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# Using Human Resource for Health Data: Health policy and program planning examples from four African countries



June 2008

This publication was produced for review by the United States Agency for International Development. It was prepared by the Africa's Health in 2010 project, managed by AED.



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## Acronyms and abbreviations

|             |  |
|-------------|--|
| AIDS        | Acquired Immune Deficiency Syndrome                |
| GFATM       | Global Fund to Fight AIDS, TB and Malaria          |
| Global Fund | Global Fund to Fight AIDS, TB and Malaria          |
| HIV         | Human Immunodeficiency Virus                       |
| HRH         | Human resources for health                         |
| HRHIS       | Human Resources for Health Information Systems     |
| HRHWG       | Human resources for health working group           |
| LATH        | Liverpool Associates in Tropical Health            |
| MOH         | Ministry of Health                                 |
| PEPFAR      | President's Emergency Plan for AIDS Relief         |
| RH          | Reproductive Health                                |
| SWAps       | Sector-wide approaches                             |
| USAID       | United States Agency for International Development |
| WHO         | World Health Organization                          |



## Summary

Imbalances in quantity and quality of human resources for health (HRH) are increasingly recognized as perhaps the most critical impediment to achieving health outcome objectives in most African countries. However, reliable data on the HRH situation is not readily available. Some countries have hesitated to act in the absence of such data; other countries have not acted even when data are available while others have moved ahead in spite of the lack of reliable information. This paper addresses the issue of data use for HRH policy-making. It will provide valuable information to the body of literature available to policy-makers and their development partners as they grapple with the development and implementation of workable HRH policies.

Data was collected in 2006 from key informants (they included heads of Human Resource functions at the ministries of health and their technical advisors) from a convenient sample of countries known to have conducted HRH assessments in the last three years. Data collected covered the years 2003 to 2006. Responses were received from four out of the 12 sampled countries: Zambia, Lesotho, Côte d'Ivoire, and Malawi. Due to the low response rate, additional data was collected through a limited amount of research carried out on published HRH documents that address any of the issues covered in the survey to validate the findings from the four.

The low response rate to the survey makes it difficult to generalize our conclusions about the use of HRH data for policy-making. Despite this limitation, the conclusions drawn are fully consistent with the body of HRH literature currently available.

### **Key Findings, conclusions and recommendations**

**HRH management information systems:** Very few countries have functioning systems that can routinely provide data without the need for special studies. Countries seem to rely more on ad hoc studies to generate data that should be routinely available from a functioning Human Resources for Health Information System (HRHIS). As part of their package of health systems strengthening activities, countries need to invest in HRHIS with linkages to the national Health Management Information System to facilitate workload-based workforce planning.

**HRH development and management:** In countries that have carried out HRH assessments, local participation was limited to the design of the assessment, data collection and dissemination. Data analysis was done by consultants. This indicates that technical capacity in HRH is still lacking. Ministries of health are severely constrained by the lack of skilled human resource managers. Many countries do not have, and still need assistance in developing, comprehensive HRH policies and plans. Capacity strengthening for HRH management is necessary to build in-country expertise in this area. There is need to invest in the development of a skilled cadre of HRH managers and the creation of fully-resourced HRH management units in ministries of health. Such investment should systematically address the factors that underlie the current HRH crisis in Africa, particularly, training, recruitment, retention, motivation and deployment. Without this kind of investment Africa's health sectors will not be able to go beyond the current routine of assessments, analysis, reports and no action.

**Human resources for health advocates** play a key role in ensuring that available data is used for policy action. Due to the cross-cutting nature of HRH, the more senior and credible the advocate, the easier it will be for action to be taken both within the MOH and in other ministries

especially the Ministries of Finance and Education. It is important that countries that are currently working on their HRH policies build an advocacy plan with credible champions who can lead the process. The use of a broad-based HRH Technical Working group or similar body to steer the policy-making process has been shown to improve the chances of effectively translating HRH data into implementable policies.

**Financing HRH:** One of the most critical constraints to policy action is financing. All countries in the study cited this as a key constraint. In order to attract more resources, however, comprehensive HRH policies and plans must be put in place. The MOH should then engage a broad stakeholder base to look into the HRH financing needs within the context of the agreed sector plans.

**HRH stakeholders:** Involvement of all key stakeholders improves the acceptability of proposed HRH policies. The MOH must obtain broad stakeholder consensus from the outset in dealing comprehensively with the HRH crisis. Stakeholders should be representative of all key interests, especially all the relevant ministries (e.g., finance, education, social services, labor and planning), and other institutions that directly influence the development and management of health workers.

**Health systems approach:** Due to the complex and multidimensional nature of the HRH crisis, it requires a response that is embedded within comprehensive strategic plans for health that address the development of the health system as a whole. The HRH policies and plans would then fit into this plan and could be more readily defended for resource allocations. Addressing the HRH needs outside of this broader framework can be, at best, only a temporary measure.

## Background

The health sector in Africa is grappling with unprecedented constraints in the health workforce. The numbers, skills (and skills mix), distribution and management of health workers are critical areas of concern; although it is only in the last five years that serious and sustained international attention has been paid to the situation. The imbalances in quantity and quality of human resources for health (HRH) are increasingly recognized as perhaps the most serious impediment to scaling up interventions for achieving health outcome objectives in most African countries, and more specifically the health-related Millennium Development Goals. In spite of the general recognition of this bottleneck, countries vary in their response to the issue. Various studies have been conducted looking at the factors that have led to what has been correctly described as a “crisis”<sup>1</sup> and what countries are doing to address them.<sup>2,3</sup> The migration of skilled health workers from the public sector to the private sector or out of the country altogether in search of better pay and career opportunities has been well documented.<sup>4</sup> Staff motivation and retention efforts and the productivity of health workers have all been addressed in recent years. The World Health Report 2006 “Working together for health” was devoted to HRH. One issue, however, that has received little, if any, attention, is the availability and use of data on HRH.

Policy-makers do not have good data on available human resources for health or do not have confidence in the accuracy, timeliness, and usefulness of available data. Some countries have hesitated to act in developing RH policies in the absence of such data; other countries have not acted even when data are available, while others have moved ahead in spite of the lack of reliable information. Most countries in sub-Saharan Africa do not have comprehensive national strategic HRH plans and many of the solutions being proposed are driven by disease-specific funding and interests. Recently countries have sought relief for human resources for health constraints in their proposals to the Global Fund to Fight AIDS, TB and Malaria (GFATM also referred to as the “Global Fund”).

A recent review of proposals to the Global Fund by five African countries showed that those that did address human resource issues lacked a comprehensive situation analysis for the health workforce and a lack of overall health workforce development plans.<sup>5</sup> A health system cannot function without the input of human resources.

Also of critical importance, human resources must be competently planned, distributed, managed, and motivated in order to get the most productivity from them. Human resource management has been identified by African health policy-makers as one of the key issues that

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<sup>1</sup> Taking the Human Resources For Health Agenda Forward At The Country Level In Africa: The human resources for health crisis in Africa: Taking the action agenda forward at countries. Proceedings of a regional consultation meeting. WHO, World Bank, Nepad, ACOSHED. 2005.

<sup>2</sup> SARA Project. “The Health Workforce Crisis: Dimensions and illustrative immediate and long-term responses.” Academy for Educational Development, 2004.

<sup>3</sup> Bernhard Liese and G Dussault. ‘The State of the Health Workforce in Sub-Saharan Africa: Evidence of crisis and analysis of contributing factors.’ World Bank, 2004.

<sup>4</sup> Physicians for Human Rights. “An Action Plan to Prevent Brain Drain: Building equitable health systems in Africa.” 2004.

<sup>5</sup> Sigrid Dräger et al. “Health Workforce Issues and the Global Fund to Fight AIDS, Tuberculosis and Malaria: an analytical review.” Human Resources for Health, 4:23, 2006. [Accessed at <http://www.human-resources-health.com/content/4/1/23>.]

need to be addressed in Africa, including retention policies and practices, productivity and performance management.<sup>6</sup>

Recently, some countries have conducted reviews and assessments of their HRH status. Some of these (e.g., Namibia and Malawi) have been nationwide assessments aimed at analyzing the overall health workforce situation. Others have been more narrowly defined to meet the specific objectives of vertical health program needs, e.g., scaling up of HIV/AIDS activities in Kenya, Zambia, Côte D'Ivoire, Nigeria and Rwanda. All of these assessments have yielded valuable information for decision makers but the extent to which this information has been used varies from country to country. These studies have also tended to be externally funded and lack in-country leadership and coordination with other health sector strategic plans.

Given the enormous health workforce challenges facing ministries of health countries have no choice now but to devote more resources to understanding their HRH needs more fully and designing appropriate policies and strategies to address them. These challenges include the absolute numbers of skilled health workers, their distribution and skills mix and the conditions under which they perform their work. The strategy of the World Health Organization Regional Office for Africa (WHO/AFRO) for HRH in the region set two goals for the period 1999–2008. It is clear these will not be achieved in the envisioned timeframe:

- By the year 2004, the 46 countries of the region will have developed a policy for human resources development for health
- By the year 2007, the 46 countries of the region will have acquired the capacity to implement their policy of human resources development for health

The achievement of these targets, even in a revised timeframe, will rest on countries being able to do a thorough analysis of the state of their human resources for health and to engage policy-makers to commit to specific action in this area.

This paper aims to address the issue of data use for HRH policy-making. It will provide a valuable addition to the body of literature available to policy-makers and their development partners as they grapple with the development and implementation of workable HRH policies. For the selected countries, it looks at:

- Whether data had been collected on HRH within the last 3 years
- If so, the degree of local participation in the HRH data collection
- Use of these data or of other available data in policy and program design
- What policy actions (e.g., staff deployment, staff skills and mix, distribution, incentives, etc.) had been taken and whether these actions were linked to data availability and use
- What program design and implementation actions were linked to data availability and use

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<sup>6</sup> Capacity Project. "Human Resources for Health Action workshop." Johannesburg, South Africa, January 2006.

## Methodology

Data was collected in 2006 from key informants (including heads of human resource functions at the MOH and their technical advisors) from a sample of countries receiving funds from GFATM and the President's Emergency Plan for AIDS Relief (PEPFAR). Data covered the years 2003–2006. Among the countries sampled were those known to have conducted HRH assessments with PEPFAR funding. The sample included: Zambia, Ethiopia, Kenya, Côte D'Ivoire, Nigeria, Tanzania, Swaziland, Rwanda, Lesotho, Malawi, Mozambique and Namibia. Data was collected through an email questionnaire (see Annex 1) followed up by personal interviews in-country, where possible. Responses were received from four countries: Zambia, Lesotho, Côte D'Ivoire, and Malawi. Data from these four countries was obtained with the help of Capacity Project and PHRplus Project country-based staff or consultants.

In view of the light response from the sampled countries, additional data was collected through a limited amount of research carried out on published HRH documents that address any of the issues covered in the survey. This data served to validate the conclusions that were emerging from the four respondents. Data was also obtained for Tanzania, Uganda, Rwanda, and Botswana.

## Results

### Scope of assessments and local participation

All four countries that completed the questionnaire have conducted comprehensive HRH assessments within the last three years. Table 1 shows the kind of HRH data that were gathered during the assessments.

Table 1: Scope of assessments

|  | Malawi           | Côte D'Ivoire | Lesotho           | Zambia      |
|--|------------------|---------------|-------------------|-------------|
| Number of health workers at selected facilities across the country | √                | √             | √                 | √           |
| Type of health workers   | √                | √             | √                 | √           |
| Type of health facilities  | √                | √             | √                 | √           |
| Type of services delivered by each cadre                           |                  | √             |                   | √           |
| Time spent on delivering services                                  |                  | √             |                   | √           |
| Number of new graduates entering the health sector                 | √                | √             | √                 | √           |
| Number of health workers leaving the public health sector          | √                | √             | √                 | √           |
| Reasons for leaving the public sector                              | √                | √             | √                 | √           |
| Distribution of health workers                                     |                  | √             |                   |             |
| Source of funding for assessment                                   | MOH              | Donor         | Donor             | Donor & MOH |
| Use of external technical assistance in assessment                 | Yes              | Yes           | Yes               | Yes         |
| Inclusion of private sector in assessment                          | Yes              | No            | Yes (faith-based) | No          |
| Year(s) of assessment  | 2003/4<br>2005/6 | 2005/6        | 2003/4            | 2004/4      |

(Check marks indicate the items that were covered in the assessment)

The Côte D'Ivoire and Zambia assessments focused more on the staff requirements for the implementation of HIV/AIDS scaling-up activities. All assessments, except Malawi, were either commissioned or funded by donors and required external technical assistance.

### **HRH Information Systems**

Human Resource for Health Information Systems (HRHIS) is not well developed. Information obtained indicated that this area has not received the required attention, although some countries are moving in that direction. A recent analysis of HRH strategic plans by the Capacity Project also pointed out the inadequacy of information stating that the plans reviewed were all "based on an analysis of workforce data that are incomplete in most cases."<sup>7</sup>

### **Action taken based on the data**

Countries are in the process of acting on data from the assessments. Most assessments are no more than two or three years old and implementation of various reforms as shown below, is ongoing. The most recent assessment was in Côte D'Ivoire in 2005 and results have just begun to be used for policy-making with the initiation of a national HRH plan.

There is great diversity among the actions taken in response to the available data. From the responses received, four key issues emerge:

**HRH management:** All four countries have taken action to address some aspect of HRH management.

- Malawi has implemented an increase in health worker salaries and has developed retention packages. A framework for HRH monitoring and evaluation was also developed.
- Cote D'Ivoire is in the process of developing an HRH country plan.
- Lesotho has drafted an incentive package, although it had not yet been implemented at the time of data collection in 2006. Job profiles have also been developed. "Ghost" workers have been weeded out of the public health payroll.
- Zambia has piloted a rural incentive scheme with the help of the Dutch Government and health worker salaries have also been increased. The Human Resource Unit at the MOH has been strengthened and job profiles have been developed.

**Human resource development:** Both Zambia and Malawi have taken steps to strengthen pre-service training by expanding training capacity (Malawi) and developing a Training Unit plan (Zambia).

**HRH Policy:** A number of policy-related actions have been taken as follows:

- **Malawi** has developed a six-year Emergency Human Resource Program (EHRP) this has informed the development of a Strategic HRH Framework. A 10-15 year Workforce Plan, incorporating a Workload Analysis Framework for an expanded Essential Health Package (EHP) and a Health Sector Training Policy & Plan, are also in the process of being developed.
- In **Lesotho**, the HR unit was elevated to a Directorate and a country HRH plan was developed.

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<sup>7</sup> Ummuro Adano. "Collection and Analysis of Human Resources for Health Strategic Plans." Capacity Project, December 2006.

- In **Zambia** the MOH developed a costed HRH plan as well as an antiretroviral therapy implementation plan.

**Financing:** Malawi secured funding from the Global Fund for the Emergency Human resource Plan, including scaling up of training and recruitment activities. Zambia too has applied to the Global Fund for additional funding. The MOH in Lesotho has also secured additional funding from other sources. From the responses received, it is clear that countries want to use the data, but all are constrained by lack of funding to implement the activities. This reported lack of funding may be the product of many factors, including the ability of the ministries of health to advocate for resource allocations.

A 2004 analysis of HRH studies in 10 African countries by WHO highlighted the “poor record of policy implementation” and noted that whereas all of the countries whose HRH studies were analyzed had or were developing human resource for health plans, these plans had not yet been translated into action.<sup>8</sup> Indeed they noted that “the fate of these studies was unknown as there was no follow-up identified.” It appears that most data available was collected to provide quick information on HRH needs and had no further policy use.

### Determinants of and Constraints to policy action

Table 3 summarizes the responses received regarding what were considered enabling factors for, or constraints to, the use of HRH data for policy actions. The following paragraphs discuss these factors.

Table 3: Enabling factors and constraints to policy action

|  | Malawi | Côte D'Ivoire | Zambia | Lesotho |
|--|--------|---------------|--------|---------|
| Enabling factors                                 |        |               |        |         |
| Local policy champion is present                 | √      | √             | √      | √       |
| Stakeholders involved from the beginning         | √      | √             | √      |         |
| Strong stakeholder interest and participation    |        | √             | √      |         |
| Report linked to specific policy actions         | √      | √             | √      | √       |
| Report available in electronic and hard copy     |        | √             |        |         |
| Constraints                                      |        |               |        |         |
| No strong stakeholder interest and participation | √      |               |        | √       |
| No funding available to take action              | √      | √             | √      | √       |
| No local policy champion                         |        |               |        | √       |
| Stakeholders not involved from the beginning     |        |               |        | √       |
| Report not available in electronic and hard copy |        |               |        | √       |

### Stakeholder interest

Both Malawi and Lesotho (which were also part of the 2004 WHO ten-country analysis<sup>9</sup>) identified lack of stakeholder interest as a constraint to implementation.

<sup>8</sup> Barbara Stilwell and M Dieleman. “Analysis of country studies.” Unpublished. World Health Organization, 2004.

<sup>9</sup> Barbara Stilwell and M Dieleman. “Analysis of country studies.” Unpublished. World Health Organization, 2004.

## **Advocates for human resources for health**

Each of the study countries identified key people who have been active champions for HRH. These advocates or champions were cited as one of the factors that contributed to the use of the data generated by the assessments. In Malawi the Secretary for Health, a Senior Technical Advisor and a HRH Technical Working Group were key advocates. Côte d'Ivoire identified the Director of Training and Research and the Assistant Director of Human Resources as champions for the HRH cause. Zambia's efforts have similarly been boosted by the active participation of the following: Permanent Secretary in the MOH, Director of Human Resources, Director of Clinical Services, the Director of National AIDS Council, and the HRH Working Group. HRH champions in Lesotho were the Directors of Human Resources, the Health Training College, and the Directorate of HIV/AIDS.

## **HRH Technical Working Group**

In Malawi the HRH Working Group (HRHWG) was an important advocate for action. In Tanzania and Zambia, there were HRH Working Groups too that guided the development of HRH policies

## **Funding**

Funding was cited by all four countries as a constraint to policy action, though none specified the exact areas that have been affected. This can be a binding constraint to policy implementation, particularly when combined with lack of stakeholder buy-in. It is quite clear that countries have the desire to use the data but all are constrained by lack of funding to implement the activities. The reported lack of funding may be the product of many factors, including the ability of the ministries of health to advocate for resource allocations.

## **Local participation in studies**

In all four countries the assessments were performed with good local participation, in "conceptualization of the study," "data collection" and "dissemination." The lowest rating for local participation was in "analysis" and "report writing" with all four claiming to have been either "remotely involved" or only "partially involved." This indicates that external technical assistance remains an important factor in HRH analysis and perhaps even the formulation of policy recommendations and calls attention to the lack of local capacity for such HRH planning, development and management.

Local participation in any study or assessment is an important factor to ensure ownership by policy-makers. It also provides a more solid foundation for the study by providing inputs into its design as well as enriching the interpretation of results. Studies with little or no local input have a poor record of implementation as they tend to satisfy external rather than internal demand for information.

## **Dissemination to policy-makers**

The results of the assessments were presented to users primarily through technical reports but also in one-on-one briefings. "Policy briefs," i.e., summaries of key findings, and media briefings were only used by Côte d'Ivoire.

Presentation is an important factor to consider in any advocacy strategy. Key policy-makers are busy and constantly bombarded with information. They need information that captures and maintains their attention and communicates the key messages quickly and easily. Large, complex reports are soon laid aside after the dissemination event. One-to-one briefings of key

policy-makers are a useful tool to clarify issues, to ensure that key messages have been understood, and to elicit commitment to action.

### **Other evidence of data use**

Other evidence collected from the literature on the use of HRH data for policy-making supports the findings noted above.

WHO conducted an 18-country study that examined HRH policy-making and concluded that the countries that have made the most progress were notable as follows: 1) they had conducted a comprehensive review of HRH policy with official adoption at a high policy level, including endorsement by Parliament or a head of government, thus lending strong political support to the HRH initiative; 2) there was strong consistency between the HRH policies and national policies; 3) they made good use of data to guide priority setting through a highly consultative process; and 4) they had good HRH leadership.<sup>10</sup>

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<sup>10</sup> D Egger et al. "Achieving the right balance: The role of policy-making processes in managing human resources for health problems." WHO/Geneva, 2000.

## Discussion

### HRH Information Systems

Many countries in Africa do not have functioning Human Resources for Health Information systems (HRHIS) to facilitate proper human resource management. For example: the Capacity Project is addressing this issue and in its 2006 concept paper stated that in many developing countries there is “lack of current, accurate data about health professionals working in the country. Even where data are collected, usually on paper forms, that data often cannot be used effectively.”<sup>11</sup> In a 2005 study in Rwanda, the researchers reported that in 2003, out of 402 health sites, only 142 had submitted their annual staffing reports.<sup>12</sup> Working documents for the establishment of the HRH Observatory in Africa also bear these facts out.<sup>13</sup>

The case of Malawi is also illustrative: *“Ministry of Health HRH data collection and usage is considerably weak. There are no clear systems and/or mechanisms in place for HRH information collection and accurate and up-to-date monthly staffing returns are seldom submitted from District Health Offices (DHO). As a result the MoH has not been able to compile and submit a consolidated staffing return since September 2004.*

*There is a priority focus on the need to relate HRH progress in individual areas to overall 6-year Emergency Human Resource Program (EHRP) targets, and in turn to link these to the Essential Health Package (EHP) targets and impact within the Sector Wide Approach (SWAp) in the health sector. Systems for this remain weak; however a growing focus on HRH monitoring and evaluation is now beginning to translate into action. The MoH is in the process of agreeing a common framework for monitoring EHRP progress and impact across the SWAp including agreement on essential baseline information, data sources, collection and utilization.*

*Recently there has been limited collection, compilation and utilization of data from MoH and Christian Health Association of Malawi (CHAM) health units at district level. However, a comprehensive HRH Monitoring & Evaluation Framework was completed, and is to be embedded within the overall SWAp M&E mechanism. The framework contains 22 HRH specific indicators, in line with the EHRP and the recently developed Strategic HRH Framework for the health sector. Capacity for implementation of HRH M&E, information and research will need to be determined and strengthened, with robust mechanisms institutionalized and in place, both at central headquarters and district level. There is an inability to access accurate up-to-date staffing figures and deployment trends and gaps, therefore recent initiatives include the ongoing development and planning of a proposed sector-wide HRH Data Census”<sup>14</sup>*

The Uganda Human Resources for Health Policy document observes that: *“Lack of information on Human Resources for Health requirements (i.e., when, how and where) is a major shortcoming at present, hindering Human Resources for Health development. A significant number of existing Human Resources for Health data systems cannot share information with each other because of lack of standardization, and differences in definitions and coding, and*

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<sup>11</sup> McQuide p. Human resource information system strengthening concept paper. 2006. Capacity Project. IntraHealth.

<sup>12</sup> R Furth, R Gass, and J Kagubare, “Rwanda Human Resources Assessment for HIV/AIDS Scale-up. Phase 1 Report: National Human Resources Assessment.” Quality Assurance Project (QAP), 2005.

<sup>13</sup> Taking The Human Resources For Health Agenda Forward At The Country Level In Africa: The human resources for health crisis in Africa: Taking the action agenda forward at countries. Proceedings of a regional consultation meeting. WHO, World Bank, Nepad, ACOSHED. 2005.

<sup>14</sup> Paul Marsden. Personal communication with author. Capacity Project/MOH Malawi, 2007.

*because information flows bypass potential consumers. Commonly, data is still hand processed, and lacks accessibility and updating. Evidence of best practices is required to inform policy and management decisions, but management and planning of Human Resources for Health is hampered by lack of knowledge and insight. Information on staff dynamics and attrition is particularly lacking.”<sup>15</sup>*

Botswana developed HRHIS as early as 1994 and MOH staff have used the data as a starting point for coordinated national workforce planning efforts with other agencies and ministries, such as the Department of Local Government which employs health workers in local regions. However, there are still issues with the quality of data and the level of effort required to get the correct staffing information for each facility or district. But the process has helped to gain acceptance of the resulting human resource projections. In addition, the MOH is using the HRH data for improved annual budget forecasts and for use in the five-year National Development Plans.<sup>16</sup>

### **HRH management**

The low priority placed on HRH management in most ministries of health<sup>17</sup> is an indication that this aspect of the crisis is not fully understood. HRH management in most ministries of health remains primarily an operational support function with little, if any, strategic focus or leadership, and lacks authority over the health workforce. Ministries of health rely on “civil service HR practitioners who are continually transferred across various ministries, thus undermining efforts to adequately build and strengthen ‘Human Resource for Health’ specific functions and institutional capacity (particularly in the critical areas of HRH policy & planning as well as HRH systems strengthening, M&E and operations research).<sup>18</sup>

Credible HRH data is hard to find because there are no proper management systems in place. HRH management was identified as one of the most critical issues that need to be addressed at a workshop of HRH professionals in January 2006 in South Africa.<sup>19</sup> Some of this effort (probably most of it) is led by donors with expertise sourced from both within Africa and externally.

Unless ministries of health acquire skilled HRH managers, they will be unable to translate available information into policies or to implement correctly policies that are now being developed with donor assistance. As one HRH professional put it *“the primary reason why the road from analysis to action has been bumpy has a lot to do with the lack of sufficiently qualified professional HR managers who are able to articulate and champion all the policy changes and actions to be taken. In other words, there is an urgent call to professionalize HR management in the health sector. Adequate investments will be required to create a cadre of professional HR managers in ministries of health with skilled staff, sufficient budgets and authority – and who are fully supported by senior leadership to introduce and implement HRM policies, practices and procedures at all levels of the organization... We require better tools to monitor and evaluate HR*

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<sup>15</sup> Uganda Ministry of Health. “Human Resources for Health Policy.” Government of Uganda, April 2006.

<sup>16</sup> D Egger et al. “Achieving the right balance: The role of policy-making processes in managing human resources for health problems. WHO/Geneva, 2000.

<sup>17</sup> Regional strategy for the development of human resources for health. Report of the Regional Director. WHO Regional Office for Africa.

<sup>18</sup> Paul Marsden. Correspondence with author. Capacity Project/MOH Malawi, 2007.

<sup>19</sup> Capacity Project. “Human Resource for Health Action Workshop. Johannesburg, South Africa, January 2006.

*management efforts, especially in low resource setting...[to] go beyond the current cyclical impasse of assessments, analysis, reports and no action.*<sup>20</sup>

### **Constraints and enabling factors in use of HRH data**

The difficulties countries are likely to experience in implementing HRH policies should not be underestimated. New policies normally demand significant financial and other resources and require the management of complex relationships at a technical and political level outside of the MOH. In the short-term, financial requirements may include external technical assistance for the development of appropriate actions, especially in areas of HRH development and management. Long-term financial requirements can be heavy as policy changes with regard to recruitment, retention and motivation require remuneration commitments that will be a fixed cost for the MOH for years to come. In the face of rigid wage bill caps imposed by the IMF and donors on governments, there are many hurdles to any HRH policy changes.

The fact that the HRH crisis has only recently come to the forefront of policy-makers' attention may also be a contributing factor to the limited use of available data. Ministries of health have tended to handle only the routine management, mostly clerical aspects of HRH. This is evidenced by the minimal level of investment in HRH management functions within the MOH. A major investment in the health system structures to support HRH development and management in the health sector and to enable ministries of health to provide leadership in this area is essential.

### **Health financing constraints**

Financing for HRH was cited as a binding constraint by all four countries that responded to the survey. As mentioned above, this is one reason why HRH policies must be developed with adequate representation from the ministries responsible for finance and planning. These two ministries are key to the allocation of funds to the MOH for its wage bill. They must have an understanding of the nature of the health workforce and the factors that drive the numbers, skills mix and ultimately the cost to the Treasury. This understanding is usually lacking especially when the MOH does not have a strong enough voice to present the HRH needs for budgetary allocation. The ministry therefore suffers along with all other ministries when restrictions are imposed on civil service personnel costs in relation to the government's total spending, as has been happening in Africa under World Bank and International Monetary Fund (IMF) lending conditions. HRH interventions that have been implemented recently have covered a broad array of issues including: development of staff retention packages (Malawi, Zambia, Lesotho (not yet approved)); HRH policies developed (Uganda, Tanzania, Malawi, Côte D'Ivoire, Zambia); development of staff deployment plans (Zambia, Malawi).

While funding is recognized as a valid constraint, most countries have not costed their HRH requirements and so it would be difficult for them to make a case for resource allocation even if funding did become available. The PEPFAR supported studies in Côte D'Ivoire and Zambia included a costing of the projected health workforce requirements.

### **Stakeholder interest**

There is no shortage of studies covering all aspects of the health sector in Africa. Many well-intentioned studies have gathered dust on the shelves of the very people who commissioned and were supposed to implement them. In view of the resource requirements mentioned above,

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<sup>20</sup> Ummuro Adano. Correspondence with author. Capacity Project, 2007.

it is critical to gain broad (MOH and non-MOH) stakeholder involvement from the outset since HRH issues are much broader than the MOH and touch on other sectors, e.g., education, finance, social services, labor and planning. A Zambian participant at the Human Resources for Health Action Workshop in Johannesburg, South Africa in 2006 noted the importance of keeping *“all stakeholders involved in Strategic Plan development process from the beginning. One strategy that worked in Zambia was holding short, regular meetings with the minister. In this way, the Permanent Secretary understood the background, process and goals thoroughly and was able to act as an HR champion when presenting to the wider audience (e.g., President).”*<sup>21</sup>

### **HRH Champions/Advocates**

The importance of advocates or champions for the adoption and implementation of any health policy intervention is well documented. Locally committed and respected individuals play a key role as advocates for the introduction of policy changes. It is therefore important to try to get on board individuals who can influence key policy-makers to support the formulation and implementation of recommendations. The more senior the HRH advocate, the easier it will be for policy-makers to be brought on board to support action. HRH planning, development and management is closely tied to policies in other government ministries and departments other than the MOH. It is critical that there is agreement to the proposals at the highest levels within the MOH first. This requires a senior advocate to champion the cause.

In Malawi and Zambia where the Principal Secretary/Secretary of Health at the MOH was championing the activity, data appears to have been more effectively used and resulted in more significant reforms. Both have made progress in addressing their health workforce shortages by implementing staff retention strategies.

### **HRH Technical Working Groups**

A broad-based group to champion the HRH cause is an effective strategy for taking HRH data from research to policy. These technical working groups were present in Malawi, Tanzania and Zambia. They had broad representation from government, donors and other stakeholders and hence ensured that their message was being heard not only in the MOH but in other relevant ministries as well (particularly Finance), and that donors were also on board for a more coordinated approach to an expensive crisis. For example, in Tanzania, *“the most visible expression of the need to address the crisis was perhaps the appointment of a HRH Working Group in May 2004. The group, which has members from several ministries (Health, Finance, Regional and Local Government, Public Service Management), WHO, World Bank, bilateral donors and research institutions, serves an advisory role to the Ministry of Health on issues related to the health worker crisis...momentum to the process seems to have increased during 2005. The recruitment restriction on the clinical officer cadre was lifted as of January 2005.”*<sup>22</sup>

### **The need for a health system approach**

It is becoming increasingly clear that the HRH crisis is a complex and multidimensional one, requiring a response that extends beyond ministries of health. Some of the actions that have been taken in the past to address HRH shortages and imbalances have been ad hoc and in

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<sup>21</sup> Capacity Project. Human Resource for Health Action Workshop. Johannesburg, South Africa, January 2006.

<sup>22</sup> O Maestad. “Human Resources for Health in Tanzania: Challenges, policy options and knowledge gaps.” CHR. Michelsen Institute, 2006.

some cases driven by disease-specific funding. Coupled with the complexity of the problem is the financial burden that many of the potential solutions entail.

Macroeconomic management targets set by governments and their development partners have imposed spending ceilings that have made it nearly impossible for some countries to adequately address shortages in critical cadres of the health workforce. The absence of comprehensive HRH policies and plans makes it difficult for ministries of health to make the best use of available staff or to argue their case for resource allocations to mitigate HRH shortages. This absence of national HRH policies and plans can be partly blamed on the weaknesses apparent in African health systems.

When a health system is weak, governments are not able to respond in a coherent manner to pressing health sector needs: there is fragmentation of responses and the Ministry of Health is not able to exercise its leadership role in the face of competing political, donor, and consumer priorities. The health workforce is a key component of the health system. A high level of skill is required to develop and manage this resource. This has been one of the failures in Africa's health systems. This study points to the need for HRH policy-making that has a broad participation base in recognition of the multifaceted nature of human resource policies and the interdependence of multiple institutions. In many countries, the health workforce is employed by a civil service directorate and managed by the MOH. The Ministry of Finance dictates the level of the wage bill for the MOH and must be consulted. Schools that train health workers may fall under the Ministry of Education while others are the responsibility of the MOH. These relationships need to be managed skillfully, but sadly this has not been the case.

HRH issues must be addressed with the whole health system in view. Piecemeal interventions may provide temporary relief but ultimately fail to provide the desired long-term solutions. It is important that countries develop holistic HRH policies and plans that are embedded in national development plans.

### **Limitations of the study**

Only four of the twelve countries selected responded to the survey. Such a low response rate makes it difficult to generalize our conclusions about the use of HRH data for policy-making. However, it is important to note that the findings above are fully consistent with other HRH literature. The conclusions that follow below should therefore be interpreted with this in mind.

## Conclusions and recommendations

**HRH management information systems have been neglected.** Very few countries have functioning systems that can routinely provide data without the need for special studies. Countries seem to rely more on ad hoc studies to generate data that should be routinely available from a functioning Human Resources for Health Information System. As part of their package of health systems strengthening activities, countries should invest in HRHIS with linkages to the national Health Management Information System to facilitate workload-based workforce planning.

**HRH development and management:** Local participation in conducting HRH assessments was limited to the design of the study, data collection and dissemination. The more technical data analysis was left to consultants. This indicates that technical capacity in HRH is still lacking. Ministries of health are severely constrained by the lack of skilled human resource managers. Many countries do not have, and still need assistance in developing, comprehensive HRH policies and plans. Capacity strengthening for HRH management is necessary to build in-country expertise in this area. There is need to invest in the development of a skilled cadre of HRH managers and the creation of fully-resourced HRH management units in ministries of health. Such investment should systematically address the factors that underlie the current HRH crisis in Africa, particularly, training, recruitment, retention, motivation and deployment. Without this kind of investment, Africa's health sectors will not be able to go beyond the current routine of assessments, analysis, reports and no action.

**Human resources for health advocates:** Advocates play a key role in ensuring data is used for policy action. Due to the cross-cutting nature of HRH, the more senior and credible the advocate, the easier it will be for action to be taken both within the MOH and in other ministries especially the Ministries of Finance and Education. Countries that are currently working on their HRH policies must build an advocacy plan with credible champions who can lead the process. The use of a broad-based HRH Technical Working group or similar body to steer the policy-making process has been shown to improve the chances of effectively translating HRH data into implementable policies.

**Financing HRH:** One of the most critical constraints to policy action is financing. All countries in the study cited this as a key constraint. In order to attract more resources, however, comprehensive HRH policies and plans must be put in place. The MOH should then engage a broad stakeholder base to look into the HRH financing needs within the context of the agreed sector plans.

**HRH stakeholders:** The MOH must obtain broad stakeholder consensus from the outset in dealing comprehensively with the HRH crisis. Stakeholders should be representative of all key interests, especially all the relevant ministries (e.g., finance, education, social services, labor and planning), and other institutions that directly influence the development and management of health workers.

**Health systems approach:** Due to the complex and multidimensional nature of the HRH crisis, it requires a response that is embedded within comprehensive strategic plans for health that address the development of health systems as a whole. The HRH policies and plans would fit into this plan and could be more readily defended for resource allocations. Addressing the HRH needs outside of this broader framework can only be a temporary measure.

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# ANNEX 1: Study questionnaire

## Human resources for health assessments

### Policy impact survey

The Africa Health 2010, Partners for Health Reformplus and Capacity projects are collaborating to learn from health planners, managers, policy analysts and policy-makers how human resources for health (HRH) policy is influenced in countries heavily impacted by HIV/AIDS, TB and Malaria. In particular, this inquiry will examine the importance of, and use of, targeted HRH assessment findings and data to inform policy-making. Policy actions could include: staff deployment, training, incentives, skills mix etc. Some countries have conducted detailed national human resource assessments that review all aspects of staffing in the health sector including: required numbers and mix of staff, staff recruitment and retention, training policies etc. Others have done more limited assessments looking at specific issues e.g. staff requirements for the implementation of an antiretroviral therapy policy. These should all qualify as “HRH Assessments” for the purpose of this questionnaire.

Analysts and policy-makers are learning how human resources for health (HRH) policy is influenced in countries heavily impacted by the HIV/AIDS epidemic. In particular, this inquiry will examine the importance of, and use of, targeted HRH assessments and data collection.

We hope this information will assist in improving use of information and policy decision-making on HRH.

For further information, please contact [smusau@aed.org](mailto:smusau@aed.org) or [gilbert\\_kombe@abtassoc.com](mailto:gilbert_kombe@abtassoc.com).

Name of Country: \_\_\_\_\_

Respondent's Name: \_\_\_\_\_

Respondent's Position: \_\_\_\_\_

Respondent's Affiliated Institution: \_\_\_\_\_

What year was the HRH assessment conducted?

|             |           |           |           |
|-------------|-----------|-----------|-----------|
| Before 2000 | 2001-2002 | 2003-2004 | 2005-2006 |
|-------------|-----------|-----------|-----------|

What was the scope of the HRH assessment?

|               |                |                           |                  |
|---------------|----------------|---------------------------|------------------|
| Public sector | Private sector | Faith-based organizations | Others (specify) |
|---------------|----------------|---------------------------|------------------|

What data was collected?

|   |  |     |    |
|---|--|-----|----|
| a | Number of health workers at selected facilities across the country | Yes | No |
| b | Type of health workers   | Yes | No |
| c | Type of health facilities  | Yes | No |
| d | Type of services delivered by each cadre                           | Yes | No |
| e | Time spent on delivering services                                  | Yes | No |
| f | Number of new graduates entering the health sector                 | Yes | No |
| g | Number of health workers leaving the public health sector          | Yes | No |
| h | Reasons for leaving the public sector                              | Yes | No |
| g | Others (specify)   | Yes | No |

Who commissioned or funded the HRH assessment

|  |     |    |
|--|-----|----|
| Ministry of Health   | Yes | No |
| Other government agency (e.g. Civil Service Commission; Public Service Commission etc) | Yes | No |
| Donor agency   | Yes | No |
| Academic institution   | Yes | No |

|                        |     |    |
|------------------------|-----|----|
| Other (please specify) | Yes | No |
|------------------------|-----|----|

Was there external technical assistance to conduct the assessment?

|     |    |
|-----|----|
| Yes | No |
|-----|----|

On a scale of 0 –3, please rate the degree of local participation in the following activities:  
(0 = no involvement; 1=remotely involved ; 2 partially involved 3 = fully involved)

|   | Activity                          | 0 | 1 | 2 | 3 |
|---|-----------------------------------|---|---|---|---|
| a | Conceptualization of the activity |   |   |   |   |
| b | Data collection                   |   |   |   |   |
| c | Analysis                          |   |   |   |   |
| d | Report writing                    |   |   |   |   |
| e | Dissemination                     |   |   |   |   |

How were the results of the study presented to policy makers?

|   |  |     |    |
|---|--|-----|----|
| a | Technical Report   | Yes | No |
| b | Technical dissemination workshop/seminar or other large meetings   | Yes | No |
| c | One-to-one meetings (e.g., Ministerial briefing)                   | Yes | No |
| d | “policy brief” (i.e., a summary of key findings for policy-makers) | Yes | No |
| e | Media briefing   | Yes | No |
| f | Other (please specify)   | Yes | No |

What actions have been taken as a result of the HRH Assessment findings or other HRH interventions?

|   | Action   | Action taken by whom? | Action taken when? |
|---|--|-----------------------|--------------------|
| a | HRH Policy action taken on:                          |                       |                    |
|   | (i) Incentives/remuneration                          |                       |                    |
|   | (ii) Training  |                       |                    |
|   | (iii) Staff deployment                               |                       |                    |
|   | (iv) Skills mix                                      |                       |                    |
|   | (v) Other (specify)                                  |                       |                    |
|   | (vi) Other (specify)                                 |                       |                    |
| b | HRH Policy revised                                   |                       |                    |
| c | HRH country plan developed                           |                       |                    |
| d | Secured additional budget to hire new health workers |                       |                    |
| e | Health workers redistributed                         |                       |                    |
| f | Health workers fired                                 |                       |                    |
| g | Other (specify)                                      |                       |                    |

What other types of data/information were used (or combined with the HRH assessment findings) to contribute to the policy-making process?

|   | Other data | How used |
|---|------------|----------|
| a |            |          |
| b |            |          |
| c |            |          |
| d |            |          |
| e |            |          |

Who specifically used the HRH report or other HRH intervention for policy purposes?

|   | Position   | Ministry or Organization |
|---|--|--------------------------|
| a | Minister   |                          |
| b | Principal/permanent secretary or chief technical person in ministry (please specify who) |                          |
| c | Planners (Planning units)  |                          |
| d | Chief Medical Officer in Ministry of Health  |                          |
| e | Other policy makers  |                          |
| d | Financial analysts (Finance units)   |                          |
| g | Academic institutions  |                          |
| h | Others (specify)   |                          |

What has been the strategy or process of getting the HRH assessment findings or other HRH intervention to be used by the government for policy purposes?

Have there been "HRH policy advocates" within the Ministry of Health?

|     |    |
|-----|----|
| Yes | No |
|-----|----|

If "yes", what are their positions and affiliated institutions?

|   | Position | Institution |
|---|----------|-------------|
| a |          |             |
| b |          |             |
| c |          |             |
| d |          |             |

Other

|  |
|--|
|  |
|--|

What positive contributing factors influenced the use of HRH report or other HRH intervention in policy?

|   | Positive factors   |
|---|--|
| a | Having a local policy champion                               |
| b | Having a strong stakeholder interest and participation       |
| c | Making the report available in both electronic and hard copy |
| d | Involving stakeholders from the beginning                    |
| e | Linking the report to specific action(s)                     |
| f | Having funding available to take action                      |
| g | Others (specify)   |
| h | Others   |

What were some of the negative factors that deterred the findings from being used in the policy process?

|   | Negative factors   |
|---|--|
| a | Not having a local policy champion                               |
| b | Not having a strong stakeholder interest and participation       |
| c | Not making the report available in both electronic and hard copy |
| d | Not involving stakeholders from the beginning                    |
| e | Not linking the report to specific action(s)                     |
| f | Not having funding available to take action                      |
| g | Others (specify)   |

What HRH information do you need for policy making in your country that is not currently available?

|  |
|--|
|  |
|--|

Thank you for completing the survey

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