminated realities on the ground and supplemented gaps where data were often unavailable. The qualitative information from these interviews was validated with supporting documentation or concurrence from additional inquiries.

# CASE DESCRIPTION

## Background

Despite recent improvements, Mali's health indicators remain on the low end of global rankings. The maternal mortality ratio in Mali is 550 deaths per 100,000 live births (WHO 2015). Child and infant mortality are also high, with 123 deaths per 1,000 live births for children under five (World Bank 2015b) and 78 infant deaths per 1,000 live births (World Bank 2015c). With these indicators, Mali ranks among the countries with the most urgent health improvement needs. The country's very low health worker density places Mali in the group of 57 "human resources for health crisis countries" that do not have enough health workers to provide basic health services (GHWA n.d.).

At the same time that the country has been in critical need of increasing its number of health workers, it also has been in the midst of a global financial crisis. From 2011 to 2012, Mali's health expenditures dropped from 3.0% of gross domestic product (GDP) to 2.3%; in 2013, health expenditures still had not returned to 2011 levels (World Bank 2015d). The budget allocated to the Ministry of Public Health and Hygiene's Department of Recruitment to cover new health worker salaries has declined almost by half over the last five years, falling from one billion CFA francs in 2010 to 600 million CFA francs in 2013—a reduction of 40% over the two years—and then dropping by an additional 40% from 2013 to 2015. To reach the WHO-recommended minimum ratio of 2.3 health professionals for 1,000 inhabitants, the estimated annual budget allocated to the Department for recruitment would need to increase by 333% over the next five years, from 60 million CFA francs to 2 billion CFA francs—twice the 2010 level.

The lack of access to health services is a key factor in Mali's struggle to improve its health statistics, and the access gap is particularly severe in rural areas. Not only does the maldistribution of health workers exacerbate the problems associated with the inadequate number of health workers, but the political crisis further intensified inequitable access because many health workers left the northern provinces to find better working conditions in more stable areas. In 2009, the ratio of qualified staff to population was eight times higher in urban than in rural health centers, with a particular gap for midwives in rural areas (Ministry of Health 2009a). At the same time, according to the DHS 2012–2013 report (CPS/SSDSPF et al. 2014), the burden of fevers, diarrheal disease, respiratory illnesses, and malnutrition is highest for rural and poor populations. The DHS report also indicates that these same rural geographical areas and low socioeconomic populations show the greatest shortages in public services and have higher unmet contraceptive need, a lower coverage rate for vaccinations, and lower adherence to recommended antenatal care visits.

The government has had little information to inform decision-makers on how many health workers are qualified (with up-to-date licensure), where they are working, and what gaps need to be addressed. This lack of data has impeded efforts to improve the distribution of health workers and health system performance.

## Political Environment

Needing to make greater progress toward its MDG health targets and wanting to overcome the setbacks caused by internal conflict, the Ministry of Public Health and Hygiene identified HRH as a priority. In 2009, the government approved a national HRH policy, "Development of Human Resources for Health: National Policy" (Ministry of Health 2009a), which included an HRH operational plan, "Development of human resources for health: National strategic plan, 2009–2015" (Ministry of Health 2009b). The national HRH strategic plan was articulated to address four essential HRH management functions:

- Improved training to increase the numbers of qualified providers

- Needs-based deployment to place the right skill set in the right places to meet health needs

- Retention of health workers, particularly in rural areas where attrition rates are highest

- Career development to provide mechanisms for skills improvement and provider motivation.

In 2013, the WHO and GHWA together challenged WHO member-states to develop national HRH commitments to present at the Global Forum in Recife. The commitments publicly declared by each country would serve as a mechanism for transparency and accountability both to national constituencies and to global stakeholders. Because of the severity of the health worker shortage in Mali, the government—aided by external partners—had already begun a number of

initiatives to address HRH gaps before the 2013 Global Forum. The WHO/GHWA challenge provided the government with an opportunity, at the midpoint of Mali's HRH strategic plan, to renew political support behind the Ministry's HRH objectives. It was hoped that the Recife commitments would energize continued resources and innovations to improve health worker coverage, particularly in rural areas.

In the months prior to the Global Forum, the Ministry held a stakeholder planning workshop to examine the national HRH plan and formulate proposed HRH commitments that would align with Mali's vision and help catalyze action to advance Mali's "Development of Human Resources for Health National Policy." The commitments drafted in the workshop were then validated at the next Ministry cabinet meeting. A delegation was selected to represent Mali at the Global Forum and was authorized to present the commitments to the global community.

Dr. Adama Diawara, former Ministry of Public Health and Hygiene Secretary General, led Mali's delegation to the Global Forum and declared Mali's support to four commitments to strengthen its health workforce. Upon returning from Recife, the Ministry formed a stakeholder leadership group (SLG) (Gormley and McCaffery 2011) and organized an SLG meeting to share the Global Forum recommendations and ensure the inclusion and involvement of all partners in the commitments' implementation. Although most country stakeholders already were aware of the HRH country commitments because they had participated in the preparatory meetings that contributed to drafting the commitments, the SLG was formed to ensure ongoing support and inclusion in the commitments' operationalization. To broaden stakeholder support and leverage momentum for action, the Ministry's HRH Directorate also organized a press conference to share with civil society organizations and journalists both the Mali HRH commitments and the challenges to achieving them.

## RESULTS

Progress has been made toward keeping each of the commitments. Even though a reliable monitoring and evaluation process was not developed or implemented to track and consistently report on progress toward achieving the commitments, the authors were able to construct a retrospective qualitative case description, using supplemental reports to understand and convey the actions that have been taken since the commitments were made and some of the outcomes that can be attributed to those actions.

## Commitment 1: Develop and decentralize a computerized human resources information system to better manage the health workforce by 2015

To have timely information to manage and plan the health workforce, the government of Mali adopted iHRIS Manage,[2] one component of the iHRIS open source software package (with "open source" meaning that it is available without licensing or purchasing fees). iHRIS Manage is used to manage health workforce information and was selected by Mali to replace paper-based management and tracking of HRH. In addition, the Ministry of Public Health and Hygiene made the decision to decentralize the management of iHRIS so that data could be gathered at the regional level to feed into national reports.

To accomplish the regional rollout of iHRIS Manage, the Ministry started in one region (Sikasso), with the intention of using the experience gained there to then expand to the country's other regions. The Capacity*Plus* project, led by IntraHealth and funded by the United States Agency for International Development (USAID), helped the HRH Directorate to install and update iHRIS Manage by providing the necessary information technology (IT) equipment and training to use the equipment throughout the Sikasso region. After successful decentralization of HRH management in Sikasso, the Ministry continued with decentralized implementation of the system in the regions of Kayes, Koulikoro, Segou, Gao, and the District of Bamako.

In the last quarter of 2014, the HRH Directorate received funding through WHO and the French Muskoka Initiative to expand iHRIS Manage to three additional regions: Mopti, Timbuktu, and Kidal. Data are being collected in Mopti and Timbuktu, but due to security challenges, data collection in Kidal has been slower and the Ministry is considering solutions.

*Outcome:* The Ministry of Public Health and Hygiene has seen that iHRIS Manage is enabling the Ministry to respond to identified needs and is allowing decision-makers to better plan for adequate and equitable workforce distribution. Ministry representatives highlighted four examples of outcomes that illustrate how iHRIS Manage has enabled national and subnational government planners and managers to respond to conflict area needs; more effectively staff health centers; distribute newly trained cadres to regions in need; and respond rapidly to Ebola.

- Conflict area needs: After many health workers fled from the north during the conflict in 2012–2013, the Ministry's HRH Directorate was able to use iHRIS Manage to identify those who had been posted in the Gao region and their telephone numbers. This information enabled the Directorate to contact the health workers and offer them grants to return to the region as part of the government strategy to replenish the health worker staffing that was lost and provide much-needed care for the conflict-affected populations.

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[2] www.iHRIS.org

- Health center staffing: For the opening of a large health center in Bamako's Kalaban Coura neighborhood, the HRH Directorate used iHRIS Manage to select 26 qualified and experienced providers who could be transferred to supervise the new staff.

- Deployment of new staff: In April 2015, the HRH Directorate used iHRIS data to guide the deployment of 185 newly recruited, public-sector health workers (40 physicians, 60 midwives, and 85 high-level nurses) to the regions.

- Ebola response: During the Ebola outbreak iHRIS Manage was an effective tool for tracking health worker gaps and availability, which helped Mali to be better prepared to support health centers and effectively deploy new health workers, volunteers, and partners in high-risk zones at the border with Guinea.

*Next Steps:* The Ministry still faces challenges to optimizing the use and applicability of iHRIS Manage. Although the system is open source, there are costs involved in adapting, interfacing, and overseeing the use of the technology. At this juncture, Mali has not been able to absorb these costs and still depends on external funding to sustain expansion, training, and management requirements. The capacity for using the system and applying the information to strategic planning needs to be improved, particularly within the subnational management teams where informatics competencies are weak. Currently, only a small number of people in Mali are competent in managing the software.

To address these challenges, the HRH Directorate, working with the provincial and district management teams, is planning first to complete the decentralization process through all regions. During this process, the Directorate will continue to document the benefits of using iHRIS Manage and use this evidence to advocate for increased investment in HRH and human resources management (HRM). Subsequently, the Ministry has plans to link the HRM and payroll systems, further improving management efficiencies. Additionally, the Ministry hopes to broaden iHRIS management capacity and engage the iHRIS Qualify component of the iHRIS software package to track health worker training and licensing. (See "Next Steps" discussed under Commitment #2.)

## Commitment 2: Ensure that 60% of health districts are fully staffed by qualified health providers (physicians, midwives, and nurses) by 2018

The Ministry of Public Health and Hygiene has developed and initiated several programs to expand the availability of qualified health workers, with support from technical and financial partners. These programs have helped to absorb a portion of unemployed but qualified health workers and post them in rural zones.

*L'initiative Médecins de Campagne* (the "Rural Doctors Initiative") aims to support the Ministry and "medicalize" community-level primary health centers by providing equipment, tools, seed funds, and supportive supervision and coaching to recruit and retain young physicians to rural areas. The initiative is financed by the French Cooperation, the European Union, Santé Sud, and

the Association of Rural Doctors.

Second, assistance from Gavi, the Vaccine Alliance has enabled the government to recruit and employ qualified health personnel in community health centers in the poorest health districts. According to Ministry representatives, this external funding has enabled the Ministry to recruit 75 physicians per year to rural health services and to transition them to the Ministry payroll after three to five years.

The Ministry has also embraced a targeted training strategy aimed at providers who have inadequate training, skills, and knowledge to meet urgent needs. For example, the national HRH Directorate developed a pilot training program to teach community *matrones* (midwife assistants) how to provide active management of third stage of labor (AMTSL), thus expanding the reach and coverage of obstetric care closer to rural communities.

*Outcome:* Initiatives such as those supported by *Médecins de Campagne* and Gavi have enabled Mali to employ and distribute key personnel in areas of need. Further, Mali has been able to absorb some of these health workers onto the government payroll, with a plan to bring more into the Ministry over the next three to five years. The Rural Doctors Initiative, for example, has employed 150 general practitioners, each covering a population of 10,000-15,000 inhabitants in level 1 (poverty) in the remote district areas.

The pilot test of *matrones* providing AMTSL services was so successful that the Ministry adopted a policy to enable all trained *matrones* to provide AMTSL. To date, 65% of all *matrones* have received the training.

*Next Steps:* Along with its focus on employing trained health workers in areas of high need and providing obstetric (AMTSL) skills to lesser-trained providers, the government has developed broader strategies to ensure that rural populations receive essential health services. Mali's community health worker (CHW) strategy is one of the country's major accomplishments of the last five years. In addition to the existing CHW cadre (Level 1), the strategy created a second level of more advanced CHWs (Level 2) trained and qualified to treat and prescribe medicines. Two thousand (2,000) Level 2 CHWs have been trained and deployed in villages that are three or more kilometers distant from a health center. The Level 2 CHWs supervise Level 1 CHWs and the outreach workers known as *relais* workers.

Given that there are still a large number of health workers who are qualified, available, and needed but unemployed, the government also is considering various other strategies, such as hiring health workers at lower levels or delegating some tasks to less trained cadres to affordably employ more health workers.

## Commitment 3: Offer capacity-building opportunities to the health workforce (physicians, midwives, and nurses) at least once a year

To advance toward Commitment #3, a number of training activities have been organized either directly by the Ministry of Public Health and Hygiene or through the support of external partners. These activities have contributed to building the capacities of Mali's health professionals. Even so, there is still no national policy framework or regulatory requirement for consistent standardized CPD, and there is no monitoring system. As a result, there is no way to track and record which health workers have completed which training, and there is no process for evaluating which training programs were effective or achieved performance improvement goals.

**Outcome:** Due to the aforementioned challenges and weaknesses of the CPD interventions, the actions taken thus far have been inadequate in addressing the needs or achieving impact toward Commitment #3.

**Next Steps:** For successful implementation, commitment #3 needs to be detailed, clarifying what nationally standardized trainings will be made available and whether they will be required. Further, a framework is needed to link capacity-building areas to priority achievement milestones, with specific curriculum content. Finally, milestones for improved capacity or expanded health worker competencies should be measurable and monitored within a monitoring and evaluation process.

Currently, the Ministry's HRH Directorate is developing a national CPD strategic plan, which will establish standards to be followed by all government partners. Included in those standards will be requirements for an assessment of need, a demonstrated link between the learning program and the need, consistent monitoring, and follow-up to reinforce sustained learning. The CPD strategy will also coordinate preservice education with in-service training to create a seamless framework of ongoing capacity building for health professionals. As of July 2015, the in-service trainings of the CPD plan had been outlined in a scope of work, and shared funding had been identified through a partnership between the government and Save the Children.

The government also aims to expand the iHRIS management system to include iHRIS Qualify, which establishes and maintains a registry that allows professional associations and councils to keep track of qualified health workers in the different cadres. Through these registries, the councils and associations can document and monitor which health workers have completed required training or capacity-building interventions, thereby avoiding redundancies and inefficiencies. In addition, planning is underway to develop eLearning and mLearning modules to provide on-site learning and reduce the absenteeism at health facilities that results from off-site trainings. Finally, because iHRIS Manage can interface with iHRIS Qualify, the subnational and national governments can keep track of health workers who are both qualified and available to work.

## Commitment 4: Promote an institutional environment that enables health worker retention in underserved and difficult areas

The government is pursuing several initiatives to increase health worker retention, focusing primarily on nurses and rural areas. First, the government has strengthened the Gao Nursing School to enhance the likelihood that nursing students will be recruited from the northern Gao region, which is one of Mali's areas of greatest need. This strategy of training and recruiting nurses near their family homes aligns with WHO policy recommendations for improving recruitment and retention in rural areas (WHO 2010).

*Outcome:* The government partnered with USAID/Capacity*Plus* to train nurses and, as part of that effort, Capacity*Plus* continued to underwrite scholarships for 204 Gao Nursing School students. The government is not systematically monitoring retention related to this initiative, however, nor is it investigating health workers' intention to stay in their posts. As a result, there are no outcome measurements that can be directly attributed to this strategy.

*Next Steps:* The health workforce in Mali is characterized by geographical disparities. In addition, medical personnel do not always carry out their curative role but may instead focus on administrative matters (Ministry of Health 2009a). In conjunction with increasing the training of nurses in the areas most in need (e.g., Gao), the Ministry anticipates implementing a task sharing strategy that will reduce the heavy administrative burden carried by physicians and nurses so as to optimize their clinical services. Decreasing the administrative workload is expected to improve the working environment and contribute to improved health worker retention.

# DISCUSSION

The government of Mali and, more specifically, the Ministry of Public Health and Hygiene, have joined with global, national, and local stakeholders to demonstrate commitment to strengthening human resources for health. However, challenges remain that pose barriers to achieving greater and more rapid improvements in the HRH commitments declared at the Global Forum in November 2013. For example, despite strong political will, resources for implementation remain scarce. The conflict in northern Mali greatly undermined the country's economy and infrastructure, placing more demands on the budget than can be met and weakening the health system, which will need increasing investment from the government in the years to come.

### Commitment 1
The Ministry has made marked progress in workforce planning and in implementing interventions, but documentation is weak. Much of the progress to date has been described in piecemeal fashion in individual reports rather than being consistently tracked and monitored

using standardized and reliable data. The national use of iHRIS Manage and other relevant tracking software will improve the monitoring of health workers. However, processes for continual monitoring and evaluation and for evidence-based decision-making need to be institutionalized at the district and national levels so that the impact of various interventions can be understood and progress toward achieving commitments can be validated.

## Commitment 2

Efforts to strengthen health outcomes must also address recruitment and retention problems. Coordinating with public and private stakeholders and global partners, Mali has been effective in producing more providers and redeploying unemployed health workers. In addition, it has been able to build competencies in lower-level cadres, such as assistant midwives, to expand coverage of critical skills such as those required at the third stage of delivery. However, the Ministry's ability to fund new posts or offer competitive salaries is still limited, and the government still relies largely on donor support for both expanded training and for salaries.

## Commitment 3

There has been little to no progress toward developing a national framework for continuing professional development and in-service training, which was the intent behind Commitment 3. There is seldom a clear or documented link between training provided and specific gaps in capacity, and there are few or no processes or practices applied to track the application of training in the workplace or to monitor the impact of training on service quality. Health workers are not required to demonstrate the successful uptake of new skills or competencies, either immediately following training or over time to assess the retention of the knowledge, skills, or behaviors gained. There is no standard framework for linking preservice education to subsequent capacity-building activities and needed improvements in quality services.  Further, in-service trainings are not attached to accredited programs and are often not recognized by training institutions or professional councils. The in-service training programs that are provided, which are offered by a variety of local and global partners, are not harmonized to achieve a uniform level of competency or performance.

## Commitment 4

Mali's retention strategy—to recruit and train nurses where they live—is expected to result in more nurses and midwives working in Gao, where the need for nurses is critical and where it is otherwise very difficult to recruit nurses from higher-resourced and more stable areas of the country. However, despite decentralizing preservice education to the regional level, local budgets are severely constrained. As a result, both central and local recruitment occurs in a sporadic manner, and retaining workers is still a challenge. Improved monitoring and evaluation will be needed to track interventions and their impact on health worker satisfaction and longer-term retention.

## Commitments Summary

The four HRH commitments announced at the Global Forum articulated specific objectives that would advance Mali's goals to improve its health system and advance the health of its population. Armed with those objectives, the government and Ministry of Public Health and Hygiene were able to engage stakeholders toward attainable progress, leveraging global accountability to energize action.

Some of the current barriers to strengthening the health workforce will improve over time as the country recovers from the financial setbacks brought on by the 2012 crisis. If the political will demonstrated thus far by the government continues and the Ministry is able to define a clear, benchmarked plan with monitoring and evaluation indicators, Mali should continue to make and demonstrate progress toward achieving its commitments.

In addition, the government may use a performance-based financing (PBF) strategy as a mechanism to identify the HRH strategies that result in the greatest improvements, and then reinforce efforts that advance health system goals. PBF was introduced in Mali before the Global Forum took place, as part of the government's long-term commitment to strengthening its health system and expanding coverage in rural areas. Beginning in February 2012 as a pilot program, PBF provided funds to reward health facilities (and the health providers in those facilities) for predefined and verified results. Health facilities that attract more patients and provide better quality services receive more incentive payments through the PBF strategy, which is funded by the Netherlands Cooperation MDG 5 Fund and managed by the Ministry of Public Health and Hygiene. Although the evidence on whether the PBF scheme contributes to health worker retention or performance is still limited, elsewhere (such as in Rwanda) PBF strategies have been shown to improve health worker management and performance efficiency (Meesen et al. 2011). Moreover, as management practices improve, health workers may begin to find their work more satisfying and may stay in their posts with decreased attrition. This consideration will need further investigation.

## CONCLUSION

Before the Third Global Forum on Human Resources for Health in 2013, the Republic of Mali had already committed to strengthening its health system and improving its human resources for health. It had included an HRH policy and a specific health workforce strengthening strategy as part of its 2012 plan to rebuild its health system and advance toward its MDG health targets. In remarks at the Global Forum, Dr. Moussa Guindo, the Ministry of Public Health and Hygiene's head of cabinet, said, "Human resources are the cornerstone upon which the entire health system rests, a system which in fact would not exist without them. They are the health system's most important resource." The Ministry designed the four HRH commitments presented at the Global Forum to articulate objectives that would sustain stakeholder support behind the health workforce strengthening strategy and attract resources to enable progress toward an improved health workforce.

The greatest achievement to date has been toward Commitment #1, with the rollout of iHRIS Manage to track health workers and make informed decisions for training and deployment. Plans are in place to expand the information system to include iHRIS Qualify to track the training and licensure of available health workers. Mali has also made progress toward achieving Commitment #2, with increases in the numbers and skills of employed health workers, particularly in the northern regions. However, until economic improvements lead to a stronger health budget and increased funding allocations for local recruitment and salaries of health workers, the government will continue to rely on foreign donors to support its health workforce.

Continuing education, capacity-building, and retention of the health workforce (Commitments #3 and #4) have seen little improvement. Further, the improvements that have been observed have not been part of a comprehensive framework for standardized interventions with measurable indicators to monitor and evaluate results. Mali must establish a framework and operational strategy through which it defines, advances, and monitors progress toward Commitments #3 and #4. Achievement of Commitment #3 requires a national CPD strategy that is linked to preservice education, with the intent to continue building capacity and renewing the qualifications of health providers throughout their service. The strategy should be standardized and institutionalized within regulatory requirements and linked to learning indicators and performance improvements.

To track progress and demonstrate the value of the HRH commitments, the Ministry of Public Health and Hygiene must establish a monitoring and evaluation framework with a process for tracking and reporting progress on indicators for all four commitments. Consistent and regular progress reports to constituents will help the Ministry to leverage the commitments as a vehicle for sustaining political support and recruiting resources for health workforce development.

Finally, efforts to recruit, train, and retain health workers where they are needed must be coupled with a commitment to the quality of service they deliver. To advance its overarching health goals and move toward universal health coverage, Mali will need to be sure that providers are delivering the highest quality care. This can be assessed by tracking health system performance through PBF and other mechanisms, and linking improved services and better outcomes to improvements in recruitment, training, deployment, and support of the health workforce.

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# UGANDA ON TRACK FOR KEEPING HUMAN RESOURCES FOR HEALTH COMMITMENTS

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# INTRODUCTION

An effective health system needs a qualified and accessible health workforce to provide quality health services to all and accelerate the achievement of national and global health goals. In November 2013, at the World Health Organization (WHO) and Global Health Workforce Alliance (GHWA) Third Global Forum on Human Resources for Health (HRH) (Global Forum) held in Recife, Brazil, countries, development partners, civil society, and the private sector identified a strategic set of health workforce interventions, focusing on interventions with the greatest potential to reduce health workforce barriers and accelerate improvements in health services and health outcomes. In addition, Global Forum attendees were invited to make concrete and actionable HRH commitments. Uganda, together with 56 other countries, prepared and presented HRH commitments. The four commitments were:

- Improve availability: Scaling up preservice education and training
- Provide incentives for attraction and retention
- Improve health workforce productivity and accountability
- Strengthen partnerships with the private not-for-profit service providers.

The commitments were a critical outcome of the Global Forum and the subsequent national HRH plans and strategies, and they will be influential in shaping the post-2015 development agenda. This case study examines Uganda's political process for developing the commitments, the activities pursued to implement the commitments, and the progress made to date.

## Background

The Ugandan health system suffers from dual management. Urban facilities and tertiary hospitals are managed centrally by the Ministry of Health, while district hospitals and health centers II, III, and IV are managed by district governments. However, many districts lack the financial and human resources for effective management of the health system. This means that health centers are not always fully operational, sometimes lacking necessary equipment or funds to install and pay for utilities like water and electricity or for housing for health workers as outlined in the Second National Health Policy (2010–2020) (Ministry of Health 2009). Many health professionals find it challenging or even impossible to work under such conditions, contributing to absenteeism.

The private-not-for-profit (PNFP) sector provides close to 50% of all health services, maintaining hospitals and health centers across the country. PNFP facilities are primarily faith-based institutions that operate separately from government-run clinics. They fund most of their operations from the fees they charge for services provided, although a small amount of funding also comes from the government budget. Management differences between the PNFP and government sectors include variations in salaries; physicians in government facilities are

remunerated at lower rates than their counterparts in PNFP facilities, whereas nurses, midwives, and other cadres in government service are generally more highly paid than those in PNFP service. PNFP facilities tend to have better equipment and more organized performance management and review practices. Further, housing for PNFP staff, unlike that of government-employed staff, is often provided within a community that has its own electricity, running water, and even small markets. Even so, government facilities tend to be better staffed than PNFP facilities because, according to a 2006–2007 retention study, the government facilities are perceived as being more stable and dependable, better known, and more likely to provide training opportunities and secure career paths (Ministry of Health 2007). In addition, the government hires greater numbers of health workers for a lighter workload, so health workers are required to work less in public sector facilities than they are in the more streamlined PNFP facilities. Finally, salaries and employment are guaranteed in government facilities even when health workers do not perform.

To ensure that everyone has access to a health worker, Uganda must examine the PNFP and government sectors together and consider how to better align and leverage both, acknowledging that changes in one sector may have an impact on the other. For example, if the government increases salaries, health workers may flood the public sector and leave the PNFP sector understaffed, distorting the placement of health workers across both systems. Recognizing the need for stronger coordination, the government included greater cooperation and relationship-strengthening with the PNFP sector as one of its HRH commitments (Commitment #4).

Another HRH management challenge is that, in addition to the Ministry of Health, four other government ministries are involved in different aspects of HRH development and management, as shown:

- Ministry of Education and Sports: Professional training of health workers

- Ministry of Public Service: Central-level human resources employment policies, strategies, and management

- Ministry of Finance, Planning and Economic Development: Health workforce financing and budget allocations

- Ministry of Local Government: Responsible for districts, which in turn recruit, deploy, supervise, and manage the payroll of government health workers.

Moreover, while the central government controls the funds that remunerate health workers, the latter are managed at the district level by local governments. Finally, Uganda's health professional councils are responsible for regulating health workers' professional standards and ethics and ensuring that health workers maintain relevant licensure. This multiplicity of stakeholders makes HRH decision-making processes long and often frustrating and ineffective.

Health workforce shortages are another significant challenge that plagues Uganda. These

shortages are a well-known issue and have been politicized in the recent past. In 2012, the Minister of Health, Christine Ondoa, made a strong public push for greater resource allocation toward HRH in the overall government budget. She worked closely with several Members of Parliament, who collectively refused to pass the overall budget until resources were brought up to a level where funding would be available to fill 65% of all health worker positions. At the time, only 45% of approved positions were filled, leaving large vacancies and shortages for key provider cadres, including midwives, anesthesiologists, laboratory technologists, and pharmacists. These vacancies, particularly acute in rural and remote areas, were primarily due to insufficient resources for additional health worker salaries.

The political influence achieved by Dr. Ondoa and colleagues in the Parliament significantly improved health workforce funding and enabled salaries that attracted more health workers to rural areas (Commitment #2). The government was not able to effectively utilize all available funding, however, due to delays at the district level in advertising for positions, interviewing candidates, and filling new positions. As a result, health worker shortages remain a problem, and HRH funding levels have been maintained at 2012 levels.

It was with these challenges and an urgent need to improve the staffing and consistency of services in the health system that the government of Uganda approached the 2013 Global Forum, bringing with it the understanding that the urgent need for health workforce improvements could no longer be ignored. The government was able to engage stakeholder support from both private and public sectors and national and district levels in the development of four substantive commitments.

## METHODOLOGY

The authors carried out an initial desk-based analysis of the national HRH commitments as well as an informal review of complementary grey literature and national policy documents. Authors also had first-hand involvement in activities to advance Uganda toward its commitments and gathered and validated qualitative information from interviews and informal discussions with HRH stakeholders and relevant actors. As part of this comprehensive review, authors collected historical data to understand the structure of the health system and the workforce gaps as well as current information on where the commitments had been achieved or progress had been made.

## CASE DESCRIPTION

### Political Environment

As outlined in the background section, the context in which Uganda developed its Recife commitments in late 2013 was characterized by ongoing and high-level efforts to champion the

health workforce in response to staffing shortages, salary deficiencies, and need for greater quality control. The HRH commitments were drafted through a multi-stakeholder consultative process, which involved the various ministries, professional councils, and PNFP organizations, as well as development partners such as the United States Agency for International Development (USAID), the WHO, the World Bank, Amref Health Africa, and Save the Children, among others. The process was led by Uganda's HRH Technical Working Group (TWG), chaired by the Director of Health Services Planning and Development at the Ministry of Health.

The group began by examining the commitments made by Uganda at the two preceding WHO/GHWA Forums, held in Kampala in 2008 and Bangkok in 2011, and assessed the progress that had been made toward meeting those commitments. They also examined two strategic Ministry of Health documents: the Health Sector Strategic and Investment Plan 2010–2015 (Ministry of Health 2010) and the Second National Health Policy ending in 2020 (Ministry of Health 2009)—both of which were designed to help Uganda meet the Millennium Development Goals (MDGs). Building on their review of the past HRH commitments and current policies and guidelines, the group then identified critical areas in need of support, described by one stakeholder as "the priority of priorities." The resulting Recife commitments—notable for their specificity and focus on four priority areas—are timely, as the primary health policy document guiding the Ministry's work (the Health Sector Strategic and Investment Plan [Ministry of Health 2010]) is set to expire in 2015 and will be revised in the coming months. Stakeholders view this juncture, therefore, as a key advocacy opportunity to make the Recife commitments the overarching influence on HRH policies for the next five-year window. The government, according to key stakeholders, takes the commitments seriously and views them as part and parcel of its ongoing health workforce strengthening efforts.

Since the Global Forum, Uganda has taken several critical steps toward implementation of the commitments. First, the HRH TWG, which includes key members of the Ministry of Health, decided in March 2014 to form a task force to examine what would be needed to meet the commitments. The task force then designed a fully costed plan for meeting the commitments and presented it to the Ministry's Health Policy Advisory Committee in July 2014 to inform funding decisions and prioritization by key health and development partners (Ministry of Health 2014).

Partially based on the task force's recommendations, Uganda's 2015 budget was developed with specific increases to address workforce needs. According to the budget speech of June 12, 2014, the health sector was allocated US$478,800,000[3] for the financial year (FY) from July 2014 to June 2015—an increase of 6%[4] from the previous financial year. Some of this additional funding is being allocated to build residences for health personnel in the hard-to-reach areas where health centers III and IV are typically located (Commitment #2). This funding, designed to attract and retain rural health workers, will directly contribute to meeting the goals included in the

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[3] Assuming exchange rate of U$1:UGX 2500.
[4] This represents a decline in the health sector share of the total budget, from 8.6% to 8%.

Recife commitments. Some barriers to progress remain, however, particularly around funding. The government ranks health below other priority areas, such as infrastructure development and security, and external donor funding is uncertain.

# RESULTS

The government of Uganda developed a results framework to operationalize the realization of the commitments and track progress toward results indicators (see Figure 1). This section describes the progress made for each commitment.

## Commitment 1: Improve availability: Scaling up preservice education and training

The details of the commitment specified two areas involved in scaling up preservice education and training:

- Scale up the training of professionals in scarce supply, namely, through 2015: increase enrollment of anesthetic officers from 20 to 60; increase annual enrollment of laboratory technologists by 100; and increase the annual enrollment into midwifery training by 200 per year.

- Work jointly with professional councils to enhance the quality of preservice education through synthesis and implementation of harmonized standard guidelines for establishment, accreditation, licensing, and operation of health training institutions.

### Recruitment and training

Uganda made a conscientious effort to scale up the recruitment and training of health professionals in scarce supply, initiating several strategies to overcome obstacles to enrolling students at full capacity. For example, through the USAID-funded Uganda Capacity Program, led by IntraHealth International, under-resourced pharmacy and laboratory training institutions were provided with needed equipment and learning materials to support higher enrollment. To help students overcome cost barriers to enrollment, the government provided scholarships to 200 midwives through its partnership with the Uganda Capacity Program.

*Outcome:* Due to these efforts and others, the number of health workers enrolled in training increased in several priority cadres:

- Annual academic enrollment for anesthetic officers doubled in 2014–2015 as compared with 2013–2014, growing from 20 to 40.

- The number of midwifery students more than tripled between 2013 and 2015, rising from 900 to 2,756.

- In 2014, 210 pharmacy technician students were enrolled, versus 90 in 2013.

- Although enrollment for laboratory technologist training did not increase, it was maintained at a substantial and steady level, with 458 students between 2013 and 2015.

**Health training institution guidelines**

In addition to increasing enrollment, the Ministry of Education and Sports worked jointly with the Ministry of Health and health professional councils to enhance the quality of preservice education. This was accomplished through coordinated implementation of harmonized standard guidelines for establishment, accreditation, licensing, and operation of health training institutions. The Minister of Education and Sports launched Basic Minimum Requirements and Standards at the education sector's Annual Joint Review Mission of 2014 (Ministry of Education and Sports 2014).

**Outcome:** Formal assessment of the extent of application of the preservice training standards is ongoing. However, anecdotal observations made during a recent inventory assessment of health training institutions indicate that most of the 143 institutions were following the training standards, albeit to varying degrees. The ongoing assessment will provide more accurate and quantitative information on extent of use and how well the standards are being applied.

## Commitment 2: Provide incentives for attraction and retention

Stakeholders identified four specific focus areas to improve health worker recruitment and retention:

- Ensure that at least 60% of technical staff at health center levels III and IV and general hospitals have standard institutional accommodations at their place of work.

- Enhance salaries of health workers at health center levels III and IV and at general hospitals by 50% of current gross pay and ensure that the salaries are paid in a timely manner.

- Provide full tuition support for post-basic professional training to health workers who serve in remote rural facilities for at least two years.

- Complete establishment of village health teams in all the districts and institute appropriate mechanisms for maintaining them.

**Accommodations**

The Ministry of Health developed a costed strategy for improving accommodations for at least 60% of technical staff working at health center levels III and IV and general hospitals. The Ministry is using the strategy to lobby for funding from health and development partners. Through the World Bank-funded Health Systems Strengthening Project, the Ministry plans to improve additional accommodations for staff of selected health centers.

**Outcome:** During FY 2013/14, the government constructed at least 95 units of three-bedroom

houses for health workers. More housing units were built during FY 2014/15 at health centers, general hospitals, and regional referral hospitals from different funding sources; the number is still being validated and may be reported in the Annual Health Sector Performance Report for FY 2014/15.

## Salaries

Physicians working at the health center IV level received a top-up allowance in 2013, amounting to US$400 per month, over and above their basic monthly salary of US$600.[5] To ascertain the impact of the physician salary increases on retention, the government planned an assessment in August 2015, with technical support from IntraHealth and funding support from USAID, scheduled to be disseminated in early 2016. In addition, the government has developed a plan to increase salaries for other health workers at health center levels III and IV and at general hospitals. The plan to increase other salaries has not yet commenced, however, because districts cannot raise significant funds to sustain salary increases, and the central government has not increased the resources it allocates to the districts. To compensate for this impasse, local governments are currently providing local salary top-ups when needed to attract and retain health workers.

In 2014, payroll management was decentralized to local governments to facilitate timely salary payments to all government employees. Previously, delays sometimes caused providers to wait months for their paychecks and even miss some payments. Like most of the other HRH initiatives, this intervention was put in place only recently, allowing insufficient time to be able to determine its effectiveness.

*Outcome:* In line with the plan, the Ministry of Health has been providing a retention allowance to doctors working at health centers level IV, which is 67% of their basic pay. During the budget speech presented on 12th June 2014, the government announced an US$ 180 million increase in salaries for health workers and teachers. However, that increase has not taken effect due to budget shortfalls. The government has not yet established a monitoring and evaluation plan or dashboard mechanism to track the impact of the payroll intervention. Therefore, the effect of salary interventions on recruitment cannot be assessed.

## Tuition support

The Ministry of Health and development partners are providing full tuition support for professional training of health workers such as midwives who agree (via a bonding agreement) to serve in remote, rural, or underserved facilities for a duration that is equal to the duration of the training. According to the bonding agreement guidelines, the remote service deployment is expected to begin immediately after training has been completed. Through another initiative, the USAID-funded Strengthening Human Resources for Health project led by IntraHealth, 100 partial scholarships were awarded in 2014–2015. The scholarships target students in priority

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[5] Assuming exchange rate of U$1:UGX 2500

cadres in their later years of study who come from hard-to-reach areas, with a particular emphasis on female students.

*Outcome:* With the scholarships supported by USAID, 194 students entered health worker training programs and are still in these programs. Further, due to the full tuition support intervention, 34 midwives have completed their program, have been deployed, and are currently working in public facilities.

**Village health teams**

The government identified the community level as an important area of development need. To achieve the last component of Commitment #2, the government supported a study trip for selected Ministry of Health officials to travel to Ethiopia to gain insight into how to develop and support community health workers. As a result, a new policy is being developed to support village health teams and community health workers and put in place appropriate financing and remuneration mechanisms for maintaining them. This policy development is currently in the consultation process.

*Impact:* The policy has yet to be implemented.

## Commitment 3: Improve health workforce productivity and accountability

Commitment 3 comprises three focus areas:

- Strengthen performance management by institutionalizing individual performance planning, monitoring, and appraisal for all staff at health center levels III and IV and at general hospitals.

- Apply the Workload Indicators of Staffing Need (WISN) method nationally for determining staffing requirements and efficient deployment of staff at health center levels III and IV and at general hospitals.

- Apply appropriate measures to reduce absenteeism (currently estimated at 50%) by 50% at all levels.

**Performance management**

USAID is supporting the Ministry of Health to strengthen performance management through the five-year Strengthening Human Resources for Health project led by IntraHealth (2014–2019). With project assistance, the government is institutionalizing individual performance planning, monitoring, and appraisal for all staff at health center levels III and IV and general hospitals.

*Outcome:* During FY 2014/15, performance management guidelines and processes were rolled out in eight districts in four regions, reaching 632 health workers in 56 health units.

**Absenteeism**

With support from the Strengthening Human Resources for Health project, the government is designing and implementing interventions to reduce absenteeism from current levels by 50% by 2019 at all levels of the health service delivery system.

*Outcome:* An electronic tool for documenting and reporting absenteeism has been developed and is currently being piloted in three districts, with plans to expand to all districts in 2015.

## Commitment 4: Strengthen partnerships with the private not-for-profit service providers

Uganda's fourth HRH commitment focuses on two areas:

1. Increase financial support to PNFP service providers to achieve 100% of established staffing standards at health center levels III and IV and at general hospitals.
2. Strengthen the HRH TWG to effectively embrace the functions of Country Coordination and Facilitation (CCF) and an HRH observatory.

**Financial support for PNFP staffing**

PEPFAR is supporting the Ministry of Health to increase financial support to PNFP service providers to improve their staffing. Over 500 health workers were recruited by PNFPs through this mechanism in 2013–2014.

*Outcome:* In the absence of baseline measurement and consistent monitoring, it is not possible to determine the extent to which these numbers represent an increase over prior years.

**Strengthening the HRH TWG**

Work to strengthen the HRH TWG to effectively embrace the functions of coordinating HRH strengthening efforts and leading information sharing has yet to commence.

## DISCUSSION

Progress has been achieved toward all four of Uganda's HRH commitments. Establishing a results framework and processes for implementation were important factors in sustaining that progress. Even so, the lack of comprehensive processes for consistent and timed reporting has compromised efforts to demonstrate progress and establish accountability for the commitments. Capacity for documentation and monitoring and evaluation, including productivity monitoring, are important factors in sustaining advances toward HRH commitments and broader health goals. Furthermore, monitoring the impact of investments to improve the

health workforce can help systems planners to maximize the existing health workforce, prepare for future HRH needs, deploy health workers where they are most needed, and prepare them with the appropriate competencies and adequate support to provide quality services. Evidence will help policy- and decision-makers to plan for optimum impact toward achieving universal health coverage. Further, tracking the resulting progress will allow HRH advocates to more effectively recruit and sustain political will and allocation of resources that permit continued progress.

## CONCLUSION

In response to severe shortages of critical health workers and poor performance of the health system, Uganda was poised to make tangible commitments to strengthen its health workforce. The government was able to generate traction, political will, and resources for health system strengthening prior to the 2013 Global Forum, and steps taken since the Global Forum have continued to move the government to keep those commitments. The HRH commitments formalized Uganda's resolve to improve its workforce and broaden access to quality care, and it is hoped that improved monitoring and evaluation processes will establish accountability to sustain Uganda's forward movement through concrete steps.

Uganda's experience demonstrates the importance of building and using evidence, leveraging the influence of champions, and working across ministries and sectors to accelerate momentum. Learning from these experiences, we can capture the hard lessons learned through preventable deaths and leverage those examples to demonstrate what can happen when the health workforce is not a resourced priority. Evidence demonstrates need and allows health stakeholders to track the impact of their HRH investments. Valid evidence will not only guide strategies that advance progress toward achieving the HRH commitments but will ensure that the commitments and resources maintain their initial momentum.

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# Figure 1: Uganda Global Forum Commitments: Results Framework



**Performance Metrics**
- Stock, density, and skills mix of HRH
  - Ratio of health workers to population
  - Distribution of HRH in urban and rural communities
  - Distribution of HRH by occupation, specialization, or other skill-related characteristic
  - Skills mix

**Strategic Objective**
Universal Health Workforce

**Goal**
Universal Health Coverage

**Performance Metrics**
- Proportion of population covered (population coverage)
  - Equity in access across income groups, sex, age, place of residence
- Range of services provided (service coverage)
  - Skilled birth attendance
  - Women antenatal care attendance
  - Immunization coverage: measles, DPT3
  - Insecticide-treated net coverage
- Proportion of costs covered (financial coverage)
  - Insurance coverage
  - Incidence of catastrophic payment
  - Ratio of out-of-pocket expenditures to total health expenditure

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**Increased availability of health workers**
*Indicators*
- Health workforce numbers
  - Percentage of positions filled
  - Village health team coverage
- Attendance existing health workers
  - Hours worked compared with hours scheduled
  - Days of absenteeism among health workers

**Increased attraction and retention**
*Indicators*
- Staff turnover
- Ratio of entry to and exit from the health workforce
- Duration in job

**Increased productivity and accountability**
*Indicators*
- Health outcomes given density of health workers (outpatient visits, patient contacts, antenatal care, deliveries, immunization coverage, etc.)
- Adherence to standard operating procedures

**Strengthened public-private partnerships**
*Indicators*
- HRH staffing levels in private not-for-profit facilities
- Salary differentials between public and private not-for-profit sectors

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*Strategies*
- Scale up preservice education (anesthetic officers, midwives, lab technologists, cold chain and biomedical technicians)
- Improve quality of preservice education
  - Develop and harmonize standards for establishment, accreditation, licensure, and operation of health training institutions
- Reforming education policy to respond to new global guidelines

*Indicators*
- Of each of the following health workers, number that graduated from preservice training in the reporting period
- Anesthetic officers, midwives, lab technologists, cold chain technicians

*Strategies*
- Improve health worker accommodation at health centers III and IV (quantity and quality)
- Enhance health worker salaries (health centers III and IV)
- Post-basic training for health workers in rural areas
- Complete village health team establishment

*Indicators*
- Percentage of health workers accommodated at health centers III and IV and general hospitals
- Percentage of targeted health workers with salaries enhanced at health centers III and IV and general hospitals
- Number of targeted health workers from rural areas supported to undergo post-basic training
- Percentage of districts with trained and functional village health teams

*Strategies*
- Strengthen leadership and management at the district and health facility levels
- Strengthen performance management and appraisal system
- Promote use of efficient HRH planning and management tools (WISN)
- Measures to reduce absenteeism

*Indicators*
- Existence of formal mechanism for individual performance planning and review
- Existence of performance management tools: Job descriptions and schedules
- Percentage of health workers appraised based on their individual performance plans
- Number of districts using WISN in staff deployment

*Strategies*
- Finalize development of guidelines for implementing public-private partnerships in health and harmonizing reporting

*Indicators*
- Existence of a GL for implementing public-private partnerships in health by 2015
- Extent to which GL is implemented