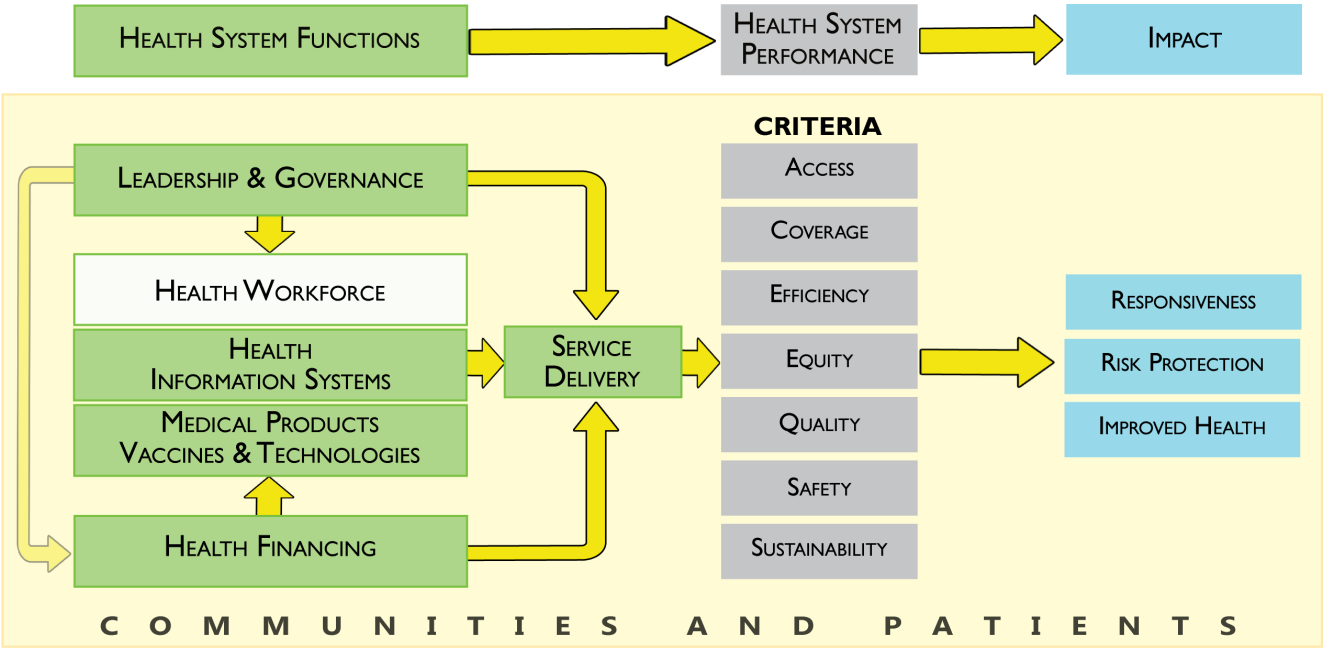
Module 5
Human Resources for Health

This module presents a framework for human resources for health and outlines specific indicators to measure to understand the strengths and weaknesses of a country's workforce capacity and the enabling environment.

FIGURE 3.5.1 IMPACT OF BUILDING BLOCK INTERACTIONS



Introduction

HRH is the foundation of the health care system. A well-performing health workforce has sufficient numbers of trained staff, who are fairly distributed throughout the country, and supported by policies and systems. This module will review the fundamentals of HRH and describe what to include in the HSA report's chapter for this topic. When assessing a country's HRH, one must consider both the government and nongovernmental sector, including not-for-profit and for-profit training institutions, health care facilities, and health care providers. Often, government does not collect and/or include private sector data in its HRH planning. This means that its estimates of future HRH requirements or plans to scale up service provision through increased employment or service expansion do not take into account private HRH. In most countries, the private sector has become a prominent producer, distributor, and employer of the health care workforce and, thus, an important element to describe in the HRH assessment.

This module presents the HRH building block of the HSAA manual.

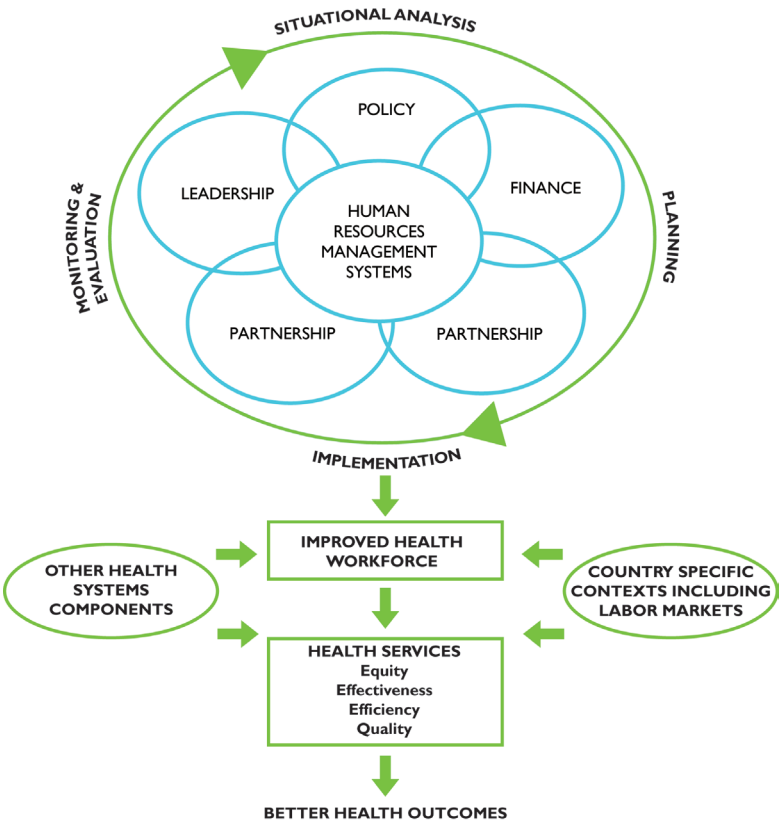
- Subsection 5.1 defines HRH and its key components.
- Subsection 5.2 provides guidelines on preparing a profile of HRH in the HSA country.
- Subsection 5.3 presents the indicator-based assessment.
- Subsection 5.4 details the process for summarizing findings and developing recommendations.
- Subsection 5.5 contains a checklist of topics that the team leader or other writers can use to make sure they have included all recommended content in the chapter.

5.1 WHAT IS HUMAN RESOURCES FOR HEALTH?

The *World Health Report 2006* (WHO 2006) defines HRH, or the health workforce, as "all people engaged in actions whose primary intent is to enhance health." According to WHO, this includes "those who promote and preserve health as well as those who diagnose and treat disease. Also included are health management and support workers—those who help make the health system function but who do not provide health services directly" (2006b). For example, health educators, such as nurse tutors, are part of HRH. Finally, there is a growing number of para- or nonprofessionals, such as CHWs and peer counselors, providing health services in communities in clinics and at home. In some countries, these CHWs have become a significant proportion of the overall health care workforce. It will be important to include these CHWs in the HRH assessment in order to fully describe the HRH capacity.

WHO recommends that country governments engage in a multi-sectoral and participatory process to create an enabling environment for effective human resources management (HRM). The factors that affect an enabling environment – policy, finance, education, partnership, leadership, and HRM – are presented in Figure 3.5.2, the Global Health Workforce Alliance (GHWA) HRH Action Framework (http://www.who.int/workforcealliance/en/). This figure also shows the components and outcome of strengthened influencing factors for HRH.

FIGURE 3.5.2 THE GHWA HRH ACTION FRAMEWORK



The framework website stresses the importance of government considering the private sector: "The HRH Action Framework…is designed to assist governments and health managers to develop and implement strategies to achieve an effective and sustainable health workforce [for the entire health sector]. By using a comprehensive approach, the Framework will help address staff shortages, uneven distribution of staff, gaps in skills and competencies, low retention and poor motivation, among other challenges." Recognizing that many of the health workforce are outside the purview of the MOH, the HRH Action Framework advocates for mechanisms and processes that foster multi-stakeholder cooperation (inter-ministerial committees, health worker advisory groups including private professional associations and donor coordination groups) and greater cooperation between public and private sector providers (see indicators under Partnership).

TIP

Human Resources Management Tools

For further information on HRM, the HRH Action Framework, or additional HRH tools, refer to the USAID funded Capacity Plus Project website: www.capacityplus.org

5.2 Develop a Profile of Human Resources for Health

To give the overall HSA team and country stakeholders an overview of the institutions and functions of the HRH in the health system, the technical team member responsible for HRH will develop a profile of the human resources component across public and private sectors.

A comprehensive profile includes the following components:

- The total number of health care workers in the public, private, and NGO/FBO sectors by cadre
- The total number of health care workers in public, private, and NGO/FBO sectors by geographic distribution
- The enabling environment for a strong HRH component (using the HRH Action Framework, described above)
- HRH planning capacity
- HRH development (education and training) through public and private institutions
- HRH performance support (includes management and leadership as well as performance management)

The following approach can guide the HRH assessment:

- If available, review the existing government HRH strategic plan. Determine when it was produced and last updated and whether it includes plans for HRH in all sectors.
- Obtain organizational charts of the MOH at central, regional, and district levels to ascertain where human resources fit into the larger system.
- Review HRH assessments that have been completely recently (within four years).
- Review the MOH's human resources establishment register or registries of health professionals, including information on degrees, diplomas, graduation, deployment, and licensure. These documents may be at either the national or regional level and may be managed by the health professional regulatory bodies or internal offices within the MOH. Some of these registries include private and NGO/FBO providers.
- Prepare lists or tables that capture and synthesize key elements of the HRH system, for example, categories, numbers, and distribution of health workers and levels of authority for key human resources functions at various levels within the system.
- Seek existing reports or survey data with total (public and private sector) estimates of HRH. Data from the World Bank, WHO, or a national statistics bureau may be useful, but they must be used with caution because they could be outdated or incomplete.

Where they exist, national registries of commercial for-profit and/or non-profit service providers can provide useful estimates of HRH available across the sectors.

- Seek data from professional provider associations or other private sector entities for augmenting or cross-referencing.

Decentralization and HRH

In the public health sector of many developing countries, HRM decisions are made at the central level. In some countries, although policy is made at central level, most other functions are managed at a lower level; district health managers, autonomous hospitals, and large municipalities often have their own HRM structures. In addition, HRM functions for health may be housed in the MOH, the Ministry of Education, the Ministry of Labor or Civil Service, local government, and so on.

In creating the HRH profile, describe:

- The relationships between the various HRH functions and how integrated or fragmented they are;
- The level of authority for hiring, firing, disciplining, promoting, and deploying workers (e.g., which level can execute rewards and incentives or initiate disciplinary action to influence performance?).

In gathering data, it is important to ascertain any differences between how things are meant to work – often described in secondary source documents – and how things are really working. Key informant interviews and field visits are useful in this regard. Assessment questions should be tailored to reflect the level of decentralization in country, so that the questions are relevant to the interviewee.

TIP

Conducting the Assessment

- Select ONLY indicators that apply to the specific country situation.
- Conduct a thorough desk review of all available secondary data sources before arriving in country.
- Stakeholder interviews should focus on filling information gaps and clarifying issues.
- Coordinate stakeholder interviews with team members so all six modules are covered and avoid interviewing the same stakeholder twice.
- Look at all health actors – public, for-profit and not-for-profit, involved in delivering health services.
- Tailor the interview questions to each level of decentralization so they are relevant to the interviewee.
- Schedule team discussions in country to discuss cross-cutting issues and interactions.
- Finalize an outline for the assessment report early on so sections can be written in country.

5.3 ASSESSMENT INDICATOR OVERVIEW

This section focuses on HRH indicators – it shows the topical areas into which the indicators are grouped, lists data sources to inform the indicators, discusses how to deal with indicators that overlap with other building block modules, defines the indicators, and, in the "Interpretation" and "Issues to Explore" subsections, shows how to work with them. Finally, the section identifies key indicators to which the HSA technical team member can limit their work, if time precludes their measuring all indicators. Annex 3.5.A lists Issues to Explore in Stakeholder Interviews to show technical team members the type of information that each stakeholder typically will know and priority topics for discussion.

TIP

PRIORITIZING INDICATORS

Team members constrained by limited time or resources should prioritize as follows:

- First, assess Indicators 1–4, because data for them are readily available from the Health Systems Database (http://healthsystems2020.healthsystemsdatabase.org).
- Second, assess Indicators 5, 7, 21, and 22.
- Third, if possible, assess all remaining indicators to get a more comprehensive picture of HRH in the country.

TOPICAL AREAS

The HRH Action Framework is a useful way to group and organize data into topical areas and to understand country-specific HRH strengths and weaknesses. Topical area A has four indicators: data for Indicator 1, the number of HRH by cadre, are available through the Health Systems Database (http://healthsystems2020.healthsystemsdatabase.org/). Indicators 2–4, concerning geographic distribution, sector, and recent trends, are likely found in country, mostly in MOH data. Information for topical areas B–H should be gathered to the extent possible through desk review and then complemented with discussions and interviews with key informants and other stakeholders. Data sources recommended for these indicators may not be readily available. As always, the technical team member for HRH is responsible for organizing and developing a process for the review of records, documents, and key informants' and stakeholders' interview responses to obtain information necessary to make judgments on the indicators listed.

Table 3.5.1 lists the HRH topical areas and the numbers of the indicators associated with each area.

TABLE 3.5.1 INDICATOR MAP—HUMAN RESOURCES

Topical Areas	Indicator Numbers
A. Current HRH situation	1–4
B. HRH management systems	5–9
C. Policy and planning of HRH	10–12
D. Financing HRH	13–16
E. Educating and training HRH	17–21
F. Partnerships in HRH	20–22
G. Leadership of entire HRH system	23–24

Data sources

There are many sources to help technical team members assess and analyze HRH systems. The sources are organized here into three main categories:

1. **Standard health indicators:** Readily available data on HRH are drawn mainly from existing and publicly available international databases.
    - A compilation of these indicators is available at a single online source at the Health Systems Database (http://healthsystems2020.healthsystemsdatabase.org/)
    - Global HRH Resource Center (http://www.hrhresourcecenter.org/)

2. **Secondary sources:** The health indicators need to be supplemented with other research and documents such as policies, regulations, and health statistics. Below is a list of secondary sources available in most countries:
    - National health strategic plans (should be the prime source for documenting national statistics, policies, and strategies, and required), current and the previous edition
    - National HRH strategic plans (should be the prime source for documenting national statistics, policies, and strategies, and required), current and previous edition
    - HRH section of national health budgets
    - Actual financial performance compared to budget allocations
    - Existing wage and salary studies
    - NHA
    - WHO Global Atlas of the Health Workforce
    - Global Health Workforce Alliance website
    - Country MOH, MOF payroll database
    - Previous HRH assessments (literature review) and/or country-level HRH assessments
    - Health sector information not included in the national health strategic plan, including other health-related policies, other strategic plans, reviews, evaluations, service delivery package descriptions, DHS, service availability mapping, and facility surveys
    - HRH information not included in the national health strategic plan, including HRH policies, other strategies and plans, evaluations, reviews, staffing norms, workforce plans, and staffing, recruitment, deployment, attrition, and training data
    - Public service information including establishment, payroll, personnel regulations, schemes of service, and job descriptions
    - Policy documents from large private sector providers such as FBOs or FBO associations

TIP

How To Get To The Core Issue Through Stakeholder Interviews

To get to the bottom of things, start at the top of the MOH structure and work your way down the organizational chart.

For example, in HRH Finance, begin with high-level MOH finance and budget decision makers. Continue with key staff in the MOH budgeting unit. Interview the key MOF staff who work with the MOH.

TIP

INTERVIEWING HEALTH WORKERS

Although the list of stakeholders to interview is long, it is critical to interview health workers themselves, where possible. Allow sufficient time during the assessment trip to include health worker interviews. An efficient way to capture health workers' perspective is to organize focus groups.

- Professional bodies such as nursing councils and medical boards. Each profession typically has a governing council that sets criteria for licensure, continuing education (if any), and emigration documentation.

3. **Stakeholders to interview:** Annex 3.5.A presents a Summary of Issues to Explore in Stakeholder Interviews.

- MOH HRM and Planning department staff:
  - MOH staff responsible for the training, deployment, practice standards, and monitoring of health care workers – including staff in departments of medical services, public health services, human resources and human development engaged in HRM activities, and any chief medical or nursing officers on the Ministry of Education staff who are involved in establishing or monitoring health professional degree programs – including staff in higher education departments responsible for medical and other health professional curriculum and training in universities or other colleges and institutions
  - Senior administrators (deans, department chairs) at national or local universities with medical, nursing, or other health professional training programs under the jurisdiction of the Ministry of Education
  - Senior administrators of non-university-based public and private training institutions not managed by the Ministry of Education, including colleges and training institutions that graduate degree and diploma nurses, clinical officers, and laboratory and health management staff. Most of these institutions will be under the jurisdiction of the MOH
  - MOF payroll clerks
  - Health professional councils or regulatory bodies (physician, allied health, nursing, pharmacy, and others) and professional associations representing health care workers. Include interviews with executive director and other senior staff and staff responsible for information and, database
  - Health information system database administrators within national and regional offices; if available, the human resource information system (HRIS) database administrators
  - In-country PEPFAR HRH/HSS technical advisors, Centers for Disease Control and Prevention, and USAID, responsible for developing HRH plans and programs
  - Global Fund HRH or HSS technical advisors or in-country staff
  - Other development partners that have a substantive role in funding HRH activities in the country

Depending on time available, you can choose to do key informant interviews, focus group discussions, and observations with a representative range of stakeholders from among the following:

- Faculty from training institutions
- Students enrolled in training programs
- Health workers representing a range of providers: physician, clinical officer, nurse, midwifes, and CHWs
- Other government agencies with human resources roles and mandates, e.g., ministries of Public Service, Education, Finance, Local Government

The following sections provide an overview of each topical area, sources for data collection, descriptions about each indicator and ways to interpret the information.

Topical Area A: Current HRH Situation

Overview

HRH statistics provide quantitative evidence of the HRH situation. For example, the numbers of health care workers, as well as ratios per population, will help the HSA HRH technical expert to judge if the country has adequate number of HRH and, if not, the severity of the HRH situation. It will also allow quick comparisons to other countries. Disaggregating these statistics allows the HSA team member to describe the allocation of specific providers across the various levels within the delivery system and the distribution of providers between geographic boundaries (rural/urban). The distribution figures are perhaps more important than overall numbers because they show geographic areas, HRH cadres, and service delivery levels where HRH is inadequate. For example, Bangladesh has a large surplus of doctors and a drastic shortage of nurses (World Bank 2009a). In Kenya, district hospitals have on average 120 percent of nurses they need, while dispensaries have 70 percent vacancies for nurses (average 1.7 out of 5) (Muchiri and James 2006).

CURRENT HRH SITUATION

Indicator	Definition and Interpretation
1. Ratio of different health personnel per 1,000	This indicator considers: • Ratio of health cadre per 1,000 people • Total number of physician • Total number of nurses • Total number of midwives • Total number of pharmacists • Total number of laboratory technicians • The number of health care providers, by cadre, is the raw material upon which all other statistics will be based. WHO gathers and presents statistics on the number of health care workers per 1,000 population, which allows easy comparisons between countries in a region, and between areas within a country. The country comparison data can be presented in a table; the table can include a column for the WHO-recommended workforce number for the HSA country (e.g., 2.28 total health care workers per 1,000 population) so that overall adequacy of the workforce is easy to judge. Note: While population ratios provide a handy comparator, additional factors such as population density may exacerbate HRH access issues. Probe for these factors in the interviews and present them in the text that accompanies the tables.
2. Total number by cadre and sector	This indicator considers: • Total number of physician by sector • Total number of nurses by sector • Total number of midwives by sector • Total number of pharmacists by sector • Total number of laboratory technicians by sector It is easy to collect by cadre the number of HRH who work in the public sector and in many countries MOH statistics include HRH in the NGO/FBO sectors. But finding the number of HRH who work in the private sector usually requires some investigation. The place to start is with professional council licensure registries; private providers are normally licensed although the registries do not indicate public or private status. A second source is professional association member registries, which often do indicate public or private status. You can "guessestimate" the number of private providers by extrapolating from the above numbers. Finally, telephone books list almost all legitimate private providers; these listings can be cross referenced with council and association registries. Taking the time to collect the total number of health professionals by sector is critical to helping the MOH understand how many providers work in the overall health sector, where are they located, and how can they be mobilized to help address some of the HRH gaps. These gaps can be shown in a table or pie chart. See Annex 3.5.B for examples of how to present these data.
3. Ratio of health care worker by geographic distribution	This indicator considers: • Ratio of health care workers by cadre and by geographic area. • If possible, break out geographic distribution by cadre and sector. Use MOH and other HRH data sources to examine HRH distribution by: (1).cadre, (2) geopolitical boundaries, (3) urban/rural split, and (4) service delivery level, including the number of CHWs (not attached to any level of facility). This will reveal inequities in service coverage. It may be helpful to present these data in four adjoining tables. It may be possible to combine (2) and (3) above through use of asterisks or other markings to tell, for example, which districts are rural and which are urban. Depending on country usage, it may also be possible to split geographic area into three categories, adding "peri-urban." See Annex 3.5.B for examples of how to present these data.
4. Trends for the past five years	This indicator considers: • Ratio of health professionals by population over time • Total numbers by cadre and sector over time • Ratio of health care worker by geographic area over time Present the client and other country stakeholders with evidence about whether the HRH situation is getting better or worse for as many years as there are data available. Where possible, disaggregate the historical data by cadre. Again, this information should be presented in graphical form; for example, historical data by cadre can typically be presented on one graph, using different shapes to present the data points for each cadre. If the resulting graph is too busy and therefore unclear, present individual graphs. See Annex 3.5.B for examples of how to present this data.

Topical Area B: Human Resources for Health Management Systems

Overview

Central to a country's health care needs is strong HRM at all levels of the health care system. HRM is an organizational function that effectively develops and uses the skills of the people who work in the organization – here, the health care system. It is important because it addresses the system's need for a competent, stable, and motivated workforce that allows the system to perform optimally (i.e., have the right number of service providers with the right skills in the right locations at the right time).

HRM comprises:

1. Planning the workforce: Accurately estimating HRH needs based on data
2. Developing the workforce: Training, recruiting, selecting, and deploying HRH
3. Managing the workforce: Retaining workers through good performance management (setting performance expectations and appraising), compensation (including benefits), career development, and related activities such as employee relations and labor relations programs

In most developing countries, achieving effective HRM is complicated. These countries' health ministries have data on public sector employees but almost none on workers in private nonprofit and for-profit sectors. MOH workforce planning and management is obviously hampered when the ministry is uninformed about an appreciable percentage – often half or more – of the country's health professionals.

Issues to Explore

The following questions can be used to assess the strength of HRM systems:

- What systems and capacity are available to ensure the collection, analysis, and utilization of HRH data to inform sound evidence-based decision making and monitoring of the workforce?
- Are health workforce recruitment and deployment systems and interventions aligned with and responsive to service demands?
- Are there persistent problems in retaining health workers and, if so, what are the reasons for this?
- What management systems and capacity are available to promote and sustain a positive working environment?
- What policies and practices are in place to protect health workers?
- How are staff needs and expectations appropriately heard and addressed in the workplace?
- How do existing mechanisms adequately address health care worker career development and staff engagement?
- What policies, mechanisms, and practices are in place to effectively manage, support, and promote health worker performance and productivity?

Human Resources for Health Management Systems

Indicator	Definition and Interpretation
5. Existence of a comprehensive HRH plan with a budget	Intrahealth defines an HRH plan as follows: "Strategic planning helps an organization make fundamental decisions about its human resources by taking a long-range view of what it hopes to achieve and, in broad terms, how [it hopes to achieve its goals]… Operational planning is related to the implementation of the strategies on a day-to-day basis. For example, if training more staff is the strategy selected for improving staffing in remote facilities, the operational planning would include the start date for training courses and the number of tutors needed." (http://www.intrahealth.org/~intrahea/files/media/health-systems-and-hrh/techbrief_9.pdf) There should be evidence that the strategic plan is being implemented. If the country has a strategic and operational HRH plan, determine when the plan was developed and/or updated. Existence of an HRH plan is a positive sign; however, plans are not always implemented. If the plan is not being implemented, probe for implementation bottlenecks. As in all qualitative data gathering, it is advisable to ask multiple interviewees the same question in order to triangulate and thereby discover more complete information. In addition, key areas to look for in the plan are: • Existence and use of HRH annual operational plans; use as a means to identify actual interventions or actions that have been taken to reach benchmarks defined in plans such as new laws, regulations, policy guidance, or system/structural changes evident at training or employment sites • Availability of strategic and operational HRM functions and structures at national and local levels • Availability of annual recruitment and deployment plans, including numbers and types of health workers required at all levels • Existence of fair, consistent, timely, merit-based, and well-defined recruitment and deployment systems and procedures • Existence of policies, systems, and procedures to choose appropriate bundle of retention interventions and to manage retention schemes • Availability of monitoring data on retention schemes and impact
6. Availability of strategic and operational HRM functions and structures at the national and local levels	Management Sciences for Health (MSH) defines an HRM as follows: "HRM is the integrated use of systems, policies, and practices to plan for necessary staff and to recruit, motivate, develop, and maintain employees in order for the organization to meet its desired goals." (http://www.capacityplus.org/files/resources/projectTechBrief_2_0.pdf) Describe or map the current status of HRM functions and structures. The HRM functions are often weak, understaffed, fragmented, and staffed by people with no human resources training, so probe to find out the current status. In mapping the HRM functions, ascertain in particular the level at which the functions are located within the organization, and whether the staff's human resources work is strategic or mainly concerned with logistical matters. Assessing the strength and gaps of the HRM function is key, as sustainable HSS cannot often be done without a reasonably integrated and strong HRM function both at the central and district levels.

HUMAN RESOURCES FOR HEALTH MANAGEMENT SYSTEMS CONT...

Indicator	Definition and Interpretation
7. Enabling environment exists for health workers to achieve goals and targets	Elements of an enabling environment include: • Clear job descriptions • Appropriate tools • Adequate supplies • Supportive supervision Does this exist in a strategic or operational plan? Is there evidence these are followed at the intended level? First, determine if a policy statement or the components of an enabling environment exist on paper, for example, in a strategic or operational plan. If so, how widely available is the plan? How easy is it to retrieve, for example, the set of job descriptions of the safety policy? Does the policy or role description appear to be up-to-date? Second, ascertain policy implementation. Is there evidence that policies (or parts thereof) are actually being followed at the intended levels? Do the enabling environment elements as described in the indicator exist – at least to some degree – at the facility level? If there is, for example, a retention challenge that HRH leaders are trying to address, is there evidence of policies, systems, and procedures to choose appropriate bundles of retention interventions and to manage retention schemes? Ascertaining what is being implemented is difficult without visiting a certain number of facilities (which should be part of the overall assessment). However, respondents – if asked – are often willing to volunteer information about the difference between what exists on paper and what is actually happening in practice. This is critical information as it will point toward intervention areas: For example, it is important to know whether the issues are more around plans and policy formulation or putting these into practice as they require different kinds of interventions to "fix."
8. Availability of and use of HRH information systems	Evidence of use includes: • capacity to collect, integrate, and analyze HRH data that include both state and non-state players; • information used to plan, train, appraise, and support the health workforce. Does an up-to-date HRIS exist, and are the data used to inform decisions about planning, training, and supporting the health workforce? The existence of the system should be easy to determine. If an HRIS exists, determine the quality of data input, as well as how broad based the system is. Describe who uses the data and for what purpose, e.g., MOH to track new graduates into the field; regulatory councils to manage licensing requirements. In many countries an MOH HRIS typically includes only government workers, leaving out significant percentage of the country's health workers. FBO-based workers alone can make up 30–70 percent of the workforce. If the HRIS is producing data, seek evidence for how the data are used. Are there standing groups or task forces, or planning functions that routinely review and use the data? Is there evidence that HRIS data has informed or driven a recent decision about, for example, medical education or in-service training?
9. Availability of mechanisms used to monitor and improve health worker performance, productivity, and expectations	The existence and use of monitoring reports that include data on health worker performance (e.g., health worker absenteeism relative to the total number of scheduled working days over a given period at a facility). Is there a documentation system in place to monitor and inform HRH performance and productivity, for each cadre separately (including community health care workers)? If a documentation process and other mechanisms exist: • Are the mechanisms actually being used? • Are they producing positive benefits in terms of improving performance? • Are any unintended consequences occurring? (Measuring productivity and doing performance management is a difficult organizational task in any system, and often makes things worse if not done well) Are workers being given clear job expectations? This is generally a key to effective performance and – unlike feedback – is generally acceptable across cultures. One proxy indicator for HRH performance is absenteeism – the higher the level of absenteeism, the lower the quality of the performance will be. However, absentee data may be difficult to find, and may also be sensitive. It may help to ask for it in general, or by type of facility, and not tie it to specific locations or regions.

TIP

Stakeholder Interviews for HRH Policy

Start interviews with a high-level MOH official. If possible, do a pre-trip telephone interview with the MOH (organized by onsite logistics coordinator) to simply gain contacts for each of the policies you are interested in (e.g., the compensation policy is with the MOF, while the recruitment policy is at the Ministry of Public Service). Ask the in-country logistic coordinator to obtain these documents to review before the team's arrival.

Also plan to interview FBO/NGO and commercial facilities and professional health associations to determine if private sector policies follow government policies or, if not, if the sector has no policies at all.

Above all, be sure to ask health care workers if these policies have been implemented

Topical Area C: HRH Policy and Planning

Overview

HRH policies formalize how health care personnel cover the entire career of a health worker, from preparation to enter medical or nursing school to retirement. Important phases include: pre-service training, deployment, retention, salaries and incentives, performance quality and mentoring, and a range of issues affecting the worker's ability to provide quality health care to communities. The better these policies are documented, the more likely it is that employees will be treated at least consistently, if not "fairly." However, simply having the policies in place is not sufficient for consistent treatment. During review of documents and interviews, especially with providers, technical team members can probe for how often these policies are followed.

Issues to Explore

- How detailed are the policies, and have the policies been translated into guidelines and other process documents?
- Are they open to interpretation, favoritism, or gaming the system?
- When were they last updated?
- Do managers or workers know what is in the policies?
- Have any health care workers ever seen the policies?
- Are the policies and guidelines actually followed? In both the public and private sectors?
- Is there an overarching HRH plan that takes into account all HRH in public, and nongovernment sectors including NGO/FBO sectors?

Policy and Planning of HRH

Indicator	Definition and Interpretation
10. Existence of and use up-to-date HRH policies	Capacity Plus explains the need for HRH policies. "To facilitate action, countries need evidence-based, costed, implementable HRH strategic plans, anchored by a policy framework that supports HRH plans with necessary legislation and regulation." (http://www.capacityplus.org/sites/intrah.civicactions.net/files/resources/HRH%20Policy%20and%20Planning.pdf) Seek evidence that the HRH policies exist and are actually used or implemented. If HRH policies exist, describe them: • Are they presented as part of an overall HRH policy? • Are they part of the health policy? • Are they part of the Public Service Commission policy? Make broad statements about the existence of the policies, who controls them, and how well they are put into practice.
11. Existence of clear and up-to-date scopes of practice	This indicator documents the existence of policies in place – often addressed in legislation – requiring registration, licensure, or certification for cadres of staff such as doctors, nurses, midwives, pharmacists, laboratory technicians, CHWs, and other personnel. This requirement is a mechanism for ensuring that certain professional qualifications are met upon entry to the profession and that periodic reassessments or re-qualification procedures are in place to ensure staff maintains their qualified status. Often these regulations also specify the documentation available upon emigration. Stronger HRH systems have more flexible scopes of practice that allow MOHs to fill shortages in certain cadres and accommodate changing health service delivery needs. For example, the scope of practice for clinical officers may be expanded because the officers can be trained to take on certain clinical procedures, and provide valuable services in places that lack access to a physician.
12. Employment policies documented and used	This indicator documents the presence of an employee manual or other written documentation of the conditions of employment – the rules and regulations that govern employees' conditions of service, and related policies and procedures such as leave and discipline. Evidence that policies are documented and used are: • Personnel policy manual that is available to all employees • Policies are actually followed Service documentation lets employees know what to expect in general from the organization and what rules they will be governed by. Lack of service documentation raises issues of fairness. It is also helpful to determine whether or not the policies described in a manual are actually carried out.

TOPICAL AREA D: FINANCING OF HRH

Overview

HRH represent the largest single cost element in providing health services in developing countries, and these countries are challenged to find the financial resources and appropriate payment methods to ensure an adequate supply and mix of health workers and stimulate productivity, responsiveness, and the provision of effective care. [1] HRH financing is defined as obtaining, allocating, and disbursing adequate funding for HRH. This covers areas such as (1) setting levels of salaries and allowances, (2) doing budgeting and projections for HRH intervention resource requirements including salaries, allowances, education, incentive packages, etc., (3) increasing fiscal space and mobilizing financial resources (e.g., government, Global Fund, PEPFAR, donors), and (4) analyzing NHA data on HRH expenditures.

FINANCING OF HRH

Indicator	Definition and Interpretation
13. Data indicating public salaries are competitive in the local and regional labor market	Having national or regional wage studies that look across the public and private health sectors. Describe how wages for public sector medical personnel compare to those in the private health care sector, to nonhealth sector wages in the country, and to public health sector wages in the region. Include allowances to get an overall picture of workers' financial compensation. Other, more specific potential comparison groups are listed below: • Other civil servants in the country (e.g., compare doctors to engineers or compare nurses to teachers) • Other professions in the country (e.g., compare doctors to attorneys) • International partners – hiring salaries for foreign service nationals in international NGOs • Similar professions in other countries, especially regionally, and then internationally (e.g., compare compensation for doctors in Ethiopia with those in Tanzania, Botswana, and Canada) If no data on wages are available, ask about wage difference perceptions during key informant interviews, especially with health workers. Such perceptions may be at least as important as actual wage differences, because perceptions of unfairness have been shown to drive staff turnover.
14. Evidence indicating that National Health Accounts regularly collect and report data about HRH expenditures	If the country carries out NHA studies, can the interviewees cite the NHA data and explain how they use the data? The extent to which HRH financial policies can be understood and improved depends on knowing how HRH are funded and where the funds are going. Virtually all countries now do NHA studies, and they are frequently completed annually. Ministries of Health and Finance should both be able to provide access to the most recent NHA data.
15. Evidence indicating budgets and projections done for HRH requirements	Is there a comprehensive account of the budget process and contents? For example, does the budget include salaries, allowances, education, and incentive packages? Describe how the country handles HRH financing: • Is there a separate line item in the overall MOH budget for health care workers' salaries and allowances? • If the health system is decentralized, how are the HRH budgets allocated (e.g., by geographic area)? • How is HRH budgeting is done: bottom-up vs. top-down? • Are HRH budget amounts allocated based on (1) need, or (2) last year's levels? • How is HRH finance treated in the country's overall budget (e.g. as a separate and important section)?

[1] Global Health Workforce Alliance: www.who.int/workforcealliance/about/taskforces/financing/en/index.html

Financing of HRH cont...

Indicator	Definition and Interpretation
16. Evidence indicating MOH makes good use of finances already available	This indicator describes evidence such as the MOH does not turn unused money back to the MOF (makes use of its entire budget) In many countries, HRH budget amounts are limited because of non-use of "last year's" funding. The MOF will have accounting reports showing the amount of funding returned by the MOH at the end of each fiscal year. In most cases, salaries and allowances will appear as separate line items on these reports. Document, for as many years as possible, the amount and/or percentage of the total budget and HRH budget that has been returned to the MOF.

Topical Area E: Educating and training HRH

Overview

Education refers to the process of producing qualified health professionals and para-professionals to address population-based health care needs. For health professionals, this process is split into several stages: pre-service education, post-graduate and specialty training, and in-service training including professional development. Pre-service education is the formative training of a health professional through a recognized, and often accredited, training institution: nursing school for nurses, and medical school for physicians. Upon graduation from a training institution, health professionals may be able to pursue ongoing training through specialty programs or continuing medical or nursing training through in-service programs. Pre-service education usually represents the largest method of increasing the workforce. In-service training is important for staff to acquire new skills, especially when staff need to gain new skills or competencies due to changes in practice standards or new roles and responsibilities.

The public sector has historically been responsible for educating HRH. However, in recent years, there has been increased participation by the private sector. In many countries, FBOs are the primary private sector actor, though not-for-profit and for-profit institutions are increasingly playing a larger role. Like the public sector, private medical institutions (PMIs) train the full gamut of health care workers: doctors, clinical officers, nurses, midwives, pharmacists, laboratory technicians, etc.

In countries with severe human resources for health deficits, PMIs serve as a necessary complement to public training institutions to increase the number of trained health care workers. Many PMIs operate outside government supervision and oversight, and a number of barriers – regulatory, policy, financial, and accreditation – can hinder the successful utilization and leveraging of PMIs as an important source for the expansion of the health workforce.

Country Story: St. Lucia

The first internationally accredited private hospital in St Lucia, Tapion Hospital, has established partnerships with Canadian and U.S. hospitals for consultation on difficult cases and continuing education of Tapion's staff. To expand this partnership, together the hospitals are building a state-of-the art telemedicine and conference center. Tapion has expressed keen desire to partner with the MOH to extend continuing medical education learning with its international partners to MOH staff.

Data Challenges

Consult regulatory councils and the Ministry of Education to determine educational requirements for each cadre. In each country, a regulatory council typically oversees the education process for each cadre, and licenses public and private education institutions. These councils keep records of the number of applicants, the number accepted, and the number graduated, by cadre. The Ministry of Education also plays a key role in pre-service education within university and other academic settings, and should be consulted to address some of the same questions.

In-service information is much harder to track, as the training is usually done in an ad hoc manner, based on whatever training opportunities are available, which vertical programs (and donors) are offering training, and what employees are due for training. Professional associations may have some requirements for continuing education for licensure, and if so, may have records of training by their members. Often, it is most expeditious to get the information through field interviews, asking workers and their supervisors about in-service training experiences over the past few years. Also, because donors often drive the in-service training agenda, they should be consulted for information.

Issues to Explore

- Is a central training planning function in place?
- May continuing professional education activities, whether off site or in-service, be sponsored by the organization or by donors?
- How are training needs identified?
- How are potential participants identified?
- Who develops the training materials and programs?
- Are the trainers specially prepared?
- Is there follow-up?
- Are there any plans or policies?
- Is training a permanent line item in the budget?
- Are private providers ever invited to updates or training programs?
- How are community-based providers trained?
- Do any policies govern leaving one's post to go for donor-funded training?
- Are training requirements enforced? If so, how?
- Is training the right solution? Does it seem to improve performance?

In the United States, continuing professional education for credit is developed only by agencies that are approved for granting credit by the accrediting bodies associated with each professional cadre (e.g., for physicians, the Association for Continuing Medical Education; for nurses, the American Nurses Credentialing Center's Commission on Accreditation). These bodies monitor and regulate the agencies to ensure their activities are developed in compliance with certain standards, including the use of sound instructional design strategies, good record-keeping, and freedom from bias (e.g., free from pharmaceutical company bias especially when financially supported by it). This oversight may or may not exist in other countries.

Educating and Training HRH

Indicator	Definition and Interpretation
17. Number of pre-service and in-service training institutions	Quantify and describe systems and institutions (public and private) to produce new health workers Document the number of health professional education institutions, including type of institution, degrees, public or private ownership, and graduation rates, job placement rates. Determine the constraints the educational institutions face. Typically the main one is the number of instructors or tutors available, not infrastructure or equipment. Heads of health professional institutions, both public and private, will have records of established teaching posts and vacancies. In very large countries with many PMIs, it may be possible to visit only a sample but PMIs should be included as they play an increasingly complementary role to public training institutions, (for example offering courses not available at public institutions, being an alternative if public schools are full, or offering more flexible course hours for working professionals). Other constraints, particularly for PMIs, include lack of public oversight of PMIs; lack of accreditation and curricula standards; and minimal or no assurance of quality of teaching instructions received. From the student perspective, PMI tuition is a major constraint to accessing private medical education.
18. Production of new health care workers is responsive to the needs of the health care system	This indicator documents the ratio of health care worker production to the need for health care workers presented in the HRH strategic plan. This indicator documents formal links between the pre-service public and private educational institutions and the health system. Pre-service education based on competencies needed to address population health needs is necessary so that the right numbers and cadres enter the workforce with the right skills. Note whether there is a systematic process for aligning the training curriculum with the competencies and skills needed by each new cadre to work at the community and facility level. This process might be coordinated by the MOH, the Ministry of Education, or a joint committee. Ideally, a stakeholder leadership group would be involved in educational planning and alignment to ensure that the numbers and skills and competencies of graduates needed are produced through a combination of public and private institutions. Specific questions to pose include the following: • Does the MOH have a relationship with related ministries, such as the Ministry of Education and the Ministry of Labor? • Are the curricula of the professional and allied health sciences schools targeted to the epidemiology and health service delivery needs of the country? The numbers of graduates produced and the skills that they are taught should be linked to the strategic HRH plans. • Has an HRH capacity analysis been done, aimed at determining the ability of the country to fill its human resources needs in the future? • Are training institutions accredited, or otherwise assessed on a regular basis, to ensure training standards are met? Often no real feedback loops exist to let the schools know if they are teaching the correct curricula or producing the right numbers and cadres of future staff.

EDUCATING AND TRAINING HRH CONT...

Indicator	Definition and Interpretation
19. Evidence that pre-service education curriculum is updated regularly	Document the last time the pre-service curriculum was updated for each cadre and by public and private pre-service educational institutions. These records can be found at the ministry responsible for training each cadre. For example, in many countries the MOH is responsible for training doctors, and the Ministry of Education is responsible for all other provider training. Rate the changes as major or minor and indicate this degree of change in a table, by cadre. 1) Is the curriculum updated regularly? An outdated curriculum is a source of poorly trained health workers. 2) The process for updating and the frequency of updating will indicate whether the quality is good and follows state of the art guidelines.
20 Frequency, quality, and alignment of in-service training to health priorities and workforce needs	This is the overall description of type of in-service training offered, to whom, with what resources. In-service training may be somewhat harder to document than pre-service education: even if there is a central training process, or a continuing education requirement, additional ad-hoc training, usually donor-provided, is sure to take place. Ideally, the training component is based on a staff and organizational needs assessment and linked to organizations' priorities and changes in the health sector and health practices. More often it is ad hoc and unrelated to needs, and often results in frequent provider absence from their sites. Training could be continuing professional education in different technical areas for cadres of health care professionals including physicians, nurses, pharmacists, and midwives. In addition to the training increasing professionals' knowledge, it has become an important incentive for better worker performance, particularly among private providers. Continuing education may be provided by the MOH, donors, professional societies, or others. A certain number of credit hours of continuing education may be required annually for membership or certification. Ask if continuing medical education is available, mandatory, and for whom (public sector workers? private? which cadres?) Ask whether training is evaluated for effectiveness, in particular, for whether employees perform better on the job, not just on how good the training was perceived to be. Also document if the training has been adapted to meet private sector constraints (e.g. providers cannot absent themselves from their practices for one-week trainings, and they often prefer training to be held in the evening and on weekends).
21. Ratio of rural vs urban admissions and graduates	This is the percentage of students recruited from rural areas/total population of admissions and/or total number graduated to pre-service training programs. Rural recruitment of medical trainees is a key intervention to improve rural retention of health care workers. Evidence suggests that providers who are recruited from and then posted to rural areas tend to stay in post as opposed to transferring to urban areas. To document the rural/urban ratio, it is likely that assistance will be necessary to list all districts/counties and to classify them as rural vs urban. Admission records will typically include the home district of the applicants. Likewise graduates can be followed up and classified as urban/rural.

Topical Area F: Partnerships in HRH

Overview

Partnership refers to the extent to which there are formal and informal linkages between all HRH stakeholders. The most formal of these systems are HRH observatories, many of which are organized and supported by WHO. Partnerships are coordinating mechanisms that bring together all the stakeholders of a country's HRH as well as smaller-scale bilateral or multilateral linkages. For example, in many countries, there is a coordinating body for all FBO facilities, and it is represented in the country's HRH strategic plan. Or there may be an NGO network to represent nonprofit facilities. In some countries, donor coordinating mechanisms exist to ensure that duplication of funding and programming is avoided and that donor funding for HRH is used synergistically.

Data Challenges

Indicators for partnerships are somewhat softer and harder to determine than provider/population ratios. Examine partnerships from both a bottom-up and a top-down approach to find examples. This includes the following:

- Providers: Which organizations do they belong to?
- NGO/FBO clinic owners: Who are the coordinating organizations?
- MOH officials: Who are the HRH working groups? Coordinating committees (e.g., donor coordination groups)? Does an HRH observatory exist?

Issues to Explore

- The first level of investigation is to learn whether these groups and mechanisms exist. If they do, examine how representative they are: Are they composed only of public sector groups or do they include commercial and NGO/FBO sectors? Do they include representative organizations for services providers as well as private medical institution?
- The second level determines how often they meet, if at all: some groups are formed around projects or donor-funded initiatives and cease to exist once the project is over. Document how often and for how long the groups have been meeting as well as the activities (e.g., HRH policy review? HRH planning? HRH framework?).
- Conduct more in depth interviews to determine the influence each group has over HRH policy and decision making. Some groups exist only as information-sharing bodies (which have value in their own right) while others instigate, review, or approve HRH policy and practices.

Partnerships in HRH

Indicator	Definition and Interpretation
22. Active stakeholder participation in HRH policy and processes	This indicator assesses whether stakeholders are involved, and through which mechanisms and bodies, composition of coordinating mechanisms, and types of processes. Are there any formal mechanisms in place to bring together the many stakeholder groups that help to create or use HRH? Provide a description of the mechanisms that include: • Who attends (public, private, FBO/NGO sectors)? • What types of organizations are involved to represent their sector's perspectives, (e.g. ministries beyond MOH, professional associations, umbrella organizations)? • How often do they meet? • How are they created (e.g., an act of the Cabinet vs. an ad hoc meeting called by a donor)? • What are they producing (e.g. HRH policies, frameworks, strategic plans)? • How are they measuring progress? Technical team members can check the WHO or GHWA website for the presence of a WHO HRH observatory in the study country.
23. Formal agreements in place between government and other entities involved in HRH	Qualitative information describing the mechanism in place and if it establishes transparent rules of engagement that facilitate the partnership among the sectors. While information-sharing groups have some value, coordinating mechanisms with formal charters and memoranda of understanding (MOUs) typically have more influence with government and donors over policy and funding. Specific examples to look for include: • The charter and/or the MOU signed by each member group • MOUs or mention of the organizations in legal or policy frameworks. Such legal recognition gives these groups more political clout.
24. Mechanisms in place to involve community in service planning and provision and to provide feedback	In many countries, communities are being given a voice to determine which services are provided and how funding is budgeted in the health sector, and to provide feedback on service quality. For example, in Kenya, each rural health center and dispensary has a village health committee, supported by the MOH. The members are elected by the community, and have formal voice in how funding is allocated. Starting at the facility levels, determine if this kind of mechanism exists. If health committees or similar mechanisms exist on paper, determine if they actually operate in the field. Conduct interviews to determine their actual influence on HRH. In some countries, these groups exist on paper, but are nowhere to be found in the field. The main areas of questioning should be: • Do the committees have a say in what kinds of providers are needed at the facility level? • Do they have any influence in advocating for positions that are unfilled? • In rural and hard to reach places, do they offer help and support to attract and retain providers? • Is there a community committee attached to each facility? The Leadership and Governance Module will examine this data as well.

Topical Area G: HRH Leadership

Overview

HRH issues will be addressed and improved to the extent that country-level leadership is engaged in and prioritizes these issues as critical to the health situation of the country's population. For example, in Tanzania, the president has called the HRH situation "an emergency" and has pointed to the HRH shortage as the key constraint to health care access. Consequently, changes are being made in HRH policies and practices that should lead to HRH improvements. When documenting leadership engagement, there are two levels (and two indicators) to consider: Is leadership aware of the HRH situation and does it see the situation as important, and is leadership actively participating in making changes to improve the HRH situation?

This information will be more difficult to find than for other topical areas. Start with high-level interviews at the ministerial or member of Parliament levels if possible. Donors such as USAID will also be privy to the extent to which country leadership is engaged in HRH. Where there are donor-funded projects dealing specifically with HRH, project directors will be aware of the leadership for HRH climate in the country.

HRH Leadership

Indicator	Definition and Interpretation
25. Government capacity to govern HRH across the sectors	Qualitative description of MOH stewardship capacity in HRH Key indicators of government capacity include staff within the government department of policy and planning charged with HRH planning and policy. • Does the staff have the needed skills to conduct sector-wide HRH planning? • Does the staff have the HRH expertise to assist other MOH entities to revise and update policies and regulation? • Does the staff use HRH data in HRH policy and planning? • How participatory are the policy and planning processes to reflect other sector's perspectives in sector-wide HRH strategic plan and HRH policies?
26. Evidence of awareness among high-level government officials of HRH issues	High-level government officials include ministers, Parliament, or Cabinet-level members as well as leaders from the private health sector. Document examples of high-level leadership speeches, articles, and proclamations, and press releases concerning high-level leadership awareness of HRH. Are HRH problems treated with importance? Are there calls for action? Do officials responsible for working with donors include HRH in donor requests?

5.4 Summarize Findings and Develop Recommendations

Section 2, Module 4, describes the process that the HSA team will use to synthesize and integrate findings and prioritize recommendations across modules. To prepare for this team effort, each team member must analyze the data collected for his or her module(s) to distill findings and propose potential interventions. Each module assessor should be able to present findings and conclusions for his or her module(s), first to other members of the team and eventually in the assessment report (see Annex 2.1.C for a suggested outline for the report). This process is iteractive; findings and conclusions from other modules will contribute to sharpening and prioritizing overall findings and recommendations. Below are some generic methods for summarizing findings and developing potential interventions for this module.

Analyzing Data and Summarizing Findings

Using a table organized by the topical areas of each technical module (see Table 3.5.2) may be the easiest way to summarize and group your findings. Note that additional rows can be added to the table if it is necessary to include other topical areas based on the specific country context. Examples of summarized findings for system impacts on performance criteria are provided in Table 3.5.3. In anticipation of working with other team members to put findings in the SWOT framework, label each finding as either an S, W, O, or T (please refer to Section 2, Module 4, in for additional explanation on the SWOT framework). The "Comments" column can be used to highlight links to other modules and possible impact on health system performance in terms of equity, efficiency, access, quality, and sustainability. Additional guidance on which indicators address each of the WHO performance criteria is included in Table 3.5.4, Human Resources Indicators by Health System Performance Criteria.

Table 3.5.2 Summary of Findings—Human Resouces for Health Chapter

Indicator or Topical Area	Findings (Designate as S=strength, W=weakness, O=opportunity, T=threat.)	Source(s) (List specific documents, interviews, and other materials.)	Comments[a]

[a] List impact with respect to the five health systems performance criteria: equity, efficiency, access, quality, and sustainability. Also list any links to other chapters.

Table 3.5.3 is an example summary of findings from the Guyana 2010 HSA.

TABLE 3.5.3 PERFORMANCE OF HUMAN RESOURCES FOR HEALTH IN TERMS OF THE HEALTH SYSTEM ASSESSMENT CRITERIA

	Equity	Access	Efficiency	Quality	Sustainability
Strengths and Opportunities	• Data and standards exist on the human resources necessary to deliver the PPGHS. • Strategic approach to providing primary care services in the hinterlands through health posts.	• Increased training numbers is bringing more health workers into the system. • Foreign doctors improve short-term access to medical services.	• HRIS has been developed and is housed in the MISU. • IMAI training to improve efficiency of health workers, especially HIV services.	• The MDP is improving the quality of health managers. • I-Tech and other stake-holders are conducting trainings for health workers to improve quality.	• A new health workforce strategic plan is currently in development and is an opportunity to plan for the future.
Weaknesses and Threats	• Doctor and nurse distribution is skewed toward hospitals and urban centers. • Significant HRH gaps exist across all health cadres, and with nurses in particular.	• Foreign doctors often have difficulty integrating into the Guyanese health system and communi-cating with clients and colleagues.	• Current health worker information is not captured by the HRIS, nor is the HRIS used to analysis workforce data and trends. • PSM rules and regulations delay hiring of qualified staff.	• Worker motivation is adversely affected by working conditions, including incentives and infra-structure. • CNE is ad hoc and not required.	• Health workers attrition is very high and retention systems have not been able to fully address the problem. • The HRH TWG does not have strong external stakeholder partici-pation.

Source: Health Systems 20/20 and Ministry of Health of Guyana (2011)

Table 3.5.4 summarizes the key HRH indicators that address each of the five key performance criteria highlighted by WHO: equity, efficiency, access, quality, and sustainability (WHO 2000).

TABLE 3.5.4 LIST OF HUMAN RESOURCES INDICATORS BY HEALTH SYSTEM PERFORMANCE CRITERIA

Performance Criteria	Suggested Indicator from HRH Module
Equity	1. Ratio of health personnel per 1,000 3. Ratio of health care workers by geographic distribution (doctors, nurses, pharmacists, and laboratory technicians)
Efficiency	5. Existence of a costed HRH strategic plan; evidence that strategic plan is being implemented
Access (including coverage)	21. Ratio of rural vs urban admissions/graduates
Quality (including safety)	7. Enabling environment exists for health workers to achieve goals and targets, including clear job descriptions, appropriate tools, supplies, and supportive supervision
Sustainability	22. Active stakeholder participation in HRH policy and processes

It may be helpful to organize the description of the HRH situation and key findings along the lines of the HRH Action Framework. Depending on the amount of data collected and their importance (e.g., a critical health system gap), some of the subheadings can be combined and/or eliminated. The headings correspond to the topical areas and include:

- Current HRH situation (see Annex 3.5.B for examples on how to present the data)
- HRH management systems
- Policy and planning HRH
- Financing HRH
- Educating and training HRH
- Partnerships in HRH
- Leadership of entire HRH system

Developing Recommendations

After summarizing findings for your module, it is time to synthesize findings across modules and develop recommendations for health systems interventions. Section 2, Module 4, suggests an approach for doing this. The recommendations should be specific and actionable, giving the client a clear sense of how to move forward. One important consideration is that recommendations come from the analysis points in the text, so that there is a logical connection between the main body of the document and the recommendations section. Additionally, recommendations should be tailored to the types of activities that the country is willing and able to do. A number of recently developed tools and guidelines will be helpful references for developing the recommendations. For example, the WHO Retention Policy Guideline document launched in September of 2010 (WHO 2010b) offers a comprehensive approach to addressing retention issues.

Table 3.5.5 provides a list of common human resouces-related interventions seen that may be helpful to consider in developing recommendations:

- Group key problems by the topic areas addressed in the chapter.
- When suggesting interventions, make sure that there is a direct link between the problem and the suggested intervention.
- Keep in mind that causes of problems related to retention and motivation overlap and thus are likely to respond to similar interventions.

TABLE 3.5.5 ILLUSTRATIVE RECOMMENDATIONS FOR HUMAN RESOURCE ISSUES

Health Systems Gap	Possible Interventions
Limited or no trained HRH/facilities in rural and/ or remote areas Shortage of health students from rural areas	• Consider training lower cadres of workers and/or CHWs in less demanding tasks and shift those tasks to them. • Explore ways to use private sector (commercial and/or NGO/ FBO) providers to deliver PHC services where there are no public services. • Establish incentive payments for rural hardship postings (e.g. special bonuses; loans; vehicles; scholarships; promotions; management responsibilities; retirement benefit packages and/or nonmonetary incentives such as congratulation/thank you notes; public recognition programs; intake of medical students from rural areas and training in the locations where physicians will later practice.) See the recently released WHO report on Global Recommendations on Retention (WHO 2010b), which includes recommendations in four areas: education, regulatory, financial, and personal and professional support.
System Performance Criteria: Access	
Limited number of trained HRH/facilities (particularly in remote, rural and peri-urban areas	• See strategies above. • Conduct legal and regulatory review to identify barriers (e.g. need to have physician supervising nurses) that limit access and prevent strategies that address HRH shortage.
Health System Performance Criteria: Efficiency	
Poor planning that does not rationalize existing HRH and PMIs	• Improve linkages between planning for needed providers and production of them that includes all sectors (public, commercial, and NGO/FBO). • Involve not only organizations that represent service providers but also medical training institutions • Explore opportunities to leverage private sector workers in underserved areas and/or with underserved population groups through a variety of financial and contracting mechanisms (see Service Delivery Module).
Shortage of qualified personnel to carry out tasks	• Conduct legal and regulatory review to ensure scopes of practices between different levels of the same health cadre do not overlap and are clearly defined (e.g., scopes between nurses and nurse's aides, pharmacist and pharmacy assistants). • Liberalize scopes of practices for and train lower cadres of workers and/or CHW in less-demanding tasks and shift those tasks to them. Extend same scopes of practice to same cadres in the private sector (commercial and NGO/FBO). Open training for lower cadres of workers in the private sector located in underserved areas. • Eliminate mandatory retirement policy for public sector. • Explore opportunities to partner with PMIs to reduce the burden at public training institutions and produce the numbers and types of health cadres needed.

TABLE 3.5.5 ILLUSTRATIVE RECOMMENDATIONS FOR HUMAN RESOURCE ISSUES CONT...

Health Systems Gap	Possible Interventions
HRH workforce not motivated and/or burned out	• Improve salary and compensation and ensure salary is paid on time. • Provide effective leadership and management at the site level. • Change existing punitive supervision practices (reducing incentives, using blame which causes fear) to supportive supervision. • Increase work-related self-efficacy (workers are trained to do the tasks; clear expectations are communicated; workers receive feedback on their performance; appropriate selection; clearly communicated job descriptions and standards; and systems for developmental appraisals) (Franco, Bennett, Kanfer et al. (2000)). • Retain and get the most out of the present set of providers through a range of incentives and better supervision. • Create "friendly" competition between public and private providers in underserved areas. • Measure and share results of HRH from all sectors public recognize and reward high-performing HRH.
Graduates of professional schools lack needed skills needed	• Establish feedback loop/link between the professional schools and the MOH. • Place students in facilities for practicum/clerkships, using faculty or facility staff as preceptors.
Lack of joint planning and review between employees and supervisors	• Introduce a process to conduct joint planning based on job descriptions tied to organization's mission/goals, and conduct periodic employee performance reviews.
Workforce at risk of HIV/AIDS	• Implement programs and policies on HIV/AIDS for prevention and protection of employees (e.g., prevention of needlestick injuries and other exposure to blood-borne pathogens; improve adequate follow-up of injured workers including post-exposure prophylaxis; provide ARV drugs to HIV-positive personnel; decrease stigma).
Health System Performance Criteria: Quality	
No employees feedback on their performance	• Strengthen supervision (management training for evaluators or supervisors; define and enforce staff review cycles).
Punitive/controlling supervision	• Train supervisors in supportive supervision techniques. • Introduce self-assessment at facilities.
Health System Performance Criteria: Sustainability	
Low HRH retention in domestic health market; Attraction and retention, including unequal distribution of health workers and poor coverage in some (usually rural) areas	• Incentive payments for rural hardship postings; special bonuses; loans; vehicles; scholarships; promotions; management responsibilities; retirement benefit packages; nonmonetary incentives such as congratulation/thank-you notes; public recognition programs; intake of medical students from rural areas and training in the locations where physicians will later practice. See the recently released WHO report on Global Recommendations on Retention (WHO 2010b), which includes recommendations in four areas: education, regulatory, financial, and personal and professional support.

5.5 Assessment Report Checklist: Human Resources for Health Chapter

❑ Profile of Human Resources for Health

A. Overview of the health workforce (can include):

a. Number of health care workers in the public, private, and NGO/FBO sectors by cadre

b. Number of health care workers in public, private, and NGO/FBO sectors by geographic distribution

c. Enabling environment for a strong HRH component

d. HRH planning capacity

e. HRH development (education and training) through public and private institutions

f. HRH performance support (includes management and leadership as well as performance management)

B. Authority structure (can include):

a. Relationship between the HRH functions

b. Level of authority for HRH decisions

❑ HRH Assessment Indicators

A. HRH country situation

B. HRH management systems

- Table – Facilities and Human Resources Sample Table

C. Policy and planning

D. Financing HRH

E. Educating and training HRH

F. Partnerships in HRH

G. Leadership of entire HRH system

❑ Summary of Findings and Recommendations

A. Presentation of findings

B. Recommendations

Notes