

# Quest for Quality

Interventions to Improve  
Human Resources for  
Health among Faith-Based  
Organisations





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## Colophon

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# Preface

All over the world, assuring sufficient numbers and quality of health care personnel is an uphill struggle. In the rich countries of Europe and North America, studies and surveys abound documenting the threatening shortages of health providers, made worse by growing health demands of an ageing population. Therefore, governments have developed a range of measures they seek to implement.

By comparison, poverty-stricken countries in regions such as sub-Saharan Africa are even more affected by the consequences of scarce human resources, which are particularly and acutely felt in urban slums and remote rural areas. Health facilities in these underserved areas face an accumulation of challenges: insufficient opportunities to train health care professionals, uneven distribution of health services, low pay for health workers, run-down and inappropriate physical infrastructure, and poor management. Health workers also have to deal with difficult working and living conditions. All these developments result in too few health workers, which jeopardises adequate health service delivery. The risk of losing those with professional training and experience casts a long shadow over health service planning.

Traditionally, faith-based health organisations have been important health care providers in many remote and other under-served areas. Currently, these facilities bear the brunt of the competition for scarce human resources. It is important for faith-based organisations to learn from recent experiences and from the creative ways in which colleagues seek to retain their health workers and improve quality of human resource management. In 2007, Cordaid established a linking and learning programme that helps bring together the experiences of partner organisations and promotes sharing and reflection. This unique publication on human resources for health is the first product of this programme.

For this linking and learning programme, some faith-based umbrella organisations in Tanzania, Ghana, Uganda, and Malawi have joined forces to share their experiences in confronting the human resources crisis: by developing retention schemes, offering in-service training, task shifting, developing the planning and management skills of their staff, better coordination of salary and incentive structures with the public systems, and the development of lobbying instruments for national and international use.

While they all share the common context of anglophone sub-Saharan Africa, these organisations' starting positions, and the contexts in which they operate, actually prove to be very diverse. But the results of their efforts to improve the health workforce indicate that a comprehensive approach to human resource management can bear fruit when it addresses not only salaries but training, working conditions and career opportunities. The shared analysis that has resulted from comparing cases underscores once again the importance of coordinating and learning from regional experiences. Last but not least, the cases illustrate the necessity to work towards more integration of the various systems of health care into one mature health system that delivers quality health care for all.

I can therefore recommend this publication in the warmest terms to anyone interested in the global crisis of human resources in health care.

Finally, on behalf of Cordaid, I would like to thank the authors for their hard work, and the directors and other staff of their organisations for their input and support. Thanks also to Christine Fenenga, José Ultrera and Ingrid van Bouwdijk Bastiaanse of Cordaid for organising the linking and learning process, to Marjolein Dieleman and Thea Hilhorst of KIT for their inspiring facilitation and putting this publication together, and to Jean McNeil for the final edit. We are also most grateful to the reading committee which was composed of Dr. G. Buckle of NCHS-Ghana, Mr. F. Gondwe of CHAM- Malawi, Dr G. Gedik and Mr. N. Dreesch of WHO, Mrs. M. Lagro and Mr. A. de Wagt of Cordaid. Thank you all. Last but not least, we would like to thank DGIS for its financial support.

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Director, Cordaid

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Introduction

The World Health Organization (WHO) has stated that achieving the Millennium Development Goals (MDGs) for health requires that at health facilities qualified health care providers are available, are well trained and perform adequately (WHO, 2006; WHO, 2001; WHO, 2000). However, there is a critical shortage of health care providers, especially in sub-Saharan Africa (WHO, 2006).

This shortage is most severe in remote rural areas and urban slums, where health services are often provided by faith-based organisations (FBOs). The scarcity of human resources results in competition over limited numbers of qualified staff between public, private and faith-based health care services. Presently the crisis in human resources for health is particularly affecting FBOs, partly due to their predominantly rural locations but also because increasingly they cannot compete with government services on issues of salaries and financial and non-financial incentive packages. The public sector meanwhile has been able to improve its remuneration packages using donor funds and debt relief. Additionally, competition has become more severe for both public and FBO-services because of the growing demand for staff by international non-governmental organisations, who often can offer a much higher remuneration package and more favourable working conditions.

Strengthening primary health care systems<sup>1</sup> is at the heart of Cordaid's policy to support access to and provision of quality health care services in low- and middle- income countries (LMIC), especially for poor and vulnerable groups. Key intervention areas<sup>2</sup> are poverty eradication, advocacy and lobbying to influence policies and development of civil society (Cordaid, 2008). In the implementation of its health care programmes, Cordaid works mostly in partnership with FBOs, who provide first line health care services. They work at community level and that have strong presence in rural areas and urban slums. Since these FBOs face considerable difficulties to acquire and retain health care providers in their facilities, they have to find creative and innovative ways to recruit and keep staff. The human resources for health (HRH) crisis touches all FBO partners of Cordaid, but the severity of the problems and their underlying causes vary between areas within countries and between organisations.

Moreover, strategies to address these constraints differ between countries and each FBOs is addressing the HRH challenges in their own unique way. However, a similar intervention may be implemented and tested at a number of facilities within the same country or in different countries, but in isolation; A facility or organisation may not be aware that another facility is trying out the same approach. Managers testing out an intervention may also be unaware that it has been tried before. Although each is gaining rich experience in their attempts, the results often lack validation. Moreover, when personnel involved in such interventions leave, institutional memory for the organisation is lost. Clearly there is a great need to find out what good practice and "success stories" exist around human resources for health in the FBO sector, validate these, and analyse how best to adapt promising experience to a different context.

One way for improving the workforce situation is to develop and document approaches that are based on evidence, followed by dissemination of proven successful interventions and sharing the lessons learned. Policy makers and managers have to be informed about what measures

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<sup>1</sup> Since the launch of the World Health Report 2008 "Primary Health Care: Now More than Ever", attention to primary health care has made a revival (WHO, 2008).

<sup>2</sup> These intervention areas are defined in more detail in Cordaid's position paper on HRH.

are successful under which circumstances, for which groups of staff and at what costs (Buchan, 2004). Despite the availability of a framework to guide HRH action, strategies and tools<sup>3</sup>, very little has been written to date on what works and what does not (see Chopra et al, 2008; Dussault et al, 2006; Lehmann et al., 2005; Rowe et al., 2005 and others).

In order to deal more effectively with the current HRH crisis, Cordaid and its partners realise that it is critical to learn better from each other's experiences. Cordaid has developed a "linking and learning" programme to facilitate exchange and joint reflection, which includes a component on HRH interventions. The goal is to create a platform for exchange and discussion in order to move the HRH agenda of Cordaid and its partners forward.

This publication is one of the results of Cordaid's linking and learning programme. The objective is to describe and analyse HRH practices in order to draw lessons learned, leading to enhanced health services performance in under-served areas covered primarily by partner organisations of Cordaid. It is intended to be a tool for HR practitioners, managers of health care facilities at different levels in the health system and policy makers, especially those working for and with FBOs. Moreover, documenting experiences on the strengthening of human resources at primary health care level is especially timely in the light of the call for a renewed emphasis on primary health care (WHO, 2008).

It is also one of the first publications to be written entirely by FBO partners and is the product of two workshops and exchanges between Cordaid and its partners, facilitated by the Royal Tropical Institute (KIT). These workshops have played a key role in assisting partners with documenting, jointly analysing experiences and drawing conclusions.

The documented evidence in this publication are narratives, each written in the author's own writing style, describing practical experiences with HRH interventions from the point of view of the partner organisation.

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3 See <http://www.capacityproject.org/framework/>



The publication allows readers to reflect on their own practices and to identify what interventions are possible in their particular context, and which conditions might be required for success.

The case studies can be used as a starting point for discussion on HRH interventions. The publication discusses programmes and approaches which have been developed by FBOs in sub-Saharan anglophone Africa, where the HRH crisis is very urgent (WHO, 2006). Due to incomplete data on HRH and the difference in definitions for various professional health care cadres used in each country, it was not possible to compare the size of the workforce shortage between these different countries. All of the described HRH practices are considered promising practices by Cordaid's partners and have been implemented for at least one year. These practices occur at three different levels:

#### **Local level**

- Improvement of performance of health workers in rural areas, by direct support to pre-service training, in-service training, retention schemes, staff motivation, and changes in skills mix;
- Strengthening knowledge and skills of local health facility managers to implement HRH policy and to negotiate with organisations and government authorities regarding HRH policies and resource allocation.

#### **National/regional level**

- Strengthening knowledge and skills of umbrella organisations to formulate, implement and evaluate HRH policies;
- Strengthening of knowledge and skills of umbrella organisations to negotiate and discuss HRH policies with a range of stakeholders at different levels;
- Strengthening capacity of training institutes (knowledge, skills and infrastructure) to improve training programmes and to relate these better to local needs.

#### **International level**

- Lobbying and advocacy work with respect to HRH issues among FBOs and exchange of knowledge and experiences regarding HRH interventions and policies.

#### **Each case study seeks to answer the following questions:**

- What HRH problem was addressed and what were the expected results?
- Which intervention(s) did the organisation put into practice?
- How was the intervention selected and implemented and who was involved?
- What were the actual results?
- What were the successes, challenges and the lessons learned?

This publication has 10 chapters. Chapter 2 provides a background to the different cases; it explains in more detail the HRH crisis, and potential interventions to improve retention and performance of health care providers. It also describes the FBOs, their institutional setting in different countries and the HRH problems that they face. Chapters 3 to 9 present the promising practices of the participating FBOs. In chapter 10, these cases are compared, connected and discussed. This chapter outlines the lessons learned around addressing specific HRH problems and provides future directions for the human resources for health agenda.

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(with contributions from Cordaid and IMA)*

# 2

## **The human resources for health crisis among faith-based organisations**

This section provides an overview of the global health workforce crisis, how this impacts on faith-based organisations, and describes the intervention areas to address HRH issues. In addition, insight is given into the health care service delivery by faith-based organisations and the role of their umbrella organisations: the Christian Health Associations.

## 2.1 The HRH crisis

The human resources crisis in low-income countries and particularly in sub-Saharan Africa has received global attention since the start of the Joint Learning Initiative in 2003 (JLI, 2004). *The World Health Report 2006* gave another important boost to this global agenda of “human resources for health or HRH” by providing a comprehensive overview of the extent of the workforce crisis and potential actions to address HRH shortages and performance (WHO, 2006).

According to the WHO, the global health care workforce consists of 59 million people, of whom 39 million are health service staff and 20 million are health management and support workers. The African region has on average 2.3 health care workers per 1,000 people, the lowest in the world; in contrast, the Americas has the highest density – 24.8 healthcare providers per 1,000 people. There are currently 57 countries with a critical shortage of health care providers, most of which are located in sub-Saharan Africa. In some countries the shortage of health care providers is so severe that less than 50% of the required staff is available to service rural populations. This has resulted in many facilities being unable to provide required services, or at times care is provided by non-qualified staff (WHO, 2006; Hongoro and Normand, 2006). This situation seriously compromises the health of many communities, particularly the poor and marginalised.

Within countries, maldistribution occurs at various levels. Relatively more health service staff are working in urban than in rural areas. There is also an inequitable distribution of health care staff between public and private-not-for-profit sector facilities and between primary, secondary and tertiary levels.



## 2.2 Interventions to address HRH problems

Although there is no conclusive evidence on the relationship between health outcomes and the number of available health workers, it is generally acknowledged that qualified and motivated human resources are essential for quality health service provision. Quality performance is the sum of sufficient number of health care providers, providing care according to standards, and being responsive to the needs of the community, patients and the health system. Addressing these aspects requires interventions in the following three areas:

1. Increasing the number of health care providers by training more health workers in pre-service training, by task shifting<sup>4</sup>, by enabling health care staff who have retired to return to work, and by getting the unemployed back into the workforce.
2. Addressing the retention of health workers through reducing recruitment of health care providers by institutes in high-income countries, and by developing, implementing and evaluating retention strategies in low-income countries.
3. Ensuring that available health care providers are actually at work, are performing well, and deliver quality care.

Interventions to address the prevailing HRH problems need to be country and facility specific, and adjusted to the context, the priorities of different stakeholders and the availability of resources.

## 2.3 Questions and framework to analyse HRH practices

Prior to the selection and implementation of HRH interventions, a number of questions need to be answered to allow for the design of feasible and sustainable interventions that match the problems being addressed. These questions are:

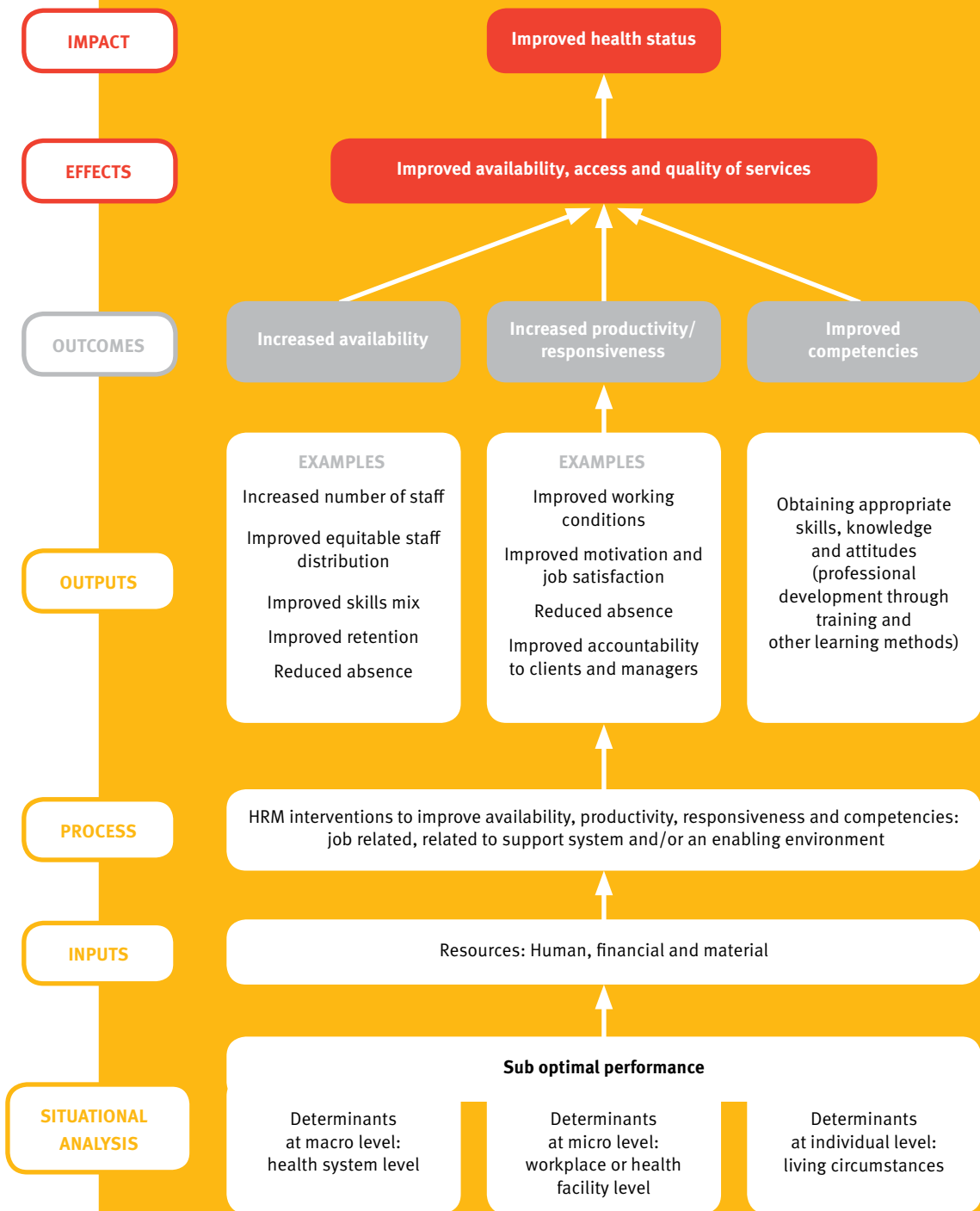
- What are the core problems that need to be addressed: for example, is it the number of health care providers, high turnover of staff or poor performance of available staff?
- What are the main underlying reasons for these problems?
- What results do we expect to achieve and how?
- What interventions have worked well to address these problems elsewhere and will they work in the particular context of our organisation?
- Who are the main stakeholders who can help address these problems and what are their interests and points of view?
- Is the intervention sustainable?
- How are we going to monitor and evaluate its implementation, output and outcome?

In this publication these questions are retrospectively discussed for each case study, so as to better understand the presented cases and to draw lessons learned.

In order to facilitate the design, monitoring and evaluation of HRH interventions KIT has developed a framework that depicts an intervention logic. It allows to identify the relation between a situational analysis and a selected intervention, and between the intervention and the expected outputs and outcomes (see figure 1, adapted from Dieleman and Hammeijer, 2006).

<sup>4</sup> Task shifting implies that tasks are moved to less specialised health care providers (WHO, 2007): [http://www.who.int/healthsystems/task\\_shifting\\_booklet.pdf](http://www.who.int/healthsystems/task_shifting_booklet.pdf).

**FIGURE 1**  
**CONCEPTUAL FRAMEWORK TO DESIGN AND ANALYSE HRH INTERVENTIONS**



## EXPLANATION OF FRAMEWORK

The framework is based on the system's approach. It visualises that implementation of HRH interventions (inputs and process) is expected to generate outputs in terms of improved motivation, improved staff retention, increased production of staff etc. These in turn result in the outcome of the intervention in terms of measurable improvements with respect to the availability, productivity, responsiveness and/or competence of health workers.

These outcomes of the intervention will then positively influence effects, defined in terms of improved service delivery, measured by for instance increased availability, improved access and improved quality of services. Improved service delivery contributes to an improved health status (the impact of the intervention), for example through a reduction in morbidity or mortality of target groups. Of course, such an impact cannot be attributed only to this intervention.

This framework aims to visualise the mechanisms on how HRH interventions could influence performance, and assist in identifying assumptions underlying selected HRH interventions.

A hypothesis underlying the framework is that the implementation process and the results of these HRH interventions are influenced by the wider socio-economic and political environment as well as community characteristics, which together form the context within which an intervention takes place.

This framework is a simplification of the reality. Moreover, outputs and outcomes can influence each other. For instance, improved competencies could lead to increased responsiveness of health workers, or enhanced motivation could lead to improved retention.

Please note that this framework is not to be used for identifying causal relations between the levels in the figure. The framework is also not showing how interventions are implemented, who should do this and which stakeholders should be involved.

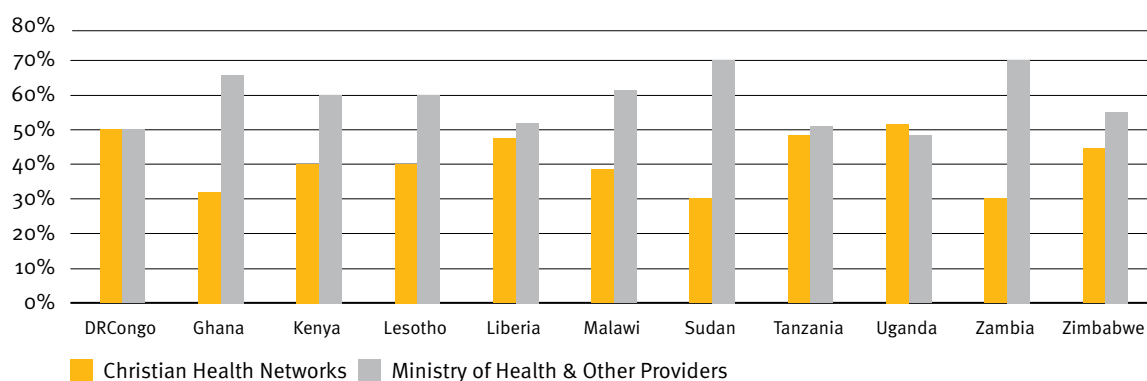
## 2.4 Health systems and faith-based organisations

### 2.4.1 Contribution of FBOs to service delivery

FBOs provide health and education services through hospitals, health facilities, medical, nursing, midwifery and allied schools, as well as via community-based programs delivered mainly by congregations of local churches and mosques. They develop and manage support systems such as stores of medical drugs, training institutes, nursing schools and universities, and are often members of district health management teams.

In sub-Saharan Africa, faith-based facilities provide 30-70% of the region's health care services. Table 1 illustrates the contributions of Christian Health Association (CHA) networks in select countries (Dimmock, 2005; Chand and Patterson, 2007). It should be noted that in statistics and when discussing resource allocation, faith-based health care provision tends to be lumped with private providers or grouped under the category of "private-not-for-profit".

TABLE 1 CONTRIBUTION OF CHRISTIAN HEALTH NETWORKS IN SELECTED AFRICAN COUNTRIES



Church health organisations are thus responsible for a broad spectrum of health care services and have a history of active involvement in primary health care delivery, with many outreach programmes extending to the most remote communities. They also implement programs to influence the attitudes and behaviours of service users towards better health. Among those who work within the faith-based community there is a consensus that FBOs are providing public goods and services. In many instances they are the only providers in rural, isolated areas where access to health care is limited. The origins of many FBO health care providers date back to the colonial era. Missionaries, pastors and nuns set up health care facilities in the vicinity of churches and missions, and which mainly focussed on curative services rather than preventative care. They also started dispensaries, small health centres and hospitals, especially in rural areas where health services were hardly available. Over time, churches and missions began to develop a more holistic vision of these services supporting community health, rather than merely offering a medical service.

The 20th Century saw a decline of missionary placements and the birth of autonomous national churches around the world. Health care facilities were turned over to the respective national church leadership to be operated and managed by them. Churches often established a national health secretariat where policies are discussed and set. In some countries these secretariats have an institutionalised relationship with the Ministry of Health (MoH).

### 2.4.2 Christian Health Associations

In many countries, the various Christian churches engaged in health care activities formed associations which eventually gave rise to the formation of networks usually referred to as Christian Health Associations (CHA). Currently there are more than 15 countries in sub-Saharan Africa with a formally recognised Christian Health Association; others are in various stages of forming a CHA. Most CHA have members of both Catholic and Protestant denominations. However, not all churches that provide health services are members of a CHA network. Over the years, most of the CHAs have developed into coordinating bodies at national level, which are recognised by the National Health Authorities as partner in the health system.

The CHAs are responsible for a number of activities, such as policy development, setting of guidelines for standards of care, channelling structural subsidies from government to the FBO sector (salaries and others), advocating on behalf of their member facilities, negotiating with their governments and other stakeholders, capacity building of their members, securing drugs and medical supplies, and contributing to the development of national health strategic plans. CHAs may also engage in fundraising for their members. Often they participate in country consultation mechanisms and as such are able to influence the allocation of donor funds.

As the CHA is an association of different member churches, decision making processes can be complicated. Representatives of the board of a CHA may be either church leaders and/or persons with a health background - it varies from country to country. The executive secretary or director of a CHA often does not have decision making power beyond the delegated authority. This might delay negotiations with the MoH.

### 2.4.3 Management of FBO facilities

Most FBO-hospitals and health centres belong to churches, dioceses or convents of different denominations. Church leaders may have an important say in the daily or overall management of a facility. In FBO health facilities, a pastor or priest is often a member of the management team and of the board of the facility. FBO health centres, dispensaries and community programmes are generally directly managed by church structures (diocese or local churches) and their plans have to be approved by the development office of the diocese or church before being implemented. However, hospitals and training institutions often have more independence.

FBOs have various sources of financing; in most countries they rely partially on patient fees and they have access to funding from international donor organisations, which often belong to the faith-based network. However, the funding given by churches in Europe and the United States to health services in sub-Saharan Africa has diminished considerably over the last decade. In several countries church health organisations now rely solely on grants and structural subsidies from the Ministry of Health. An example of the different types of funding of an FBO is provided in the box below.

## FINANCING OF FBO HEALTH FACILITIES IN KENYA

Many health facilities within the CHAK umbrella structure receive targeted donations and some have a missionary expatriate and expatriate health care professionals working at the facility. The Kenyan government supports faith based facilities through the provision of medical supplies, i.e. vaccines, TB drugs, anti-malarial drugs. Donations of supplies from overseas partners to individual facilities are irregular and custom clearance fees are often quite high. Many FBO's rely on government grants to pay salaries and the provision of medicines and medical supplies.

FBO health facilities collect "user fees" from patients in return for services received to cover the costs of providing health care services, and thus ensure continuity. Historically, in Kenya, user fees were the least significant source of funding, but today they provide a large percentage of the revenue. In 2004, within the CHAK network, 71% of funding came from user fees, 13% from donors, 9% from the National Hospital Insurance Fund, and 7% from others.

*- CHAK Annual Health Conference, 2007*

In the past, church-related health services were administratively integrated with other church services. For example, there was not always a separate bookkeeping system for a health centre or hospital as finances were managed by the convent or the diocese. This has changed in the last decade. Transparency regarding finances has become an essential element of management of church health services, because this is a key requirement for the receipt of funding from donors and government. Accounts of health facilities had to be separated from those of churches in order to be eligible for funding by the ministries of health.

### **2.4.4 Relationships with government**

Since the implementation of health sector reforms, FBOs have become officially recognised partners in the health system within many countries. All CHAs in the countries taking part in this publication have a formalised relationship with the ministry of health within their specific country through a Memorandum of Understanding (MoU).

In most African countries, FBO health services are currently included in national health plans and are made responsible for an agreed package of services. Contracts (or service level agreements) between national or local government and FBOs are then established for the delivery of services. For instance, in Tanzania church-affiliated hospitals can become a "Designated District Hospital", when they are the only hospital for a catchment area. In return for the provision of services to the population in the catchment area, the government provides the facility with funding. In Ghana and Malawi most of the staff in the FBO services is paid by the government through the CHA. In Uganda and Tanzania health staff are paid by the owners of the institutions but the health services are supported through grants or service agreements.



## 2.5 HRH problems among FBOs

HRH management has always been an important issue for FBOs. They often run training colleges which educate nurses, midwives and other paramedical staff and as such contribute to the provision of qualified staff. Some FBO institutes also train higher level staff and manage universities. Nowadays the training schools are officially recognised, with the trained cadres receiving similar qualifications as those graduating from government training colleges. The trainees can work in both FBO and MoH facilities.

Before the health sector reforms that began in the 1980s, most FBO health facilities had a low number of mid-level health professionals amongst their staff. At the time, many nursing tasks were done by in-service trained nursing assistants. When FBOs' health services were officially included in the overall national health systems, the MoH became responsible for quality control of these facilities. FBO health services now had to adhere to national health policies and staffing had to follow national guidelines regarding numbers and minimum standards of staff qualifications. As a result, more higher-level staff needed to be recruited and thus more resources were required to cover the salary costs of FBO facilities.

Regarding the management of human resources for health, several countries made progress in unifying working conditions for all church-related health staff in the country through the efforts of CHAs. As a result, salaries for church health workers and government health workers have come nearer to parity, although often there is a difference in the allowance packages. In several countries, positions at rural FBO services are less attractive than those in government facilities, due to differences in working and living conditions. The harmonisation between FBO and MoH facilities (and training institutes) also made it easier for FBO staff to move to MoH facilities.

All these developments resulted in increasing staff shortages for FBOs. FBOs have tried in several ways to address their health workforce crisis, often being creative and innovative in their methods. The following chapters present some of the promising practices implemented by the FBOs to address the HRH problems they face.



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# 3

## Attracting and retaining key professional staff in Ghana

In Ghana, there is a shortage of key health professionals. The problem is more acute at the district and health centre/health post levels, and in the private-not-for-profit sector. In the face of these acute shortages, the National Catholic Health Services (NCHS) commissioned a study in 2004 into the reasons why staff decide to leave. The findings have been used to design a programme of interventions to retain health professionals, which has moved beyond the assumption that staff retention is mostly about financial incentives for employees. Implementation started in late 2005 and already improvements have been observed in staff competencies, responsiveness and productivity. Moreover, the length of service of the health workforce is increasing. This case study reviews the approach used by the NCHS to improve retention by addressing staff expectations, and what management responses are required to ensure continuous availability of sufficient manpower.

### 3.1 The Ghanaian health care delivery system

The health service delivery system in Ghana is composed of public, faith-based and a private-for-profit sectors. Collectively, these provide preventive, curative, and rehabilitative services as well as training and health promotion. The Ghana Health Service has a hierarchical management structure; the system begins at the level of the 110 districts in the country, moves up to each of the ten administrative regions, and then to the national level. There are also a few quasi-governmental hospitals and clinics owned and operated either by corporations set up either entirely by government or in partnership with investors. The private-for-profit sector is made up of hospitals and clinics, pharmacies, laboratories, and other providers of diagnostic support services and are almost always located in cities where the patients are, who can pay for their services. The private-for-profit sector also includes traditional practitioners.

The Christian Health Association of Ghana (CHAG) is the coordinating body of the faith-based health care delivery system, also referred to as the private-not-for-profit sector. CHAG seeks to promote the identity of faith-based healthcare, and plays an important role in negotiating service conditions for the FBO sector workforce. CHAG has a contractual relationship with the MoH and deals directly with the ministry on all matters pertaining to the sector. The National Catholic Health Services represents 70% of the CHAG membership. Within the NCHS, there is a Department of Health, the executive arm of health for the Ghana Catholic Bishops Conference that provides leadership and advises the Bishops Conference on all health-related matters. There are also diocesan offices of health which provide leadership and support to all hospitals, clinics and other specialised health institutions within its diocese.

The distribution of health facilities is uneven, and reflects the political history of Ghana. There are more hospitals in the southern and middle belts than there are in the northern parts of the country. Government hospitals are mainly located in the semi-urban district capitals, regional capitals and cities. Faith-based institutions are located generally in the rural areas, where about two-thirds of all Ghanaians live.

Until 1996 the Ministry of Health was solely responsible for policy making, health service delivery and monitoring and evaluation of health services in Ghana. To separate the policy making and implementation function and to make health service delivery more efficient, the Ghana Health Service (GHS) was created by law in 1996. The GHS's task is to deliver services for the public sector, while the MoH is responsible for policy making. The role of the MoH in

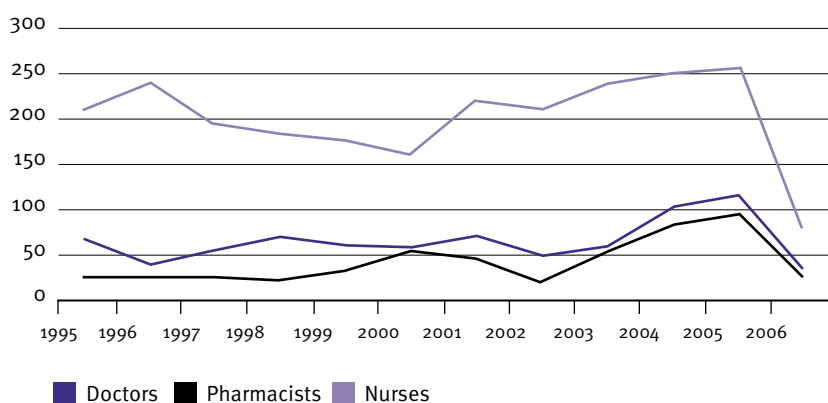
service delivery is to contract service providers, allocate resources, and to monitor and evaluate service delivery. At the same time, Ghana's two teaching hospitals became autonomous.

In 2003, the National Health Insurance (NHI) Act was voted to introduce mutual health insurance schemes, both private and district-based, as a means of financing health care. The NHI is supported by a government tax fund. The aim of this reform was to improve access to health services by removing financial barriers. Indeed, immediate increases were recorded in demand for health services, resulting in increased attendances at all levels.<sup>5</sup> However, Ghana is also facing a shortage of key health professionals. This increase in demand for health services means an even heavier workload, which may be at the expense of the quality of care.

### 3.2 A growing human resources crisis

In 2007, the total number of health professionals in Ghana was 57,031 persons. CHAG employed 13% of this total, of whom about 2/3 work in NCHS facilities. NCHS has 32 hospitals and 66 clinics nationwide, and accounts for 27% of health care services in the country. CHAG has also lobbied successfully for more access to resources from government. Since March 2008 the MoH has begun posting newly-qualified nurses directly to CHAG institutions, just as it does with the Ghana Health Service. Thus far, 241 nurses have been placed directly in FBO facilities and are paid for by the MoH. The once-important (temporarily) secondment of staff from the government sector to the faith-based sector, which concerned about 45% of the FBO workforce, will be phased out.

FIGURE 1 LEVELS OF STAFF ATTRITION 1995 -2006



The health system referral structure guides the distribution of staff between facilities. Specialised staff, such as doctors, are concentrated at the tertiary level of health care (hospitals), while most of the less skilled staff work at the primary health centre level.

5 Ghana Health Service Annual Report, 2007 p.65.

Since the 1990s, the NCHS observed growing staff attrition amongst doctors, pharmacists and nurses, a trend which was reaching alarming proportions. Newly-trained staff did not report to their duty stations, and those already working were leaving their post in growing numbers, even without notice to the employer. Staff who requested to go on leave did not return. The bulk of this staff movement was towards government sector facilities in urban areas to fill the vacancies created by the migration of large numbers of professionals to Europe and the Americas.

Overall, the ratios of key health professionals to population being served have been worsening over the last decade (MoH, 2007). Moreover, there has been a heavy workload for remaining staff. The paradox was that although the productivity of manpower use went down, staff costs were rising due to an increase in payments for overtime and increased sick leave. This development is also undermining the possibility to reach the targets set by the health sector and may even erode gains already made, such as in reducing certain communicable diseases (GHS, 2006).

The growing shortage of key professional staff impacted negatively on health service delivery at all levels and everywhere in the country.<sup>6</sup> But, these trends were more severe in rural areas, particularly in the northern parts of Ghana, where they started to threaten the sustainability of the health delivery system. The first activities to suffer were the prevention and promotion aspects of health services delivery. The availability of curative care could diminish too, particularly in already underserved areas.

### 3.3 The Ministry of Health's response

The HR situation alarmed policy makers and service delivery institutions. Government responded in 1998 by increasing the pay packages of public sector employees through the additional duty allowance scheme which also benefited faith-based institutions. The role of the Health Service Workers Union in negotiating these pay-packages was important as well. Initially the scheme was only open to doctors; in 1999 nurses were also eligible. The government also introduced the Car Loan/Allocation Scheme for all cadres in 1999. However, these measures did not stem the tide as hoped (Ruwoldt et al, 2007, see also the graph above). Moreover, most of these packages aggravated the problem for the faith-based facilities as these could not offer similar conditions to their staff.

The trend towards a growing loss of staff was reversed only around 2005, when a bilateral agreement was reached with the UK government to limit the granting of working visas to health professionals by the British High Commission in Ghana. Another contributing factor was the imposition of more stringent contractual terms for entitlement to government sponsorship for training, such as having guarantors and withholding of certificates until five years of service have been completed.

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<sup>6</sup> *The two teaching hospitals in Accra and Kumasi made sure that they kept some of their trainees to maintain their level of service delivery.*

### 3.4 The NCHS study on retention

The NCHS Institutions (hospitals, clinics, diocesan health pharmacies and specialised institutions) were increasingly concerned about the sustainability of their facilities in their respective catchment areas. By mid-2004 the staff attrition problem was becoming so acute that if nothing was done, about half of the NCHS facilities were under threat of closure due to shortage of staff. Therefore, the NCHS decided to commission a study to better understand why staff decided to leave and what interventions were possible.

The study targeted the entire workforce and nearly all staff in post at the time of the study were interviewed. Employees were asked to rank a number of factors with respect to their influence on continuing to work within the NCHS. These included financial and career development and training, the location of the facility and other non-financial incentives.

The NCHS study found that staff needs and expectations vary among the different cadres. The data showed that 68% of doctors had been in the service for five years or less and only 13% had been in the service for more than ten years (Adjei et al., 2005). For doctors and pharmacists, financial incentives per se were not the most important factor for continuous service. Access to professional training, career and personal development were more important for remaining at post. Some doctors wanted to hold managerial positions, just as some of their colleagues in the public sector were able to do, but this is often not possible in the NCHS system. Occasionally doctors complained about interference by religious authorities in their professional work.



The study also revealed that some doctors joined the NCHS only to acquire professional skills quickly and intend to quit as soon as possible to pursue their career elsewhere. Another reason to join the NCHS was to be close to their spouses working in the locality where the NCHS facility is situated. They would then leave when their spouses were transferred or relocated.

For nurses and other paramedics, salaries and incentives were reported as being important for remaining within the NCHS. Other factors were perceptions of fairness of management in applying work rules, opportunities to be transferred when becoming bored in their present position, lack of availability of good schools for their children and concerns about end-of-service benefits/packages.

The study showed that the total salary package for employees in the NCHS is actually better compared to the public service, as serving in rural localities entitled them to diocesan allowances and incentives. However, these varied both in value and types between the respective dioceses. And even although some dioceses offer no or very minimal allowances, there are still staff who accept posting in their facilities and will serve for many years.

### 3.5 NCHS interventions to improve retention

The aim of the package of interventions is to improve retention (staff turnover) and length of service of health professionals in NCHS hospitals and clinics, also reducing the costs of health care delivery. More particularly, the range of specialists available on the referral hospital levels is to be improved.<sup>7</sup> In consultation with managers of the NCHS health facilities the most appropriate interventions were selected for retaining the most critical staff members for sustaining service delivery: doctors, pharmacists, nurses, anaesthetists and technicians (laboratory, dispensing, x-ray/imaging).

Next, the NCHS designed an implementation plan in consultation with the diocesan health offices and with Cordaid, which is funding part of the activities. They opted for a multi-faceted approach, while addressing issues in context. The NCHS also decided that interventions should move beyond addressing the financial incentives for health workers only. There was hardly any resistance to the propositions from within the NCHS structure, as all stakeholders accepted the findings of the retention study, and agreed that it was urgent to act. However, concerns were raised over the risk of overloading the system with so many activities running simultaneously. This concern was addressed in the Department of Health Strategic Plan and Programme of Work (2008-2013) by way of prioritising activities. Implementation started in late 2005. The various interventions have been grouped in three categories: competence, availability and productivity/responsiveness.

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<sup>7</sup> All the 32 hospitals of the NCHS are district hospitals and provide basic surgical interventions in surgery and obstetrics and gynaecology, among others.



### 3.5.1 Competence

With respect to enhancing competence, the focus is on support for career development and training. One group of interventions aims at meeting health workers' need for training to strengthen their technical skills and knowledge. The assumption is that such training schemes will enhance staff retention, while also improving their performance and productivity. Refresher and specialist courses and in-house training are offered to serving employees. For sponsorship, priority is given to the critical skills lacking in a particular institution. The management team of a facility is responsible for identifying and recommending relevant training programmes for its employees. For the moment, the sponsorship package is limited to training in Ghana to enable a good number of employees to be trained. The NCHS also started to work on improving management of hospitals. Management teams are composed of at least an administrator, a medical superintendent and the nurse manager. Reinforcing the capacity of these managers is another area of competence building aimed at a more efficient and even-handed management of the workforce, again with the aim of improving retention. First, a needs assessment was undertaken by the NCHS by analysing the management systems in place and organising consultations with all stakeholders. Next, manuals were developed for the management teams on procedures and themes such as general management, financial management and administration and human resource management. Every year the NCHS selects a special topic. In 2007 for example, management teams were trained in the laws relating to human resource management. The teams were then trained in general management concepts, the new systems, and how to use the accompanying manuals. New management procedures were developed to relate HR decisions better to financial management. For example, managers can now assess the full extra costs of a long-term training programme for a staff member (the trainee will stay on the payroll while extra expenditure is needed for temporary recruitment or for paying overtime to existing staff). The NCHS is also exploring ways to align organisational structures and to improve management effectiveness.

### 3.5.2 Availability

The pre-service sponsorships and professional training received most financial support, partly through Cordaid. The condition attached to this package is that training should be local, so that many staff could benefit. To improve the availability of doctors for facilities in underserved areas, pre-service sponsorships are made available to medical students during the clinical years of their study. These sponsorships are accompanied by a legally-binding agreement that obliges the student to join the NCHS immediately after graduation. There is an option for the NCHS to request that the guarantor of the student refund the monies spent on a trainee should he or she fail to serve for at least three years within five years after training. In enforcing this agreement the NCHS has recourse to the courts.

The NCHS will also accommodate skills transfer programmes that enable non-health professionals to perform tasks that do not require technical skills, but are part of service delivery. It is assumed that this will reduce the burden on professional staff and will allow them to concentrate on more specialist work, thus improving the availability of services and staff productivity. One example is the use of ward assistants to perform some of the nursing duties such as dressing beds, bathing patients and preparing medicine trolleys for use by nurses in drug administration. Medical assistants are trained as prescribers for simple ailments, but are not allowed by the Medical and Dental Association to perform other tasks.

Improving salaries and allowances is another approach implemented through CHAG and the dioceses. In this way, the purchasing power of the workforce will remain comparable with the public sector. There are reward schemes for long service to meet employees' expectations. Moreover, offering end-of-service packages that permit staff to enjoy a decent retirement is another approach to improving retention. It is assumed that such packages will promote length of service and thus staff availability.

Nowadays, the NCHS takes care that newly-introduced services or an expansion of infrastructure by government or other partners are matched by an adequate allocation of human resources. One example is the building of dental units for two hospitals by the MoH. The NCHS signed a memorandum of understanding with the MoH to ensure that sufficient staff will be made available to run these units. Agreements like these guarantee that new services do not result in overloading on existing staff as has happened in the past, when no extra personnel were deployed.

The NCHS also organised visits by foreign specialists to improve availability of professional care and specialist medical services which are normally not available within NCHS hospitals. These visits help to reduce the workload of the existing workforce, and may even improve competence through on-the-job training, mentoring and supervision. Receiving visiting professionals is also a way to promote linkages between health facilities and sharing of skills. One challenge is the insistence of at the Medical and Dental Council and the Nurses and Midwives Council on undertaking a thorough background check on foreign-trained professionals and the official certification of the diplomas. These are time consuming procedures.



### 3.5.3 Productivity/responsiveness

Promoting voluntary inter- or intra-diocesan transfers will be introduced for two reasons: firstly, to stimulate interest for serving employees who desire to be relocated, and secondly to improve the skills mix for the hospitals and clinics. Therefore voluntary staff transfers may improve retention and keep staff productive.

However, one challenge is that perks and allowances vary amongst dioceses, often reflecting available resources. Dioceses are autonomous in these decisions. A voluntary transfer scheme will only work when allowances and other remuneration packages are at least similar.

Therefore, dioceses should work towards harmonisation, a process that may benefit from the involvement of the bishops and archbishop. Another issue is that a diocese may fear to lose key skills when allowing staff members to transfer. Finding a suitable replacement is often a condition before a person is released for transfer. A protocol to address these challenges is under development by the NCHS, which seeks a harmonisation of both financial and non-financial incentive packages and obtain the willingness of all stakeholders to respect it.

### 3.5.4 Monitoring system

A monitoring system is put in place and provides feedback on staff mobility. Monitoring is on-going and feedback is received on a monthly basis on a number of the interventions.

However, reporting is incomplete. The submission rates of these reports show some improvements, but there are still problems with timely reporting. A possible solution will be to link the entire system so that inputs on human resource movements and developments can be picked up instantly at all levels of the NCHS.

In addition, a new retention study has been planned for 2009 to assess the impact of the interventions. This study is expected to generate lessons for the NCHS but also for the GHS, MoH and other service providers. The study will also provide the basis for a mid-term review of the HR interventions in 2010.

## 3.6 First results

### 3.6.1 Sponsorships

Pre-service sponsorship and subsidies to students under a bonding agreement are used increasingly to attract new employees where recruitment is difficult (Zurn, 2002). This practice has also enabled better staff planning in NCHS institutions, particularly with respect to filling gaps as a result of the absence of serving staff, who are attending a specialist course of several years' duration. The assurance that there will be a replacement makes it possible for this serving staff member to enrol as scheduled.

In 2007, four doctors accepted pre-service sponsorships and 103 nurses, two nurse anaesthetists, and seven medical assistants benefited from other sponsorship programmes. Another six new doctors benefiting from a pre-service employment sponsorship are expected to join the NCHS in 2008, following their graduation. The University of Ghana Medical School has assisted the NCHS with identifying students for sponsorship, who are ready to work in rural areas.

But surprisingly some dioceses located in hardship areas have not shown interest in the programme. One reason given is that they do not expect these doctors to stay on after serving

the bond, because they do not hail from the locality. For these areas, the training institutions have not found a single student who meets the requirements for receiving a sponsorship to enter into the medical schools and is originally from these dioceses. Even when students originate from an underserved area, facilities may remain hesitant to engage with the programme, fearing that the sponsored student will not stay after serving the bond. As a result, eight medical students who have been selected by the Director of Health have not received a sponsorship yet, because the dioceses selected for future posting have shown no interest in taking them on.

Initially, the sponsorship programme was to also include dispensing/pharmacy technicians but it was later realised that there was no more need because the Kumasi Polytechnic was turning them out in larger numbers. They were readily available for employment, including in underserved areas.

### **3.6.2 Training**

NCHS records indicate that almost all nurses, pharmacists and administrators as well as some technicians (x-ray, laboratory and dispensing) have attended short courses and in-service training. The dioceses and institutions have played an important role in identifying potential trainees.

However, a number of challenges are inhibiting the training and capacity building efforts. On the part of employees, some are not interested in further training either because they are not willing to leave their work environment, or they do not find it necessary. Some mid-career professionals have shifted their attention to family issues and rather spend time educating their children than building their own skills.



On the other hand, not all staff who desire to be trained are eligible. Some lack the entry qualifications for enrolment in a certificated programme. Others seem no longer able to deal with the theoretical requirements of a certificate course. Moreover, training in some medical specialisations, such as neurosurgery and cardiothoracic surgery, are not yet available in Ghana. Access to training is also sometimes refused by facilities having many vacancies and fearing lack of skilled manpower.

Anecdotal evidence seems to indicate that these new training opportunities are appreciated. They appear to have reduced requests for transfer back to the GHS by staff who were seconded (before the recent cancellation of secondments). However, there is a need to measure the actual impact on skills and competence, and determine if it has indeed improved staff motivation and retention. Finally, some staff have their own career plans or want to concentrate on family life. They will thus move on when their partner is placed elsewhere. Such staff will not be retained no matter what the facilities offer.

### **3.6.3 Management capacity building**

Overall, the process of building management capacity has been slower than expected. One reason was that the capacity of most managers of facilities was rather weak, and the required management competences are considerable. Often, clinicians are heading management teams. There are only a few professionally trained health service administrators in these management teams. Most doctors and nurses in the management team rose to their positions following promotions after long years of service. Many have not received any formal training in management before. This implies that the manuals need to be very detailed, as these have to guide every activity. Another constraint is that some teams do not function well and are not able to implement decisions taken jointly.

Members of most management teams have received a basic two-month residential course and once a year a retreat is organised for all management teams to discuss experiences on HR issues and practices. The attendance records showed that while almost all professional managers of health service facilities have followed the course, the attendance rate of clinicians and nurses is much lower. Some were not that interested in building their management capacity because they considered this as a secondary to their medical work. Others found a two-month course too long to be away. It seems that the clinicians heading management teams do not want to become full-time managers and leave their medical practice entirely.

At their annual meeting in 2008, the management team members who have followed the capacity building activities acknowledged that these have resulted in a more transparent and participatory management processes in their facilities. In their opinion this has improved teamwork and enhanced job satisfaction, both for themselves and within their workforce. Anecdotal evidence seems to indicate that these changes have improved staff's perceptions of the quality of management.

The management manuals have provided guidance, although not all management teams are using the manuals and applying the new procedures. These manuals were also useful for the less experienced non-professional managers, which shows that this group can be guided effectively too, provided that they have a positive attitude and are willing to be good team players.

### 3.7 Conclusions

The NCHS experience shows that the design of effective HR interventions that indeed contribute to improve length of service of employees has to be based on an assessment of expectations of the different cadres of employees and an analysis of causes of attrition. Merely improving financial rewards may not be sufficient, as some employees value access to training and other non-financial incentives even more than money. The package of interventions needs to be based on a multi-faceted approach. The NCHS experience also shows that the needs of employees differ between cadres and geographical locations, and change over time.

The challenge for the NCHS is to review the interventions regularly to ensure that these stay responsive to the evolving needs of staff. It is also planned that increasingly dioceses, hospitals and clinics will take on board best practices and integrate these in their planning, resource allocation and implement plans at their respective levels.

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# 4

## Improving management competencies in hospitals in Malawi

An important cadre in the health system are hospital managers, who enable the system to function. The Christian Health Association of Malawi (CHAM) has 19 hospitals and many management posts are regularly vacant. As the high turnover of staff is affecting the functioning of its facilities, CHAM decided to develop an integrated hospital management improvement programme. The aim is to equip managers and accountants with the required knowledge and skills to manage hospital resources. The programme also established sustainable systems and procedures to promote better management of resources even in the absence of trained hospital managers. This case study discusses how this integrated management programme came about, its implementation and first results.

## 4.1 Background

In Malawi, faith-based organisations manage 40% of all health facilities. There are 171 member health facilities, of which over 80% are located in rural areas. There are 19 hospitals and 20 community hospitals.<sup>8</sup> Of the 19 hospitals, eight hospitals are in rural areas and 11 are in semi-urban areas, while 10 have training colleges attached. The other facilities are nutritional rehabilitation units, dispensaries and health centres with or without maternity wards.

Administratively, Malawi is divided into three regions which are in turn sub-divided into 29 districts. Within each district, there is a district health officer who is the chief executive of all health facilities. The district health officer has dual reporting responsibilities. He or she reports to the district commissioner, who heads the district assembly, as well as to the central office at Ministry of Health.

The faith-based organisations work together in CHAM, an umbrella organisation of registered Christian-owned health facilities. CHAM was established in 1966 by the Episcopal Conference of Malawi (ECM) and the Malawi Council of Churches (MCC). CHAM provides technical support and coordinates and develops health services among all members so that they may provide quality health care. The CHAM secretariat employs strategies such as capacity building, provision of technical support, resource mobilisation, representation of its members, and advocacy. CHAM has technical committees which are arms of the Board of Governors. The Ministry of Health, professional bodies and other stakeholders are represented on these committees depending on their areas of expertise.

CHAM is a key partner for the Ministry of Health given its large share of health facilities. The Ministry of Health and CHAM collaborate on many issues. For example, to make an essential health package (EHP) accessible to all Malawians, service level agreements are signed with CHAM member facilities to provide services to patients for free. The Ministry of Health is paying all costs. CHAM members also participate in national disease control programmes such as tuberculosis, anti-retroviral drugs distribution, and the Expanded Programme on Immunisation (EPI).

In addition, a Memorandum of Understanding was signed between CHAM and the Ministry of Health in 2002 which stipulates that the Malawian government pays salaries for all workers in CHAM facilities on the basis of an approved staff establishment for the health facility.

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<sup>8</sup> Community hospitals do not have a medical doctor and have less beds than hospitals.



The government also provides grants to CHAM for personnel emoluments (leave grants, allowances and pension) and supports CHAM training colleges with scholarships to all students and provides tutors through secondment.

At the national level, technical working groups are put in place as advisory bodies to the senior members of MoH. They are composed of MoH, CHAM, donor groups, professional bodies and other stakeholders. CHAM is active in all working groups such as the Human Resource Technical Working Group and the Finance and Procurement Technical Working Group.

## 4.2 Human resources for health

Health workers employed in the public sector are managed by the Department of Human Resources Management and Development within the Office of the President and Cabinet. This department manages the entire public service. Its main function is to develop, introduce and administer the public service conditions of service, codes and ethics. The authority to fill vacancies is the prerogative of the Department of Human Resource Management and Development of the Office of the President and Cabinet.

The Health Service Commission is responsible for recruiting, managing and utilising human resources for health, including setting and reviewing terms and conditions of HRH. In the Ministry of Health's central office there is a section for human resources management and development within the Directorate of Finance and Administration. This section is responsible for all aspects of human resource management which include strategic human resource forecasting and planning. Currently 18,826 posts of the 24,931 established posts of health workers are filled, leaving 24% of the positions vacant. The proportion of vacancies varies from one cadre to another as shown in Table 1.

TABLE 1 ESTABLISHED POSTS AND VACANCY RATE FOR DIFFERENT CADRES

	Established	Filled	Vacant	Vacancy rate
Administration (from PS to security Guard)	3371	2932	439	13%
Human Resource (from Controller to Copy typist)	401	340	61	15%
Accounting (from Controller to Accounts Assistant)	375	288	87	23%
Specialist (medical and dental)	122	28	94	77%
Doctors	156	86	70	45%
Clinical (from Director of Clinical Services to Medical Assistant)	1151	1109	42	4%
Technical (from Director of Preventive Services to HSAs)	1212	672	540	45%
Nursing	6102	2775	3327	55%
Attendants	3417	3514	-97	-3%
Planning	89	58	31	35%
Nutrition (from Chief Nutritionist to cook)	498	242	256	51%
<b>Total Established Posts</b>	<b>23106</b>	<b>17296</b>	<b>5810</b>	<b>25%</b>
<b>Total Industrial Posts<sup>9</sup></b>	<b>1825</b>	<b>1530</b>	<b>295</b>	<b>16%</b>
<b>Total</b>	<b>24931</b>	<b>18826</b>	<b>6105</b>	<b>24%</b>

Source: Malawi Ministry of health et al., 2007

9 Such as cleaners, carpenters etc.

### 4.3 Hospital management

The CHAM hospitals are managed by a team of five people: the medical doctor, the hospital administrator, nursing officer, accountant and human resources officer. In most of the hospitals under CHAM, the hospital administrator is also the chief executive of the hospital and he/she is responsible to the Board of Governors. The board of governors is responsible to fill the positions at management level in the CHAM hospitals.

The role of hospital administrators in the delivery of quality service by MoH and by CHAM has not received the attention that it deserves. Hospital administrators act as liaisons between Governing Boards, medical staff, and department heads and integrate the activities of all departments so that they function as a whole. By following the policies set by their respective boards of governors, administrators plan, organise, direct, control and coordinate medical and health services, as well as hospital resources. They need to be well qualified to undertake these tasks. They need to keep up with developments in medicine, diagnostic and treatment equipment, data processing technology, government regulations and financial management and financial options.

### 4.4 The challenge of filling vacancies of managers

The turnover in management positions within CHAM-affiliated hospitals is high. Since October 2004, seven hospital administrators out of the required nineteen and six out of nineteen accountants have left. The problem is more pronounced in health facilities situated in the rural areas. Filling the vacancies with replacements takes a long time. On average finding a suitable replacement took three months, but in one hospital a year passed before a vacancy was filled.

Apart from one hospital, all accountant posts in the CHAM hospitals are currently filled. Accountants support hospital management on financial management issues and often have to advise hospital management. However, most accountants have only a diploma in accounting and have not been trained for such an advisory role.

Clearly, hospitals under CHAM have difficulties recruiting hospital administrators with the appropriate training in hospital management. To date, most hospital administrators have either a Bachelor of Business Administration or Bachelor of Public Administration, which does not include a focus on hospitals. Some CHAM-affiliated hospitals have been employing managers who have retired from the public or private sector. This has been effective in that vacancies have been filled. However these managers have no specific experience in hospitals.

In Malawi, there is no training institute with expertise in hospital management. This lack of training opportunities has resulted in a skills gap for hospital managers, which is only being addressed recently. Since 2008 the College of Medicine introduced modules in management for hospital managers.

#### 4.5 The CHAM financial and material management improvement programme

Given the inadequate management capacities in the health sector, CHAM introduced a financial and material management improvement programme in October 2004, with the support of Cordaid. This programme ended in 2008. The aim was to improve the quality of care and have more effective and efficient services delivery in hospitals by improving management of resources and accountability. The programme represented a comprehensive approach to hospital management and was developed by a consultant in close collaboration with CHAM management. The focus was on increasing the capacities of hospital administrators and accountants of all 19 CHAM hospitals and improving financial and material management systems. The approach sought to assure that quality in management remains in the facility, even when trained hospital managers leave.

The assumptions of the programme are that training, combined with quarterly peer review and improved procedures, would improve management skills and working conditions. This would lead to better productivity and responsiveness of managers to address needs of health workers, thus improving their working conditions. In turn, this would lead to higher productivity and responsiveness of health workers to patients (for example, being able to prescribe drugs that are actually available).

Initially, Cordaid proposed to include the six hospitals with which it had already a working relationship on preparing and implementing strategic plans, but CHAM wanted to improve management at all its hospitals. Therefore, the programme was implemented in stages, rolling out the financial management improvement programme to all the CHAM hospitals in a period of 3 years. In the first year, the programme ran on a pilot basis in six hospitals with expatriate technical support. From January 2005, six more hospitals were incorporated. From January 2006, the remaining six hospitals were incorporated, resulting in 100% coverage of the 18 hospitals under the umbrella organisation.



The programme has the following components:

- Quarterly peer review meetings of hospital administrators and accountants;
- Procedures, salary and stores administration programs;
- Practical training workshops for hospital administrators and accountants on procedures, followed by two supervision visits with feedback per year by a CHAM officer;
- Support on call (by telephone or email).

#### **4.5.1 Quarterly peer review meetings between hospital administrators and accountants of different hospitals**

Before the quarterly peer review meeting, each participant prepares a report on the improvements made in the hospital during the past three months and the plans for the next three months. These reports are discussed with the other hospital managers and permit a direct comparison of progress and difficulties. Sharing knowledge and experience is thus stimulated, which can contribute to finding solution for issues managers have been confronted with in their work. The box below presents an example of how hospital managers learn and exchange with each other. At the moment of writing this case study, ten of such reviews have taken place.

#### **LEARNING EXPERIENCES: PATIENTS WHO CAN'T PAY**

One hospital had a problem with increasing numbers of unpaid patients' bills. Enforcing these debts was difficult as patients claimed that they were too poor to pay. Most debts were in the end cancelled, but this caused cash flow problems for the hospital. During a peer review meeting, another hospital shared its experience with dealing with this situation. They did follow up the debts by involving the village chief. The chief would summon the person who had not paid the bill and then they would agree on a way for settling the debt within a reasonable period of time.

#### **4.5.2 Procedures, salary and stores administration programs**

A standard management manual was developed by CHAM's Deputy Executive Director and a Programme Officer with the support of an expatriate technical assistant. The manual explains standard procedures on financial management, salary administration, stores and transport management, taking into account a hospital's requirements. A draft was sent to all hospital managers for comments and feedback and then finalised for publication. This process took nine months.

These procedures made it possible to develop new tools for management decision-making, such as a computerised payroll which also generates reports. The payroll holds human resources data, for example numbers in employment per position, and gives a payroll summary amount by, for instance, department. Another tool is the cash budget, which requires that the annual budget is split over twelve months according to information about seasonal flows, specific payment periods and expected income. This cash budget tool makes it possible to forecast timely the periods of cash flow difficulty. The earlier shortages are identified, the easier it is to adjust activities to expenditures, avoid salary delays or problems with creditors. This tool has been useful also to clarify the financial situation to the other management team members and bring them on board with respect to the programme.

All hospitals now use the manual as a guide in the management of the hospitals' financial and material resources. However, this manual is to be adopted also by each hospital, adaptations are allowed. To date, it has been approved by the Board of Governors of about half of the hospitals. Some have included indeed minor adjustments to adapt the manual to their own situation. Implementation of procedures is sometimes hampered by the reluctance of some employees to accept change or they regard control measures as a sign of distrust. In one case, for example, a programme to better streamline drugs and medical supplies stores could not be implemented because the medical doctor and the pharmacy technician viewed it as an needless extra job, while the latter was already very busy. Such resistance may be an indication of communication problems between medical and administrative staff, within the management team and/or between the management and the other staff in the hospitals.

#### **4.5.3 Training workshops for hospital administrators and accountants on procedures**

To assist hospital managers and accountants in using the manual practical training workshops were organised. Managers were given exercises and role plays, showing how they currently manage and apply procedures. This was followed by plenary discussion to analyse what was done correctly and what was not. The workshop ended with a presentation of the correct procedure. In total seven five-day workshops were organised and 12-24 people participated per training.

For each hospital, two supervision visits per year were undertaken by the CHAM programme officer. These visits included direct observation and on-the job-support, and space to discuss problems and challenges. During the monitoring visits, the CHAM programme officer goes through the assessment matrix with the accountant or administrator. This (self-) assessment tool is used to track progress made and allows CHAM to compare hospitals in an objective way. The self-assessment addresses accounting policy, cash control, stores management, transport procedures, fixed assets, salary administration, financial statements and budgeting. The scoring is done on a five-point scale by the CHAM programme officer together with the hospital administrator and/or accountant. The assessment is based on evidence, so proof of the activities under assessment has to be shown. The scoring forms provide space for additional explanations. At the end, a total score is calculated and a performance level is established. The management team is informed about progress, success achieved and weak points. The results of the self-assessment tool are used by hospital management to determine which areas need to be improved.

#### **4.5.4 Support on call**

Hospital administrators and accountants are supported by CHAM by telephone or email for specific technical assistance or in emergency situations. Support on call is easy and quick although only simple questions can be answered. To date, eleven calls have been received. Most questions were on issues around the implementation of the payroll. Other areas were the preparation of financial management accounts and maintenance of a fixed assets register.

#### **4.5.5 Monitoring and evaluation**

The M&E system consists of biannual monitoring visits, quarterly peer review meetings and the self assessment tool. Moreover, a mid-term review was carried out in the third and final year of the programme. In future, there is a need to involve peers in the monitoring to promote learning across facilities. For example, a monitoring visit to one hospital should involve staff from another hospital.

The findings of the mid-term review show that over the last three years remarkable results were achieved, although these have not always been quantified. The participatory (self-) assessments are done regularly and the tools used are understood well by the hospital management teams. The accountants and the hospital administrators evaluated the programme as practical, and well-suited to their work. The combination of training with external technical assistance for the day-to-day running of the hospital was much appreciated.

The mid-term review report lists progress with internal control systems and procedures such following the development of a financial and material resource manual. Tools such as the computerised salary and stores packages are also used by those hospitals having computers. The programme had a positive effect on the skills of accountants, although no details were provided in the evaluation report. The quality of the financial reporting has been improved.

However, the impact of the programme on retention of administrators and accountants has been limited. In 2008, 16 out of the 36 people who participated in the programme have left CHAM facilities. There were no exit interviews to determine the reasons for their departure.

#### 4.6 Discussion

The interventions were focused on hospital administrators and accountants only and could not be extended to directly involve all management team members – others could only be briefed about general issues. Without the understanding and support of the full management team, the changes achieved so far only have a limited impact. For example, more detailed financial reports are now produced more frequently. But as the skills to use the reports for decision-making are still limited, the full benefits to the institution have yet to be felt.



The management improvement programme uses an integrated approach to enhance the capacities of hospital managers and accountants. The programme is a combination of training, peer review, and the provision of management tools and procedures to ensure continuity of good management practices even when the trained managers leave their post. However, differences in performance occur between the hospitals, mostly reflecting the qualification of the managers, and the degree of support and supervision by their board of governors. The transparency in management is another factor that is influencing the successful use of tools and procedures. The peer review meetings might stimulate hospitals to improve performance, as the discussions will show that most problems are not unique to a specific hospital, and solutions can be found sharing experiences.

Also, the management improvement programme does not come cheap and its costs were carried by donors. Financial resources for implementation such as the introduction of cost centres in hospitals and computerisation of the financial systems and the stores were made available to the six pilot hospitals only. CHAM does not have enough resources to assist also the other 13 hospitals with these investments, which makes it difficult for them to fully implement the interventions. Sustainability of the training and peer review programme are other concerns. CHAM has therefore developed a proposal for other donors.

There is a great need for a formal training in hospital management in Malawi. But until this happens, specially organised, additional training and support is required. The MoH hospitals have their own financial management improvement plan (FMIP), which is implemented by the MOH Central Office. It has almost the same objectives as the CHAM programme, but is focused mostly on training, while the CHAM approach also includes review meetings, visits, email support and the development of tools (manual, computer programmes and progress assessments). CHAM has kept the MoH informed regularly through reports presented to the meetings of the Finance and Procurement Technical Working that take place on a quarterly basis. Although at the start of the programme in 2004 the MoH had offered to fund part of the costs as part of its agreement with CHAM, but later this was no longer possible, this has not happened. In 2008, the MoH informed CHAM that the FMIP budget is part of the financial management improvement plan of the Ministry and included in the 2008/2009 budget. Should the budget be approved by parliament then at least the supervision visits and peer review meetings will continue.

Currently performance-based financing of hospitals is introduced on the basis of the assessment forms developed by the FMIP and CHAM based on agreed hospital performance indicators. Hospitals' performance is assessed in the first quarter of the year and a similar assessment will be undertaken in the last quarter of the year. Only hospitals whose performance in identified functional areas is 75% or higher will receive a reimbursement for their annual transport and other incidental costs incurred while working on the FMIP. The link between performance and receiving funds is relatively new, and should reinforce the use of manuals and procedures.

## 4.7 Conclusions

Overall, the management improvement programme has been very successful. Manuals that explain principles and set procedures are available, various tools have been introduced, individual skills have been upgraded, proper systems have been set up in the hospitals and regular exchanges to promote linking and learning are in place. These changes have improved performance of several individuals, and the systems in place. Management of finances and resources has improved. Disruptions in supply of medicines or payments have become rare and staff feels more assured that managers will take action where required. In addition, administrators and accountants now communicate better within the hospitals and across hospitals. As such the programme has contributed to changes that will be sustained and developed further in the years ahead.

Key to the success of the programme was the integrated character of the activities. Clarity on structures, roles and systems, together with skilled and motivated staff are the ingredients for effective management of health systems. The challenge now is to maintain these improvements, and take them even further. More capacity building is necessary in the area of human resources and financial management. Moreover, hospital managers need training specific to the needs of running a hospital; there is a great need for a formal training in hospital management in Malawi. More attention is also needed for the management of other health facilities.

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# 5

## Task shifting to improve pharmaceutical services in Uganda

Pharmaceutical staff are in short supply in Uganda and qualified staff are not interested in remaining very long in rural areas. This was affecting service delivery in the catholic hospitals, such as regular exhausting of supplies and poor drugs dispensing. To address this shortage, the Ugandan Catholic Health Network decided to create new complementary cadres of staff, by training staff already employed in the hospitals to support pharmaceutical service delivery, but who were not formally trained. The case study discusses this experience with task shifting undertaken to improve the availability of pharmaceutical staff in Uganda and the East Africa region at large.

## 5.1 The health system in Uganda

Uganda's health system is a four-tier system, with responsibilities for policy making, coordination, support and service delivery defined at the central, regional, district and sub-district levels.

The responsibility for health services delivery is spearheaded by the Ministry of Health, with substantial contributions from the private-not-for-profit health providers (PNFP), private-for-profit health providers, and traditional healers. The facilities of the PNFP health sub-sector are located mostly in rural areas and it is estimated that these provide about one third of all health services provided to the people of Uganda (see table 1).

**TABLE 1 DISTRIBUTION OF HEALTH FACILITIES AND HEALTH TRAINING INSTITUTIONS BETWEEN GOVERNMENT AND PRIVATE SECTOR.**

LEVEL	Government	PNFP	PFP	Total
Hospital	56	44	4	104
HC 4	143	8	3	154
HC 3	650	147	12	809
HC 2	845	362	262	1469
Total	1694	561	281	2536
Health Training School	8	19		27

Source: MoH, 2007a

Around 75% of the PNFP facilities belong to faith-based organisations of various religious denominations and are coordinated by three medical bureaus: Uganda Catholic Medical Bureau, Uganda Protestant Medical Bureau and Uganda Muslim Medical Bureau.<sup>10</sup>

<sup>10</sup> This document provides information using data drawn mainly from UCMB, which forms three quarters of the PNFP facilities, extrapolating for the others.

## 5.2 Human resources for health

The census of 2002 indicated that there were 59,680 people working in the health sector, of which about 36,000 are estimated to work in the government and the PNFP sub-sector. The PNFP sub-sector employs about one-third of this workforce, about 12,000 health workers. The total number of health professionals is insufficient to assure access to quality health services in Uganda. Population-to-health worker ratios for medical doctors are 8373 and for nurses and midwives 1212 (MoH, 2007b). Uganda is one of the 57 countries that has been identified as having a critical shortage of health care workers (WHO, 2006).

The workforce situation is aggravated by the poor distribution of already scarce health workers. Although each of the four regions in Uganda harbours roughly a quarter of the population, the great majority of the health workforce is concentrated in the Central Region. Some 70% of medical doctors and dentists, 80% of pharmacists and 40% of nurses and midwives are based in urban areas, serving only 12% of the population (MoH, 2007b).

Distribution is particularly skewed for cadres with academic degrees, mainly due to low salaries and a lack of attractive incentive packages to attract and retain health workers in rural areas. The staff distribution is less skewed for mid-level cadres, such as clinical officers, who are better distributed over the different regions in the country. One way of dealing with this uneven distribution could be to train clinical officers to implement certain tasks currently done by medical doctors.

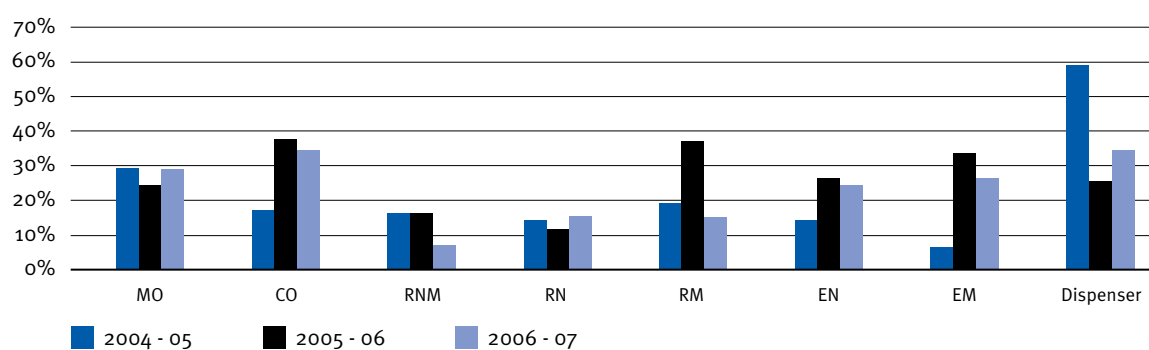
Another issue faced by the Ugandan health sector is low pay levels and a great disparity in staff salaries between government and the private-not-for-profit facilities. In Uganda, the FBO health facilities do not receive government funding to pay salaries. UCMB facilities, for example, get their funds mainly from collecting user fees. These are deliberately kept as low as possible so that the costs of using health services remains affordable for patients. Consequently, church facilities can neither afford nor retain qualified personnel due to their low financial capacity and also because most are located in rural areas. Many health professionals prefer the living conditions of urban environments. For example, an enrolled nurse earns about USD 180 in a government facility, but will earn about 40% less in a FBO health facility.

FBO facilities experience a rise in staff turnover. Some FBO staff prefer to leave for government services where they are better paid and have less heavy workloads as well. NGOs working in the field of HIV/AIDS, TB and Malaria programmes, which are financed by Global Initiatives, can pay even better salaries than government, let alone the FBO sector. FBO staff are moving from (rural) FBO facilities to (urban-based) government facilities, to international NGOs and Global Initiatives projects, or they migrate to the UK, Australia and other countries.

### 5.3 The situation of the UCMB health network

The Uganda Catholic Medical Bureau (UCMB) represents the health services of Roman Catholic Church (RCC) in Uganda, which is comprised of 19 dioceses. There are in total 27 hospitals, 11 health training institutions and 236 lower-level health facilities. In all, 7,525 health workers are employed, of whom 4,782 work in hospitals (data of 30th June 2007). UCMB provides about 40% of the FBO health infrastructure, 17% of outpatient department services (OPD) services and 35% of deliveries (UCMB et al., 2007). While there has been no net reduction in the UCMB workforce, the number of health cadres leaving has increased markedly since 2004, especially for the nursing cadres. Figure 1 indicates the levels of staff attrition from the UCMB hospitals for some of the selected cadres for the period 2004–07. In 2006-07 the attrition of enrolled nurses, midwives and clinical officers stood at 24%, 26% and 26% respectively in the UCMB affiliated hospitals alone<sup>11</sup>

FIGURE 1 LEVELS OF STAFF ATTRITION 2004-2007<sup>12</sup>



MO = medical officer, CO = clinical officer, RNM = registered nurse midwife (double registered nurse), RM = registered midwife, EN = enrolled nurse, EM = enrolled midwife.

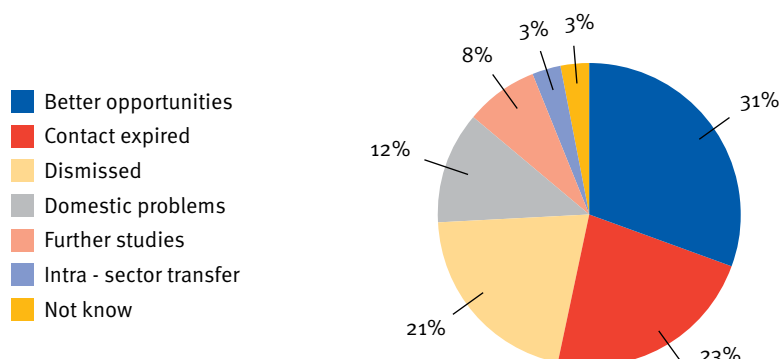
A study<sup>13</sup> showed that 30% of the professional staff leaving had worked for more than three years for UCMB. They take with them the acquired experience and knowledge and part of the institutional memory. The main reason given by health professionals for leaving UCM facilities is the search for better opportunities in terms of remuneration, career development and living conditions (31%). Another 23% left because their contract expired naturally and was not renewed. Some staff will not have opted for better paying jobs elsewhere. Finally, 21% were dismissed due to various disciplinary issues or misconduct (see figure 2, on the next page).

<sup>11</sup> Facts and Figures about the PNFP sub-sector, August 2007.

<sup>12</sup> From the Human Resource Data analysis of the UCMB as of 30<sup>th</sup> June 2007.

<sup>13</sup> Data was collected from 27 hospitals and a total of 429 staff were interviewed.

FIGURE 2 STAFF ATTRITION: REASONS GIVEN



Most of the time, FBO health facilities can only replace experienced leavers by recently qualified staff without any working experience. Staff departure has a negative impact on service delivery. Firstly, when a staff member leaves, he or she is likely to create more workload for those who remain behind until a new person is recruited. Secondly, the quality of services is likely to deteriorate because the new, inexperienced staff need time to learn to do the work properly and establish confidence in patients.

#### 5.4 Formalising task shifting of pharmaceutical services

Amongst the health cadres in short supply in the UCMB network were pharmaceutical staff. Qualified dispensers are in overall short supply in Uganda<sup>14</sup> and are mainly found in urban areas. Only three out of 27 UCMB hospitals could afford a qualified dispenser. The other 24 hospitals lacked the financial capacity to employ this cadre and were providing pharmaceutical services either through nurses or secondary school drop-outs, who did not have any pharmaceutical training. Pharmaceutical services in most UCMB facilities were thus left to untrained personnel and left a lot to be desired. There was frequent exhaustion of supplies, inefficient management of the essential drugs scheme, problems with procurement, poor drug dispensing and poor records management.

In the early 1990s the health sector in Uganda introduced an essential drugs scheme country-wide to which all health facilities had to comply, including the FBOs. However, it was difficult to comply with the scheme without appropriately trained staff. The pressing need for trained pharmaceutical staff for FBOs became clear in 1993 at a conference titled “Sustainable Essential Drugs Schemes in the church-related health care system”.<sup>15</sup> The conference was held in Uganda and brought together managers of church health care programmes, or joint procurement units from 8 countries in eastern and southern Africa, and observers from international organisations (WHO, UNICEF, International Federation of Red Cross and Red Crescent Societies).

<sup>14</sup> A person can only enrol a course rewarded with the diploma of qualified dispenser when having obtained two principal passes in science subjects at A-level.

<sup>15</sup> Held in Mukono and sponsored by the pharmaceutical advisory group of World Council of Churches.

At the conference, it was decided to carry out a survey in 11 countries to examine the pharmaceutical services available in the church systems. A technical advisory group (TAG) was also put in place, comprised of executive directors and secretaries of the five church secretariats in East Africa,<sup>16</sup> the director of the Pharmaceutical Programme at the University of Western Cape plus the course co-ordinator. They were mandated to come up with a proposition.

The TAG concluded that there was an emergency situation. The fastest way forward was to better equip the untrained personnel already dispensing drugs, mostly nurses and midwives, with the necessary basic skills around pharmacy. To address the lack of qualified dispensers among FBO facilities a decision was reached for a regional training programme for pharmaceutical assistants (PAT) leading to the award of a certificate in pharmacy.

In fact, the TAG was formalising the task shifting that had occurred already by introducing a new cadre, the pharmaceutical assistant, who could implement and maintain essential drug schemes and promote rational drug use in the church-affiliated health facilities. The pharmaceutical assistant<sup>17</sup> would be trained with a lower entry criteria (a medical background in any field) and selected from among the people who were already serving in the hospitals.<sup>18</sup> According to the TAG, people with a certificate would be easier to retain, thus ensuring that pharmaceutical services would be offered in the facilities at a lower cost.

The TAG proposal dealt only with training. No attention was paid to other aspects such as salary, career structure and entry levels, as the staff concerned were already employed. On completion of studies, the newly trained pharmaceutical assistants were offered a salary increment to match the increased responsibilities. Their job description was based on the training curriculum, but did not mention explicitly which tasks were shifted from the dispensers to the pharmaceutical assistants.

## 5.5 Setting up a pharmaceutical assistant training programme

The two-year pharmaceutical assistant training (PAT) was established in 1995 as a joint training venture of the church health programmes in East Africa. It was planned to meet the immediate training needs of Kenya, Tanzania and Uganda. Kenya was selected as the host nation. These countries would pilot the training, after which the other countries could then adopt the format and adapt it to their own circumstances. Following the proposition of the TAG, the UCMB developed a training regime for existing cadres to increase the availability of pharmaceutical personnel and their competence. The assumption was that in this way the quality of pharmaceutical services could be better guaranteed and that FBO facilities would meet the requirements set by the MoH for general hospitals in terms of numbers and skills. The TAG laid down the following procedures and protocols relating to the training:

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<sup>16</sup> *Uganda Catholic Medical Bureau, Uganda Protestant Medical Bureau, Christian Social Services Commission (CSSC) Tanzania, Christian Health Association of Kenya (CHAK) and Kenya Catholic Secretariat (KCS).*

<sup>17</sup> *The difference between a dispenser and a pharmaceutical assistant is that while both are trained in compounding, the regulations do not allow a pharmaceutical assistant to compound while the dispenser is authorised to do so. The pharmaceutical assistant is a junior to the dispenser just as the nursing assistant is to the nurse.*

<sup>18</sup> *The TAG decided that a minimum level of nurses and midwives should enrol in the training, as they formed the majority of the personnel serving in the pharmacies.*

- Examination and approval of the prepared curriculum and the format of the training;
- Selection and recruitment criteria and guidelines;
- Financial participation of the church facilities;
- Short- and medium-term strategies for the training;
- Recommendations for staff retention.

The pharmaceutical assistant training was designed to last two years, with one intake per year. Entrants were to have attained a minimum of O-level education with an overall grade of third division or equivalent, with passes in English, mathematics, and one science subject. The curriculum was developed based on the knowledge, attitudes and skills outlined by the TAG under guidance from the Mission for Essential Drugs and Supplies, Joint Medical Store and the Ecumenical Pharmaceutical Network and in consultation with other training institutions including the universities in the three countries. The curriculum was also reviewed thoroughly by the West African Pharmaceutical Federation.

The main topics covered during the course were:

- STAGE 1: Introduction to pharmacy; the human body in health and disease; chemistry; microbiology; communication and social skills; computer application skills;
- STAGE 2: basic pharmacology; fundamentals of pharmaceuticals; drug supply and management.

The candidates were nominated by the facilities. These names were then forwarded to their respective church secretariats, which would select, interview and send the short-listed names to the training secretariat. During the training, trainees would have to follow two practical sessions, in which they would be attached to a hospital and work under the direct supervision of a qualified pharmacist or pharmaceutical technician. The trainees would also undertake practical work in their own hospital to gain a better understanding of the system, and they would receive technical support during supervisory visits by qualified pharmacists.

The costs of the training programme were USD 6,000 per student, but it was offered at a subsidised cost of USD 500 per student, to be paid by the beneficiary health facility. The rest of the costs were covered by donors, who have funded the training from 1995 until 2003. This sponsorship was given to the health facilities and not to the candidates. Each facility would be given only one scholarship.

As this training is to be paid by the hospitals, the enrolled cadres will have to serve for an agreed period of bond after completion. Upon finalisation of the course, bonding contracts between the hospital and the trained staff were signed, to ensure that the investment made in them would benefit the hospitals. This contract varied from one hospital to another as the conditions were determined by the church facilities.

## 5.6 The accreditation and recognition of pharmaceutical assistants

The issue of certificates, the awarding body and official recognition was discussed in a number of meetings. Although in the beginning the urgency was in getting trained persons managing the drug stores, the need for accreditation and recognition for career

advancement were noted. Bodies such as Commonwealth Health Secretariat, University of Nairobi, and University of Western Cape were consulted. The quality of the course was then assessed after which the University of Western Cape agreed to give it accreditation. However, in spite of several presentations of the syllabus and curriculum to the relevant bodies in Kenya, Uganda and Tanzania, there has not been a formal recognition of the course in these countries.

## 5.7 Evaluation of the programme

In 2002 the PAT programme was evaluated to assess its performance and decide on the way forward.

### 5.7.1 Results

The evaluation produced the following results:

- a. From 1995 up to 2003, 133 pharmacy assistants were trained (Kenya – 45, Uganda – 51 and Tanzania – 37) of whom 56% were women. The trainees came from 114 hospitals. All trainees from the Catholic Health facilities returned to their health facilities.
- b. All hospitals and secretariats participating in the evaluation felt that the course did address the shortage of skilled pharmaceutical staff, and 92% of the respondents believed that the subjects taught were appropriate and adequate.
- c. All the beneficiary hospitals felt that the trainees from PAT were doing a good job as a result of the training. All were satisfied with the quality of work being performed by the graduates.





- d. All hospitals reported improvements with drugs management and procurement, and they now rarely ran out of stock. Over 70% of the hospitals indicated that the PAT graduates had helped their hospitals in managing stock efficiently, avoiding un-required purchases, and producing cash savings (through better stock management).
- e. Pharmaceutical assistants returned to their workplace after training. They were willing to serve a period of bonding in return for the training they received and actually served beyond the bonded period.
- f. The training programme enabled the hospitals to acquire sufficient pharmaceutical personnel. In Uganda, to date, all 27 hospitals of the Catholic Church have at least one trained person in the area of pharmacy: either as pharmacist, dispenser or pharmaceutical assistant. In fact, in Uganda the failure to get formal recognition from the government bodies contributed to the retention of the PA graduates in FBO health facilities because there was no demand for them in the public service. As these cadres were not trained according to international standards, they could not find comparable employment in non-UCMB facilities.
- g. Almost 95% of the respondents felt that the programme should be upgraded to ensure that it provides training to the level of a diploma.

The evaluation of the programme also brought to the fore a number of challenges facing the continuity and sustainability of the PAT training.

### **5.7.2 Financial sustainability of the training course**

Over 90% of the programme income was received from grants from two donors.

The perception of many of the PAT programme clients was that very few would be in position to pay the full fees if donor support was withdrawn. There was also a need to reduce related costs, especially student accommodation, to make it more affordable for the church facilities.

The organisers had improved the financial basis of the course by allowing participation of trainees from other types of health facilities (paying full costs) and widening the range of courses on offer. Other funding options and possibilities for diversification had to be pursued such as higher tuition fees, and more consultancy fees as well as increasing the number of donors.

In order to ensure the sustainability of future initiatives, funding should be raised locally as much as possible, so that a training programme is not completely dependent on donors, who may withdraw funds any time. Programmes should consider also expanding admission to students from other networks so as to raise enough funds to subsidise students from founding institutions.

### 5.7.3 Getting the training recognised

The lack of recognition for the PAT programme by the relevant authorities in all three countries was a preoccupation of the trainees. Directing pharmaceutical assistants towards the career path of pharmaceutical personnel was often hampered by the entry conditions (two principal passes in science subjects at A-level). These problems had begun as soon as the trainees had completed training and had returned to their stations of service. The UCMB sought to get their training recognised and given the corresponding status by the professional regulatory authorities. Moreover, there was need for the further professional development of trainees. Despite all these attempts, the PA graduates have never been given appropriate recognition.

When the TAG had decided in 1994 that a new cadre was required, this proposition was shared with the Ministry of Health and the Pharmacy Council. The representative of the Pharmacy Council was willing to accept the development and mentioned that it would take Uganda 50 years to produce the required numbers of pharmaceutical personnel, given the low levels of output at the time. The Ministry remained indifferent and also made no effort towards facilitating its recognition by other stakeholders. The National Drug Authority did not see the need for this cadre and was not ready for task shifting.

At the time of the evaluation of the PAT programme in 2002, there were on-going health sector reforms towards improving health standards in Uganda. Persistent and widespread calls were made to upgrade certificate-level training in the pharmaceutical area to diploma level. But this would undermine the possibilities for recognition of the certificate level in pharmacy training. Non-recognition would mean that the graduates could only practice under close supervision by other cadres. Since 2003 the UCMB has lobbied again the Ministry of Health and the Ministry of Education and Sports to ensure recognition for the PA graduates and to find an appropriate entry level for their further training in Uganda. The UCMB gave them a copy of the curriculum which was used to train the PA graduates so that the two ministries could work on modalities for placing the pharmaceutical assistant appropriately in the professional hierarchy. However, the ministries responded that since the PA graduates entered into the pharmaceutical training with lower academic grades than are usually accepted according to the standards in Uganda, they could not be placed at any level of pharmaceutical training.

The UCMB also approached the National Drug Authority, which continued to decline to accept the cadre because they did not see the need for task shifting. UCMB then contacted the school of pharmacy and presented them with the curriculum of the pharmaceutical assistants so that they could be placed in their appropriate level. This would allow them to pursue upgrading courses. The school of pharmacy declined to place them and decided that this cadre would have to begin afresh. Their main argument was that these people entered with a lower grade (O-level and enrolled nursing) compared with what was required for dispensers.

However, in June 2008, during an informal conversation with the director of the paramedical schools (of which the school of pharmacy is part), UCMB again floated the idea of revisiting the position of the pharmaceutical assistants. This time, the director seemed willing to consider the possibility of reviewing their curriculum to give them an appropriate entry into the profession. This change in position could be attributed to the growing acceptance of the need for task shifting. This issue was given also much prominence in the Global Health Work Force Alliance Forum which took place in Kampala in March 2008. We are yet to explore this new opportunity so that our pharmaceutical assistants can upgrade their training to dispenser level and above.

## 5.8 Conclusions and recommendations

The pharmaceutical assistant training programme has produced 51 pharmaceutical personnel for Uganda of whom 37 work in UCMB facilities. This increased the availability of adequately trained dispensing personnel in UCMB-affiliated hospitals, all of which now have at least one qualified person in the area of pharmacy. However, there has been no monitoring of the proportion of trained pharmaceutical staff still serving in the UCMB hospitals after completing their bonding contracts, their current employment and career development.

### *Stakeholder involvement*

The initial consultations on task shifting by the TAG did not include all the stakeholders concerned. Future initiatives around task shifting should involve particularly the professional regulatory bodies and the MoH right from the conception of the initiative, and keep them involved at all stages. There is need for wide consultancy and advocacy to avoid task shifting to lower cadres being perceived as employers creating a source of cheap labour to be exploited, while undermining existing professions. Professional regulators should be part of the supervision process during and after training for quality assurance and to ensure their co-operation and support. The Ministry of Health should be an integral part of the supervision as well.

The negotiations and programme design should also address issues related to the job description and scope of the trainees, remuneration, integration into the health system and career development. The view of the managers of the health facilities where the trainees will be employed also needs to be taken into account.



Finally, it is difficult for small voices to start innovations in health training and around task shifting. Despite all the attempts of the UCMB, the Pharmaceutical Assistant graduates are still not given appropriate recognition. When developing this type of innovative but sensitive programme, it may be useful to work more in alliance with international bodies such as UN agencies, which will also build more credibility. For example, now that the WHO has embraced task shifting, it has become more acceptable – even by those who opposed similar innovations before.

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# 6

## Providing evidence on human resources for advocacy in Tanzania

In Tanzania, faith-based organisations are important providers of health services, particularly in rural areas. When the government of Tanzania improved working conditions in public facilities in 2005, such as an accelerated salary package and other allowances, the result was a significant loss of personnel by the FBOs, as they lacked the financial resources to take a similar action. This may affect service delivery, which would leave some areas entirely without health care services. Clearly, there is a need for government to coordinate policies better with FBOs, and even to consider structural financial support to this sector. The first step is for FBOs to demonstrate their unique contribution to health service provision in Tanzania. Most FBOs are represented by the Christian Social Services Commission (CSSC). The CSSC decided in 2006 to set up a human resources information system. Having this data will make it easier to discuss HR constraints and the need for support with national and local government. This chapter sets out how the human resource information system came into place, how it functions, and how the CSSC has used the findings, and lessons learned.

## 6.1 Health service delivery in Tanzania

The population of the United Republic of Tanzania is estimated at 34.5 million people (2002 census) with most people living in rural areas (77% of the total population). The percentage of people living within 5 km of a health facility is 72%.<sup>19</sup> It is the policy of the Ministry of Health and Social Welfare (MoHSW) to improve the health and well being of all Tanzanians, with a focus on those most at risk, and to encourage the health systems to be more responsive to the needs of the people. A goal is that everyone should have access to health facilities within 5km of where they live, and that every village has a dispensary.

## 6.2 The Christian Social Services Commission

The Christian Social Services Commission (CSSC) is an ecumenical body representing the interests of about 15 member churches and ten church-related organisations. It was established in 1992 by the Tanzania Episcopal Conference (TEC) and the Christian Council of Tanzania (CCT). CSSC aims for increased availability and accessibility of social service delivery that is of quality, transparent and respects equity. CSSC is involved in research, policy advocacy, technical support, consultancy and development activities. The goal of the advocacy work is to make sure that the perspective of FBOs and other civil society organisations are taken into account by policy makers. At the national level, CSSC participates in sector-wide approaches (SWAp) related meetings and several taskforces.

CSSC has staff in each of the five zones of Tanzania. They are responsible for supervision of activities and coordination with bishops and diocesan church leaders. A “Zonal Policy Forum” is also in place, which serves as an ecumenical “conference” (think tank) of church leaders, who analyse and discuss policies around social services by FBOs, government or other bodies. Representatives of the dioceses attend the District Comprehensive Council planning meetings organised by local governments. In these district-level meetings, policies and plans are discussed with community representations.

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<sup>19</sup> (Annual Health Statistical Abstract-MoHSW; April, 2006).

CSSC's functions in relation to social services in health and education are to:

- Participate effectively in the formulation of policies and/or present comprehensive policy proposals to the government;
- Harmonise and reconcile churches' policy relevant to provision and support of social services;
- Facilitate strategies to improve planning, financing, coordinating, organising, expanding and/or maintaining quality social services;
- Facilitate monitoring of social sector programs designed by the churches;
- Administer, manage and monitor the use of finance, borrowed, granted, generated or allocated through the CSSC for the purposes of strengthening provision, improvement, expansion and maintenance of social services facilities in Tanzania;
- Strengthen technical services in education and health sectors through research and consultancy services;
- Provide essential support in service provision to church institutions.

Health services are provided by the government, parastatal organisations, private-not-for-profit providers (mainly religious and voluntary agencies), private-for-profit practitioners and traditional healers. The referral systems start with community health centres, followed by dispensaries and health centres. There are hospitals at the district level, which are served by regional hospitals which in turn can refer to specialised consultant hospitals. The MoHSW planning system is bottom-up, starting at the district level, where consultation takes place between public and private stakeholders. At present there are 220 hospitals of which 87 (40%) are managed by FBOs, including 23 district designated hospitals (DDHs) because there is no alternative in the district. A DDH will receive a full grant from government when the work plan is approved.



The CSSC facilitates the provision of social services by church institutions in over 87 dioceses and provinces and covers 40% of all health and 24% of all education services in Tanzania. In rural areas, the share of CSSC in health service delivery increases to 53%. CSSC health related facilities include dispensaries, health centres, district designated hospitals, referral hospitals and training institutions. In total, Tanzania has registered 33,805 hospital beds of which 55% are found in government facilities and 39% are managed by CSSC facilities. The rest are found in private and parastatal facilities (MoHSW, 2006).

TABLE 1 NUMBER OF HEALTH FACILITIES BY TYPE AND PROVIDER (2006)

Areas of Involvement	Facility	Public Sector	Private Sector	
			Private for Profit	FBOs
Service Delivery	Hospitals	96	37	87
	Health Centers	341	439	101
	Dispensaries	3183	733	763
Training	Universities	1	3	3
	Allied Health Colleges	45	7	7
	Nursing Colleges	27	2	28
	Institute of social work	1	1	
	Day Care training Institute	1		12
Research	Institutions	1	1	1
Social Welfare	Remand Homes	5	-	-
	Approved School	1	-	-
	Children's Homes	1	-	69
	Homes for Elderly	17	-	26
	Day Care Centers	270	812	541
	Drug/alcohol abuse counselling centre	2		1
	Marriage Reconciliation Boards	258	-	-
	Centers for Street Children	-	-	46
	Vocational Training Centres for PWDs	7		4

Source: MoHSW, 2008)

Tanzania uses a mix of financing sources to support the health system and about 70% is from public financing, of which the main source is taxation. Contributions from government revenue are allocated only to public hospitals. Health basket funding is made available to both public and private-not-for profit actors. External funding for government facilities is complemented by user fees, so costs are shared with patients. The MoHSW has introduced a National Health Insurance Scheme (NHIS) and a Community Health Fund that allows households to prepay their health care costs.



Resources made available to hospitals are allocated according to bed capacity, which is monitored by the district medical officer (DMO). If more beds are required at a FBO facility, CSSC needs information on bed ratios and service provision in the area to prepare its case.<sup>20</sup> A concern for CSSC is that the amount paid per bed is no longer covering all costs and therefore CSSC has started discussions with MoHSW about setting new fees.

Since 2007, the MoHSW works with service level agreements through which CSSC facilities can access public resources, in a type of performance-based financing. The contracts between the health provider and the government indicate the outputs to be achieved (e.g. number of pregnant mothers or children under five being served years; essential drugs provision; number of trainees). CSSC is encouraging all its members to sign service level agreements.

The devolution policy being pursued in Tanzania means that more public resources are delegated to the local government level (districts), within the context of fiscal decentralisation. The MoHSW developed a pre-fixed formula for government grants and basket funds to allocate resources to local government. Criteria used for allocating these block grants are the total population in the region or district (70%), under-five mortality (10%), morbidity (10%), and access to health facilities (10%) (TNBS, 2007). The allocation of block grants between facilities is decided at the district level in consultation with other stakeholders, but minimum and maximum amounts are set, to ensure that between 50 and 70% of the funding goes to the DMO office and the hospitals, while the rest is divided between health centres and dispensaries. FBO facilities can also benefit from block grants (MoHSW, 2003). However, many local governments are not aware of the funding constraints. Some think that FBOs have enough resources at their disposal. CSSC facilities need to talk more to local government and build partnerships.

### 6.3 The human resources situation in FBOs

The availability of sufficient and qualified health workers is essential to providing quality and accessible health care. However, the overall supply of health workers in Tanzania is decreasing from 67,600 health workers in 1994-95, to 49,800 in 2001/2, and 35,202 in 2006, of which 17% work in FBO and other private facilities. The shortage of health workers in 2006 is estimated at 90,722 workers, of which 41% are lacking in FBO and other private facilities (MoHSW, 2008).<sup>21</sup> In order to achieve the MDGs in 2015, Tanzania would require 120,000 full-time health workers. The gap may be even larger, as the standards being used by government seem inappropriate with respect to actual workload. For example, the current standard for minimum requirements of number of doctors per hospital is set at three, while actually five doctors are needed to maintain quality of care.

<sup>20</sup> The District level of the MoHSW may give permission to add more beds; but approval for payment for extra beds is granted at the central level only. A problem faced by CSSC is that such approval meetings are often delayed.

<sup>21</sup> These calculations do not include community health centres which would almost double the shortfall according to the Primary Health Services Development Programme (PHSDP).

TABLE 2 HUMAN RESOURCE STATUS BY FACILITY LEVELS IN PRIVATE HEALTH FACILITIES (INCLUDING FBOs)

Facility Level	Health Professionals – required for existing facilities	Health Professionals – available 2006	Health Professionals – shortage 2006	Shortage %
Hospitals	26,004	3251	22,753	87.5%
Health Centres	5,400	758	4,642	86.0%
Dispensaries	11,487	1,842	9,645	84.0%
Training Institutions	756	288	468	61.9%
<b>Total</b>	<b>43,647</b>	<b>6,139</b>	<b>37,508</b>	<b>85.9%</b>

There is thus a growing shortage of health workers, while those who are available are not equitably deployed, properly trained, nor adequately supported. One way for dealing with shortages is to increase the number of professional training institutes and to expand the capacity of existing training institutes in both the private and FBO sectors. Therefore, new universities have been started by churches, and the government is planning to develop zonal training institutions. Still, training of new staff is hampered by the low attractiveness of health work; not enough people want to join this profession.

An additional challenge is the HIV/AIDS crisis. It increases demand for health services but simultaneously also affects the health work force through attrition and lower productivity.<sup>22</sup> Moreover, the well-funded, vertical programmes for HIV/AIDS and TB may create more shortages in general health facilities, particularly for nurses.

The HR shortages are higher in the private-not-for-profit sector, which is partly explained by the salary gap between health workers in the CSSC and the public sector. Since 2006, the average salary of nurses working for CSSC is Tshs. 172,000 or USD 122<sup>23</sup> per month, while the public sector pays an average salary of Tshs. 402,000 (USD 287). Moreover, public sector workers have also a higher housing allowance and higher pension. Indeed, interviews with 48 employees who had left a CSSC hospital to work in public sector health facilities showed that the main reason for leaving was the salary gap.

This departure of health workers from the FBO system will affect access to health care services, particularly in remote rural areas where FBO facilities are the only service provider.

CSSC also wants to look beyond the salary gap at how to motivate staff to remain in the FBO system. In 2006, the CSSC commissioned a team of international and national consultants to

22 *The health workforce operates in unsafe environment with occupational hazards, accidents and other diseases posing a constant threat. At present, the HIV/AIDS pandemic is causing the most danger (Fimbo et al., 2006). A survey carried out in two hospitals in 2004 found HIV prevalence of 13% among health workers (Strategic Plan for the control of HIV & AIDS for Health Workers at the workplace; 2006-2007). The MoHSW developed an HIV/AIDS Workplace Policy to support workers affected or infected by HIV/AIDS. There is however a need to strengthen implementation of universal safety precautions and post-exposure prophylaxis.*

23 *Exchange rates in January 2009.*

design an incentive package for health workers that is relevant to FBO facilities. A mix of financial and non-financial incentives was perceived to be the most effective strategy for improved retention of health workers (Schwerzel, 2006). Accordingly, the following recommendations were made for the proposed incentive package:

- A Rural Area Allowance (RAA): For health workers and staff members who work in FBO hospitals and have been selected based on the remoteness classification criteria;
- A Health Worker Recruitment Fund (HWRF): for a selected number of key health workers to assist FBO hospitals that meet the remoteness classification criteria;
- Continued professional development opportunities can become available to all FBO hospitals;
- Improved social security arrangements;
- A Utility Support Fund (USF) for FBO hospitals that meet the remoteness classification criteria;
- A rural health workers savings and credit scheme.

No data is available as yet on the extent to which the recommendations have been implemented and the subsequent effectiveness (Munga and Mbilinji, 2008).

CSC wants to invest in upgrading skills and knowledge of health workers. There is an annual skill training organised by IMA World Health and the Government of Tanzania, for clinical staff and nurses covering 14 facilities.<sup>24</sup> There are also sponsorships (supported by Cordaid and also the government), but the number is too limited to meet demand<sup>25</sup>.

CSSC is also looking into the use of Information and Communication Technology (ICT) applications to reduce the workload, and improve health delivery services in remote areas, such as promoting telemedicine to assist doctors or using e-learning and CD-roms to improve management capacity.<sup>26</sup> AfyaPro software<sup>27</sup> assists in correct record keeping of patients and medical details; managing income, expenditure, billing and user accounts of the facility; controlling drugs management and other stocks. The system generates automatic MTUHA<sup>28</sup> reports for Government use. The health data produced can also be used for further analysis. All these factors have to be part of a solid human resource development strategy. This also includes good HR management, such as with respect to timely promotions and transparency in decision making.

<sup>24</sup> It is important to ensure that people get an award or certificate as a sign of recognition that the person is at another level.

<sup>25</sup> A question with respect to sponsorships is whether the money should go to the institution or to the individual's account, which then raises the question of how to ensure that the conditions are met.

<sup>26</sup> District management information systems can be improved through Afyapro software which support daily operation services at a facility, and knowledge sharing.

<sup>27</sup> AfyaPro software is applied under district health management information system project in six FBO facilities (two hospitals, two health centre and two dispensaries) in the Mwanza Region.

<sup>28</sup> The health information system is called MTUHA, which is an acronym for the Kiswahili meaning of Health Management Information System - Mfumo wa Taarifa za Uendeshaji wa Huduma za Afya.

## 6.4 Human resources geographic information system

Overall, CSSC lacks the funds to align salaries with the public sector and will need support from government for making such top-ups available. To present its case, the CSSC needs complete, accurate and up-to-date information on the HR situation in their facilities. Such HR information would also facilitate collaboration with the MoHSW, donors, medical missions and individual churches. Moreover, the design of effective response to HRH also requires insight in the movements of personnel between facilities and out of the system. This will allow forecasting where shortages will occur in the FBO sector and to plan accordingly.

Information on HR now has to be collected from multiple sources, such as the Health Management Information System (HMIS) of the MoHSW and the registrars of professional bodies. These sources are difficult to access, are not compatible, and the quality of the data is not always good. Moreover, these health information systems are of limited use to the CSSC as FBO facilities are not well integrated yet.<sup>29</sup> There is also limited sharing of HR information between the private-for-profit (through the association of private health facilities - APHTA) and the FBO sector.

## 6.5 Setting up the CSSC HR information system

CSSC was thus faced with the dilemma that available HR data were of limited use for forecasting where shortages will occur in the FBO sector. They could not be used to convince the government that FBOs need more support, particularly those situated in rural areas. In 2006, CSSC decided to set up a system of their own, as in the short term it was not possible to better include FBO facilities in existing HR data collection by government and professional bodies. The data will be used by the facilities and CSSC for developing policies and planning, such as for training, deployment, promotion and supervision of health workers. It is further expected that the HRIS results can improve coordination within the CSSC network. And it will be a tool for advocacy as the data will be shared with the MoHSW and local governments, and used to build the case that CSSC needs more support from government. This will contribute to more efficient planning of national health assets and a reduction in staff disparities within the country. The point of departure for the CSSC Human Resource Information System (HRIS) is compatibility with the existing MoHSW system. The focus is on the quantity, distribution and capabilities of the health workforce in the FBO facilities. The information to be included in the HRIS was selected following consultation with a wide variety of decision makers. These included the bishops, CSSC's director and zonal teams, MoHSW Directorate of Policy and Planning-Information and Research Section, medical recorders, statisticians, ICT experts and technical advisors<sup>30</sup>.

Next, three questionnaires (for hospital, health centre and dispensary-level facilities) were prepared for collecting HR data and information on equipment, funding partners, and community outreach programs. Given the need to understand where health care workers are situated, a Geographic Information System (GIS) was developed to incorporate, manage, analyse and provide information on the location of health facilities and the distribution of

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<sup>29</sup> This is not only a problem in Tanzania. According to WHO the current Service Availability Mapping (SAM) conducted in many PEPFAR countries has not included FBO facilities (source Annual Health Statistical Abstract – MoHSW; 2006).

<sup>30</sup> IMA-WH, Baertracks, GMI.

human resources. The result is a hybrid health facilities–human resources (HF/HR) data set that is linked to a GIS. The location coordinates of each CSSC facilities is determined using a Global Positioning System (GPS).

## 6.6 Data collection and recordkeeping

Data collection was performed by CSSC staff from the zonal offices. They were trained in using the questionnaires and the GPS receivers. The actual data collection process took around five weeks per zone. First level data compilation was done by the zonal coordinator. The data from all five zones was then brought together at CSSC HQ for analysis.

The data collection exercise was helpful for understanding the current capabilities in facilities for record keeping and the importance attached to this task. It became apparent that record keeping is very poor, a situation that has been ongoing for a considerable period. At all types of facilities (dispensary, health centre, hospital), it was found that record keeping is not given high priority. Typically, no-one is made responsible for record keeping and only few staff members are involved. When these persons are absent there is no access to the data.<sup>31</sup>

Moreover, data entered was found to be not always correct. Even the records kept at zonal and central level on the number of health facilities were found to be incorrect. Some dispensaries, for example, have had to close down due to financial problems, but CSSC had not been informed. At the same time, newly established, operational health facilities were discovered during the survey that were not registered yet and therefore unknown by CSSC.

The experience has shown also that data collection is a sensitive issue. Collecting data was hindered by mistrust towards CSSC regarding how this data will be used, and perhaps a lack of transparency in some facilities. In order to raise awareness on the purpose, generate support and build trust, information campaigns are needed that explain why CSSC is collecting data, how they will be used and how the facilities may benefit (such as better planning, and more resources).

Despite these difficulties, data collection with respect to facility-based information is almost complete (80% of hospitals and 65-70% for health centres and dispensaries have been covered in 2008). Regarding HR data, about 60% of the surveys have been received and controlled. Cross checks showed that this data is also accurate.

Feedback discussions have been organised with the zonal coordinators to validate and discuss the findings. Additional meetings were also organised with MoHSW, development partners and other stakeholders to present the results and compare these with MoHSW standards. CSSC is also undertaking an Information and Communication Technology (ICT) needs assessment at the zonal level to obtain more insight as to how the information on the health facilities and human resources can be further used to manage resources and promote broader understanding of these shortages. Zonal Coordinators and CSSC staff were trained in the generation of maps by using GIS software and how to use these for decision making and planning<sup>32</sup>.

<sup>31</sup> At times CSSC staff travelled for hours to a facility but upon arrival were asked to come back another time.

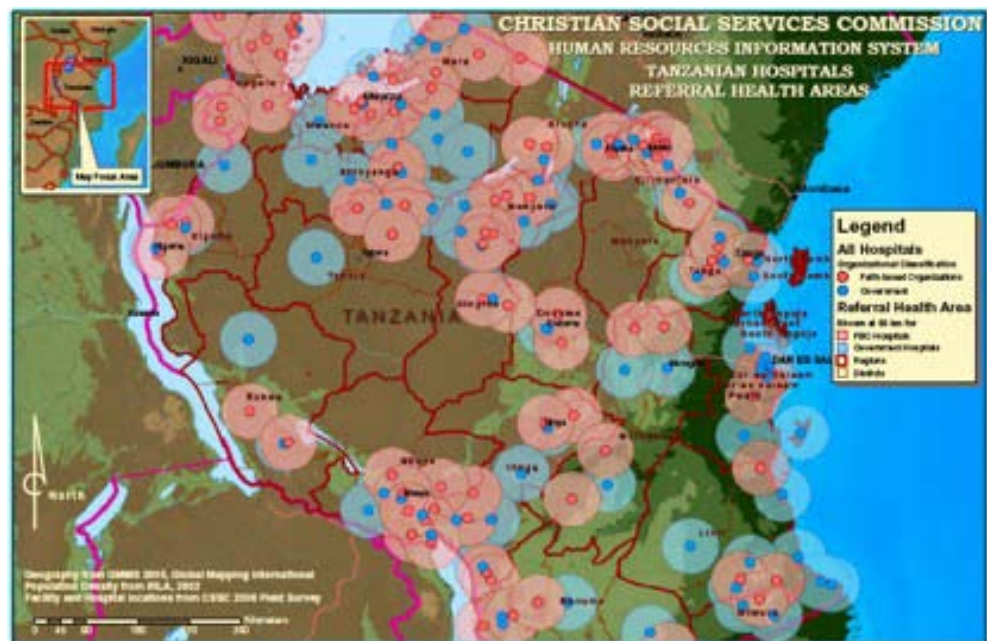
<sup>32</sup> In 2007, new software was acquired accompanied by a training session for CSSC personnel to learn to use the capabilities of the GIS. In 2008 more training was given in the use of GIS applications for zonal offices and CSSC HQ.

Clearly, in order for HF/HR data to be available and updated, the information system must be maintained on an ongoing basis. Facilities have become more aware of the importance of good record keeping.<sup>33</sup> Systems and procedures for ensuring regular updates, quality assurance and system management of the CSSC HRIS data are under development. Regular updating of data requires ongoing training of staff involved and full collaboration from facilities.

## 6.7 Findings

The HF/HR-GIS produced a geodatabase with administrative information and location coordinates for over 850 CSSC health facilities (hospitals, health centres and dispensaries) and human resource information on over 12,000 CSSC health facility staff.

Using GIS-generated maps makes it possible to relate service delivery to population density and thus better focus investments. The following map shows the location and referral health areas for government and FBO hospitals. Some remote rural areas rely completely on FBO health facilities (hospitals and health centres) but which are at risk of closing down because of too low staff levels. Moreover, services should follow population concentrations which may imply that a national policy goal such as “one dispensary for every village” may not be the best way for ensuring equitable access and making efficient use of scarce resources.



<sup>33</sup> CSSC is expanding the capabilities of the system by migrating personnel information onto the Capacity iHRIS Manage open source software platform. Access to these data will also be provided on the CSSC website.

The second map shows the availability of nurse midwives for the facilities that are running ante-natal care (ANC) programs. The large number of red and orange dots indicate that many facilities lack the number of trained personnel required to run this programme properly. The blue dots indicate possible overstaffing. These findings demonstrated clearly that it is becoming increasingly difficult for CSSC facilities to satisfy MoHSW-standard requirements for staffing.



## 6.8 Advocacy

These maps show the extent to which FBO facilities are contributing to service delivery. The HF/HR results have been used by CSSC facilities to advocate to the government and also to churches for the need to allocate more qualified HR.

CSSC staff felt more confident in the meetings with MoHSW, as they now have data to support their arguments. MoHSW has accepted that there is a problem and that mechanisms have to be set up between the government and CSSC to discuss HR issues regularly and to find solutions. CSSC is also discussing with government how best to support professional cadres so that they will continue working for CSSC facilities, particularly at the medical officer and assistant medical officer levels. Negotiations with the MoHSW have already led to an agreement on seconding staff to FBO institutions, although the Ministry of Finance is not always willing to provide extra resources to pay for FBO staff. Moreover, negotiations are sometimes hampered by insufficient coordination with other FBOs which are not members of CSSC.

There has been good progress with certain local governments in discussions on how to collaborate and share human resources. Some of the FBO health facilities, for example, have managed to retain staff by signing service level agreements with local government.

These agreements have allowed private and FBO facilities to pay for top-ups and meet other financial constraints, and ensure a smooth allocation of funds according to the planned budget<sup>34</sup>. However, other local governments still do not include FBO in district plans and budgets, as they do not understand the challenges faced by FBOs. More awareness is needed amongst CSSC zonal staff and church leaders as to how FBOs can best collaborate with local government and what options exist for sharing available resources.<sup>35</sup>

## 6.9 Towards joint human resource information systems

Currently there are no government standards for HR data collection systems or for software used for data entry and analysis. As a result, every development partner, programme and project is using their own systems. Not surprisingly, compatibility between data sets is problematic. There is a need for more concerted efforts to integrate the various HR information systems, enhance compatibility, share experiences and arrive at a standard guidance

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<sup>34</sup> Currently Bumbuli, Korogwe, Handeni districts (Tanga Region) and Marangu district in Kilimanjaro Region have signed the service agreement.

<sup>35</sup> The Tanzania Christian Medical Association meeting held in September 2008 involved local government officials, MoHSW, MoF and FBOs facilities health workers (doctors and administrators). It was agreed to share information and data at central, zonal and facility level to guide planning.





document. CSSC is therefore actively supporting the inter-ministerial taskforce that has been set up to address this issue.

CSSC has also developed a memorandum of understanding with the government to promote collaboration on data set development and data sharing.<sup>36</sup>

Data collection has been undertaken at diocese, hospital, health centre and dispensary levels. Each level can use these data for planning, developing and supporting the health workforce, but this requires more training in data management and use. Training is also needed in advocacy techniques, and for health facilities managers. To sustain the system, financial resources are required for maintaining systems, updating data and training staff. One step is more sensitisation of church leaders and local government on the importance of these datasets for planning, monitoring and evaluation, and advocacy.

## 6.10 Conclusions

The HRIS data made it possible for CSSC facilities to discuss with the MoHSW and local governments the need to assist FBO facilities in retaining qualified staff. It is essential to use scarce human resources as effectively as possible in order to arrive at a more equitable access to quality health care, particularly in underserved areas. Effective collaboration between MoHSW and CSSC on data collection will result in more complete information to guide strategic planning, for more effective management of HR resources.

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## Acknowledgements

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# 7

## Developing postgraduate training for health care managers

Health systems need managerial staff to function properly, but little investment is made in producing trained managers of health services. At the request of the Uganda Catholic Medical Bureau (UCMB), a private university in Uganda has set up a programme to train health care managers. The programme currently offers training to managers leading to either a Masters degree, a Diploma or a Certificate in Health Services Management or hospital management. This case study presents the evolution of this programme, results and lessons learned.

## 7.1 Management challenges in Uganda

The WHO describes managerial and support staff as an “invisible backbone” of the health system. Their contribution to health care delivery is as crucial as that of clinical health workers. “If they are not present in sufficient numbers and with appropriate skills, the health system cannot function...” (WHO, 2006, p.4). In Uganda, as in several other developing countries, the management of health care services has always been the preserve of medical personnel, especially doctors, save for a few administrative and political positions at central level (MoH, 2004).



The public health sector in Uganda operates under three directorates, has 83 district health offices, 214 Health Sub-Districts (HSDs), and runs 2301 health facilities - including 59 hospitals (MoH, 2006a). The entire health sector employed 59,680 health workers in 2002 (MoH, 2006b) of which an estimated 24,000 work for the public sub-sector and about 12,000 work for the private-not-for-profit (PNFP) sub-sector. The total annual government health expenditure in Uganda is about USD 230 million (MoH, 2007). Including the wage bill, National Referral Hospitals have a budget of about USD 16 million per year and employ 2,000 health workers; their regional counterparts have about USD 1.6 million and about 400 staff, while general hospitals have about USD 0.4 million and about 200 staff. The annual health budget managed by a District Health Officer (DHO) is about USD 0.8 million, and he/she has to manage about 200 health workers. At HSD level, the managers have a budget of about USD 0.2 million and 80 staff. Clearly, managers control significant quantities of material, financial and human resources.

The tasks of managers differ for the various levels, as Box 1 below illustrates. This long list of responsibilities certainly requires good management skills. The introduction of the Health Sub-Districts at the end of the 1990s exacerbated the challenge since most of the HSD functions are similar to those of the district level, and require similarly good skills.

#### BOX 1: MAIN MANAGEMENT TASKS IN UGANDA'S HEALTH SYSTEM

The managers at **central level** are responsible for policy formulation; setting standards; quality assurance; preparation of guidelines for training and human resource development; coordination of national response to epidemics and other disasters; and monitoring and evaluation of health services. The national level is also responsible for resource mobilisation, programmatic resource allocation and advocacy.

The Health Service Commission outlines the typical job description of a **district health officer** as being planning, directing, coordinating, budgeting and evaluating the delivery of health services in the district; managing and accounting for allocated resources; ensuring the implementation of the National Health Policy; requisitioning for equipment and other supplies; ensuring that equipment is secure, functional and well maintained; tendering advice on health-related issues; liaising with stakeholders for efficient delivery of health services; ensuring the implementation of the Uganda National Minimum Health Care Package; initiating and ensuring the implementation of research programmes; ensuring effective and efficient research programmes; ensuring effective and efficient development of health infrastructure at all levels of health services delivery in the district; ensuring conformity with quality assurance standards; ensuring that staff adhere to the Professional Code of Conduct and Ethics; ensuring that health information management systems are in place; liaising with professional councils on matters regarding disciplining, inspecting and monitoring physical structures in both public and private health facilities; imparting knowledge to students and staff; carrying out human resource activities like identifying manpower needs, training, promotion, leave and deployment; and compiling and submitting reports to the Chief Administrative Officer (HSC, 2005, p. 16-17).

Until the late 1990s, most health service managers at national, district and hospital levels did not have formal training in management. Most of these managers qualified as medical doctors, but their clinical training does not include much managerial knowledge nor does it emphasise skills required for the positions they presently occupy. The situation is similar for other medical cadres who are responsible for the management of lower levels of the health care system. Moreover, management training is still not a pre-requisite for holding a managerial position at MoH level or at any of the health facilities and units, including national referral hospitals. There is also no formal structure or requirement for in-service training for appointed managers. Consequently, most of the managers in the health services have not received formal managerial training to equip them with skills necessary for their present responsibilities. At the same time, rapidly changing national and international health policies (decentralisation, public-private partnerships, health insurance and other health policy reforms) continuously pose new challenges to managers.

Uganda employs many health managers, at all levels and in all sectors (public, FBO, NGO). The demand is growing following the creation of new districts<sup>37</sup> as a result of the policy of decentralisation to HSD level, and the start of health projects supported by global health initiatives. It is estimated that of the 214 HSDs in the country, only about 70 are headed by medical officers as the norms require. The rest are headed by clinical officers. Even of the 70 doctors, only about 30 have received management training, mainly as long-distance students of Master's of Public Health (MPH) programme at the government-owned Makerere University Institute of Public Health (MUIPH).

## 7.2 Management challenges in the FBO sector

By 1995, the faith-based private-not-for-profit (PNFP) health sector faced serious problems. This crisis was characterised by a large health unit infrastructure, staffed by too few, under-qualified, overworked and exhausted personnel, who, admirably, managed to sustain the large volume and enviable quality of care. These problems were partly caused by lack of funding and partly by poor management and an overzealous spirit of service, especially by the founders.

Many important managerial positions in the PNFP health units were held by under-qualified staff appointed solely on the basis of trust and dedication to their work. These managers had great difficulty in sustaining the projects started at a time when the FBO sector still received generous donations, both financial and technical support in form of expatriate health workers, which were often been channelled through missionaries. These donations had decreased or stopped altogether. User fees were charged to cover the costs but this had caused a reduction in health unit utilisation as the population could not afford these costs. Managerial staff could also not cope with the fast-moving pace of national and international health policies.

The UCMB decided that the quality of management had to be improved to address the problems encountered in the FBO services.<sup>38</sup> At that time, only Makerere University Institute of

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<sup>37</sup> *More than 30 new districts have been created over the last ten years, thus increasing the direct demand for more qualified health care managers at district and lower levels.*

<sup>38</sup> *The UCMB is the umbrella organisation coordinating health care activities of the Catholic Church in Uganda, and the technical organ for the Health Commission of the overall body of Catholic bishops, the Uganda Episcopal Conference. The UCMB coordinates a network of Catholic Church health services comprised of 27 hospitals and 236 lower-level health units. See also chapter Five.*

Public Health (MUIPH) was offering a Master's of Public Health. However, its output of ten graduates per year was not sufficient to meet the demand of all the districts, hospitals and NGOs in Uganda. In 1996, UCMB requested the Uganda Martyrs University (UMU) to start courses in the management of health services. The demand was for short, non-certificated courses for managers of the Catholic health network, as many managers holding key positions in their health units did not meet entry requirements for the MPH of Makerere University.

UMU was founded in 1993 by the Uganda Episcopal Conference under its Education Commission. Therefore, this "in-house request" was accepted and UMU agreed to start a training leading to the award of a Diploma in Hospital Administration.<sup>39</sup> The course started in 1996 and the first student cohorts were entirely constituted of staff from Catholic hospitals. The course was opened up to other facilities in Uganda by 1997 as both UMU and UCMB realised that the need for strengthening health management was a general concern.

UMU and UCM also observed that some of the managers needed to train beyond the diploma level, given the new challenges that health systems faced. The reform towards decentralisation, for example, required that peripheral facilities start leveraging resources at district and lower levels of government. The Public-Private Partnership in Health (PPPH) had also just started and the government required accountability for funds forwarded to health units, as well as for those belonging to the private sector. It required more transparency, to which PNFP managers were not necessarily accustomed. All these changes required also more of managers' skills in negotiation and advocacy, but which were difficult to impart at the diploma level.

In response, a two-year MA in Hospital Administration was started in 1997, which was changed in 1999 into a one-year MBA in Hospital Administration, before becoming a MSc. in Health Services Management in 2000. There was much interest for the UMU course. The fee of about USD 3,000 was considered by many Ugandans as good value-for-money compared to alternatives, such as studying overseas or in South Africa. The number of applicants was high, beyond the intake capacity of the programme. The combined annual output from UMU and MUIPH amounted to about 20 graduates only, and still the total demand for qualified managers greatly exceeded the supply of graduates.

### 7.3 External evaluation of the training

In 2000, an external evaluation of the programme was called for by UMU and the funders of the course: Cordaid and Doctors with Africa CUAMM, an Italian NGO. The reviewers concluded that the teaching concentrated on running health services as viable businesses and how to shield them from financial distress. However, there was very little reference to the changing context of national and international health policies, although these were having a significant impact on the way health facilities operated. Another conclusion of the review was the need for better integrating other values of the national health system and the church, in addition to financial sustainability (Murru and Koot, 2000).

<sup>39</sup> The training was set up with financial support from *Memisa Medicus Mundi*, a Dutch NGO which later merged with others to form *Cordaid*. *Memisa* had been supporting Catholic health units for a long time and was familiar with the managerial challenges they faced.

Decentralisation was one of the changes, as mentioned earlier. The management and implementation of health services was decentralised to the HSD level in 1999 and some of the PNFP units were designated heads of HSDs. Whereas decentralisation presented new opportunities, it also imposed new partners and new duties on health managers at all levels of the health system. Also, in the wake of the 2000 World Health Report, the understanding that institutional services like hospitals were a mere component in the broader definition of a health system was further enhanced. There were international initiatives for the integration of services with the aim of resource efficiency and health system strengthening.

Another conclusion of the review was the need for a better integration of other values in the training, in particular equity in access to care and the newly stated mission of the church in health services in Uganda that “...These services are committed to a holistic approach in healing by treating and preventing diseases, with a preferential option for the less privileged...” (UEC, 1999: p7). The new National Health Policy emphasised the implementation of a Minimum Health Care Package (MOH, 1999). It was agreed that efforts to achieve the health system twin objectives of efficiency and equity can be contradictory if they are not managed carefully and skilfully.

#### 7.4 Establishment of Certificate, Diploma and Masters courses

In 2004, UMU started a *certificate programme* in health services management, with a maximum intake of 20 participants per cohort. The certificate programme consists of only five modules, each lasting one residential week, and which are staggered over a one-year period to enable participants to maintain effective oversight in their jobs. Since it does not require an entry interview, the programme is open to a wide scope of managers; it is also short enough to allow busy managers to keep up with their work while developing their skills. It also introduces the participants, who are mainly clinicians, to the field of health management. In terms of employment opportunities, the Certificate programme is a short course seeking to improve the understanding of managerial issues in the health sector and offers only a few extra skills. It is an in-service course and does not necessarily lead to new jobs for the graduates. Most are already employed and will stay on after completing the training. Most realise the need for more in-depth study on management and end up applying for the diploma and Masters degree programmes at UMU and other universities.

The *Diploma programme* has an intake maximum of 25 participants per year. The content is similar to that of the Masters programme but is less demanding in terms of learning and analysis. It also lacks the module on management of refugee and emergency health services. Some graduates of the Diploma course may decide to do a research-based dissertation in order to obtain an advanced diploma and become eligible to attend the Masters programme. Graduates of the diploma are employable in lower-level health units (health centres) and in health projects and programmes. Many of the graduates now work as managers of health units, health sub-districts, hospital wards and departments, senior nursing officers, or coordinators for health services in Catholic dioceses.

The *Masters programme* lasts nine months and takes a maximum of 25 full-time participants per year. Graduates of the Masters programme are working as managers of HSDs, medical superintendents of hospitals, district health officers, project managers, senior health planners at the Ministry of Health headquarters, National Programme Officers in international and multi-lateral agencies. A few are self-employed, operating private health services.



TABLE 1 NUMBER OF GRADUATE OF HEALTH MANAGEMENT PROGRAMMES AT UMU

COURSE	Year of Intake														Total
	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008		
Certificate in HSM	-	-	-	-	-	-	-	-	20	18	21	19	20	98	
Diploma in Hospital M.	11	0	10	9	14	-	-	-	-	-	-	-	-	44	
Diploma in HSM	-	-	-	-	-	14	11	11	19	15	19	9	13	111	
MA Hospital M.	1	0	0	3	-	-	-	-	-	-	-	-	-	4	
MBA Hospital M.	-	-	-	-	4	-	-	-	-	-	-	-	-	4	
MSc. HSM	-	-	-	-	-	11	15	14	12	15	21	22	29	139	
<b>Total</b>	<b>12</b>	<b>0</b>	<b>10</b>	<b>12</b>	<b>18</b>	<b>25</b>	<b>26</b>	<b>25</b>	<b>51</b>	<b>48</b>	<b>61</b>	<b>50</b>	<b>62</b>	<b>400</b>	

*NB:HSM= health service management 2008 candidates are still on training and include four part-time students.*

## 7.5 Evolution of the Masters level training

The rest of this case study will focus on the Masters level training, as it has been the main course in the Faculty.

### 7.5.1 Developing a new course

Following the evaluation in 2000, the managers of the Catholic health network at national, diocesan and health unit levels, the government as well as the university were quickly convinced that the best way to address the new external challenges in health systems would be to revise the curriculum for the course and align it with the managerial demands in the field. This would equip their staff with the knowledge and skills required to steer their services in the new policy direction. It was decided that UMU could not stick to purely institution-oriented training (hospitals) when the other health policy actors were moving towards a systems approach. UCMB also proposed that the course would include also matters in relation to equitable access to care.

Government health services were interested in the course because it contributed to increasing the numbers of the badly-needed qualified health managers. Moreover, the course was a good communication channel through which MoH officials could access managers at peripheral level and impart to them knowledge of government policies through lectures and seminars. They also saw it as an opportunity to learn how to deal with their newly re-emphasised partners in the private sector. Moreover, UMU had established for itself a reputation in other fields of offering high quality training and producing graduates with high ethical standards. The health services management course could produce a new cadre of professional managers who had a commitment and ethical standards - a growing importance to government services, as corruption is becoming a major problem. They can sponsor also their own staff for training at UMU. Government did not have direct influence over the course curriculum, apart from the power to recognise the qualifications awarded.

The management and staff of UMU were the main actors in the transformation of the course. They had the power to approve or reject proposed changes, were responsible for resource mobilisation and had to run the course. Whereas the changes would add competitive advantage to the university, some members of the management of UMU were opposed because

of a couple of challenges. Most of the Business Administration and Management (BAM) staff were not familiar with the national and international health issues and policies to be introduced in the revised curriculum. The choice was either upgrading existing staff (through higher qualifications, training, extensive reading)<sup>40</sup>, or make use of many guest lecturers or handover the course to a new crop of to be recruited teachers. Moreover, the new organisational set-up (a condition of one of the donors) would imply that a lower echelon of the university administrative structure had to be granted more financial and administrative autonomy (Murru and Koot, 2000).

In the end, the changes recommended by the external evaluators were implemented as proposed, largely because of the flexibility of the UMU management and the commitment and consistent support of the two donor agencies to implement the new programme. This desire of the policy makers of the university, at UCMB and at the Ministry of Health in Uganda to see the programme succeed favoured its success. The university management at UMU contributed greatly to putting the new faculty in the limelight by allowing it the freedom to innovate, and test new ideas and practices which improved efficiency in the delivery of the programme. For example, the Faculty of Health Sciences (FHS) was the first academic unit to have a faculty-operated bank account (allowing prompt payment of guest lecturers), to acquire and use ICT-based teaching aids such as LCD projectors, to obtain laptop computers for individual staff and Masters students and have a computer classroom specifically dedicated for its students, many of whom are mature students and had for the most part never touched a computer before coming to UMU. As a result, all the graduates of the faculty are versatile with computers when they finish their 1 year courses.<sup>41</sup>

The Faculty of Health Sciences was also the only Faculty to independently administer the student selection process and issue admission letters on the very day of the interviews. This allowed ample time to those candidates with no guaranteed funding to solicit financial support and obtain permission for study leave early enough. The result is a high admission-to-registration ratio of over 98%.

National policy makers at the Ministry of Health have shown appreciation and commitment to the training programmes by participating in teaching, provision of materials and sending sponsored students. Ministry officials have participated in curriculum design and revision and the introduction of new courses in the faculty. They have readily absorbed the graduates of the programme into key positions in the public service hierarchy. In 2008, four graduates of the MSc. work in different programmes at the Ministry headquarters.

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40 *The BAM Faculty lost three staff as a result of the reforms - one left in protest and three went to upgrade their qualifications, but two did not return after training.*

41 *This experiment has convinced the university authorities to allow dedicated computer laboratories for other faculties and to make computer literacy an obligation for all UMU students. This has made UMU the leading university in computer access and ICT skills development for students in Uganda (NCHE, 2006).*

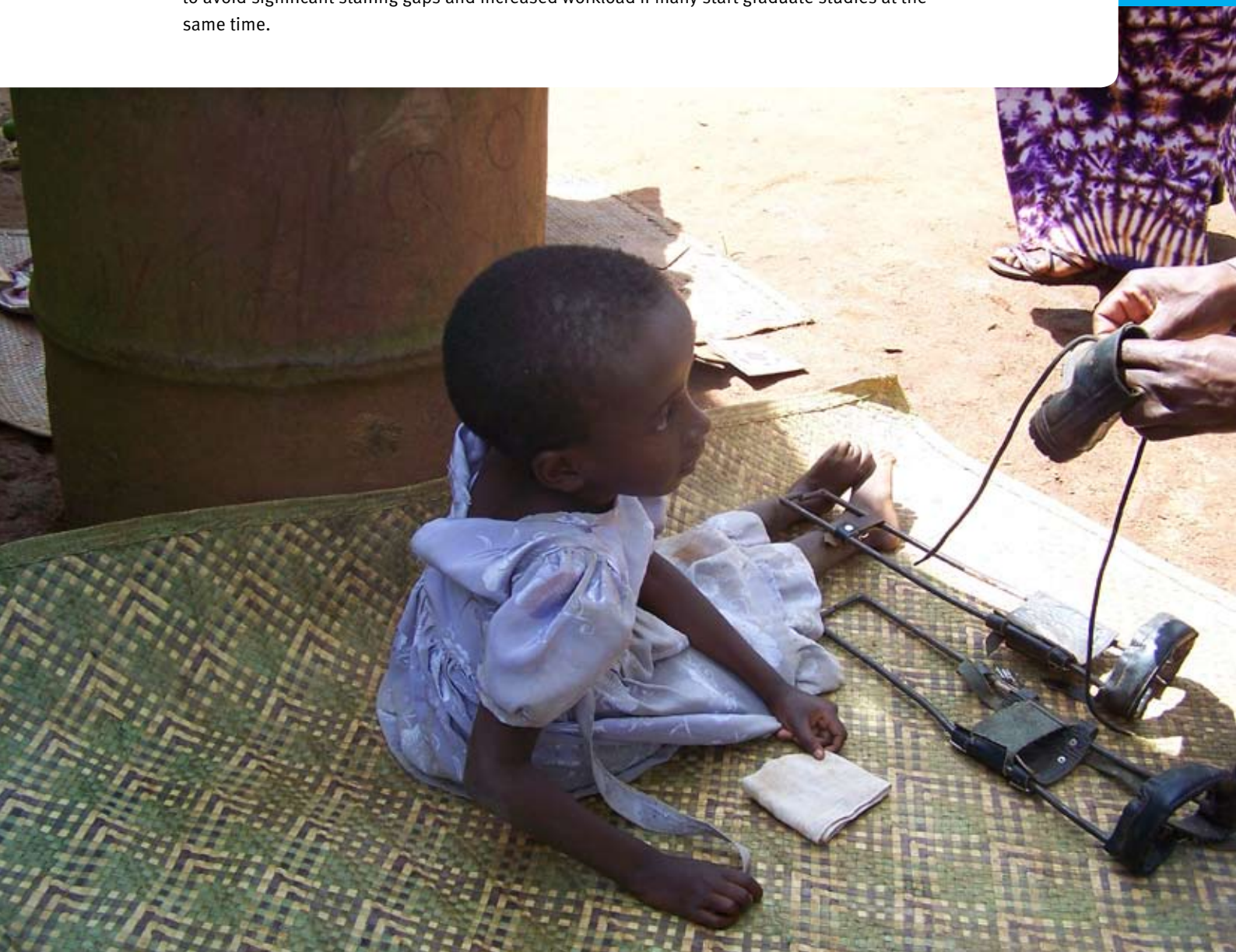
### 7.5.2 The setting up of the new MSc. in Health Services Management

The new curriculum was developed by the staff and approved by the university's Senate, the organ responsible for all academic matters including quality assurance. The course operates under the slogan "Working for a New Generation of Health Managers" to reflect the view that a new breed of manager is needed, beyond someone with a mere medical qualification.

The programme seeks to produce managers who have an understanding of the main issues in the management of health services. The course is practice-oriented and develops participants' managerial competences, as well as their analytical and critical thinking.

#### *Appropriate staffing*

The teachers are drawn from various UMU faculties, the Ugandan Ministry of Health, district and HSD levels from different parts of the country, national and international organisations, and other academic institutions from within and outside Uganda. Staff have been carefully selected and many have returned to teach again. Known attitudes and interpersonal skills such as ability to work in a culturally diverse environment were crucial points during selection. Most staff were multi-skilled and willing to do work beyond the scope of just one technical field of expertise. All staff had medium-term (three-year) renewable contracts with the university and most have served them to full term. Salary top-ups from the donor agencies have contributed to staff stability. A persistent challenge is that the majority of the staff still need to obtain a PhD. This will demand funds for sponsorship and careful management of the process to avoid significant staffing gaps and increased workload if many start graduate studies at the same time.



### *Target group*

After a careful selection interview comprising a written and an oral examination, the course admits a maximum of 25 candidates each year out of an average of 40 applicants.<sup>42</sup> The candidates should hold a bachelor's degree and have at least two years working experience in the health sector. Normally, this means medical doctors working as medical superintendents/directors of hospitals, managers of HSDs, or as medical officers in NGOs and government projects. Increasingly, the course now also admits graduate nurses on the programme. They are usually senior nursing officers of large hospitals, nurse lecturers and nurses in NGOs and vertical programmes of the Ministry of Health. Applicants with degrees in non-medical fields need to have at least three years of working experience and demonstrate some knowledge of the health sector. Normally, these are social scientists and graduates of related courses, such as public administration, business administration, and information sciences. They usually work as hospital administrators, accountants or managers in health projects or are members of the Board of Governors of a hospital.

A small window has been opened for applicants without a basic university degree. Such applicants need to have at least five years work experience in the health sector, with qualifications equivalent to a first degree and pass an intensive entry interview (with a higher pass-mark than for degree holders). Less than five candidates may be admitted through this scheme every year. Applicants have been Clinical Officers, Registered Nurses and Health Tutors.

### *Course content, organisation and teaching methods*

The course runs for one academic year comprising 47 weeks<sup>43</sup> of study and research. Candidates have the option of attending the course on a full-time or part-time basis. The course package is comprised of ten modules including a dissertation based on primary data. Teaching is done through formal interactive face-to-face teaching, reading assignments, group discussions, analysis of case studies and individual experiences which are shared in class, field visits and a short period of attachment to selected organisations, during which the students conduct research under supervision by the lecturers. The course works on competences for public health management such as in leadership, communication, team building, planning, priority setting, performance assessment, and problem solving. Other competences crucial for health managers include health care delivery, financial management and legal and ethical considerations (Pillay, 2008).

### *Student assessment*

To graduate, a student must pass all the modules of the course. The assessment of each module comprises two parts: a result for the continuous assessment of the candidate throughout the module, and that for a 3-hour written examination. Oral examinations are held at the end of the first semester and at the end of the second semester. The pass mark for all examinations is 50%.

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<sup>42</sup> Although the course is only advertised in the Ugandan print media, it has so far been accessed by students from the entire eastern African region, who obtain information about it from the university website, [www.umu.ac.ug](http://www.umu.ac.ug).

<sup>43</sup> 1536 hours including official Student Investment Time, SIT, equivalent to 95 Credit Units.

*Quality assurance*

For quality improvement purposes, the course content is reviewed each year to incorporate new developments in the fields covered. The review triangulates feedback from internal and external stakeholders - students, staff, guest lecturers. Occasionally, external reviewers are invited by the Faculty and they submit a report of their review. One such external review was done in 2000 and another one in 2007 by the Royal Tropical Institute (KIT) in Amsterdam. For quality assurance purposes, external examiners are invited from other academic institutions to examine dissertations and during final oral examinations. Efforts are also underway to have the course accredited by TropEd<sup>44</sup> and other international bodies.

**7.5.3 Funding**

The university charges every student on the course the same subsidised fees, irrespective of their source of funding. A study conducted by the faculty showed that, in the 2004/2005 academic year, it cost the university an equivalent of USD 10,095 to train a MSc. student for an academic year. The students paid only 30% of this figure (Namaganda et al., 2006). Overall, the costs of training at UMU are cheaper than training similar graduates in popular destinations for Ugandan students in Europe or the US.

The fees at UMU are rather high for the majority of the would-be candidates and only a few individuals actually pay the costs themselves. Also, most of the PNFP health units which need the services of trained managers cannot afford the fees. As a result, most of the candidates on the course are sponsored by multi-lateral and bilateral agencies and NGOs, directly or indirectly through their sending organisations or the central and local governments. Students sponsored by health facilities are usually bonded to serve the sending unit for varying periods after the training. Bonded contracts vary across institutions and courses and if for this MSc course on average three years (Candiga et al., 2008).

Through Cordaid and Doctors with Africa CUAMM, the Faculty has had a reliable flow of funding to meet its requirements. Their support includes covering recurrent costs, students' and staff scholarships, staff salaries, material support and others. In all, their support has been constant and consistent. Moreover, with their support, the faculty has just completed the implementation of a five-year Strategic Development Plan covering the period 2004–2008, the first of its kind in the university. The two donor organisations bought some components into the plan and financed them with successive projects.

**7.6 Impact of the training on availability, competence and productivity**

Although the university did not conduct a formal training needs assessment before starting the course, and although it did not fix a final target of how many graduates to train in order to attain the figurative “critical mass” of managers, the training can be said to have contributed to the creation of the anticipated cadre of managers. The training is also still relevant because of a continuous turnover and loss of trained managers. A question that still needs to be answered is whether the training has had an impact on the quality of performance of the graduates or on the mission of their sending institutions. This has not been studied yet, though anecdotal reports suggest that the programme is on the right track. The training is reported by the graduates to have improved their individual performance which, in turn, resulted in overall

44 See <http://www.troped.org/>

organisational performance. The graduates have also received personal benefits such as promotion and improvements in salary. However, evaluating the impact of the training on the performance of the individual graduates should be done formally.

*Increased number of available trained managers*

The ceiling has been progressively elevated from ten through 15 and 20 participants per year. Since 2006, the intake is limited to a maximum of 25 students per year in order to maintain quality. Since 2001, 139 people have completed the training. These output figures suggest that the programme is slowly contributing to the creation of the critical mass of health services managers. The completion rate is over 95% for all the years. Failure was caused by non-payment of fees, and failure to secure a study leave. While the Certificate and Diploma in HSM have always been dominated by females (over 60% in all the years), the MSc. is dominated by males (an average of over 80% in all the years, with no females at all in some years). The gender balance has improved spontaneously over the years; the university does not have a policy on gender-based affirmative action in admission.

In terms of retention, most of the graduates of the different programmes seem still to be working in their countries of origin and within the healthcare sector (anecdotal information). A few have continued training and are pursuing a Phd. Three trainees were recruited by the Faculty of Health Sciences of UMU as lecturers and two more came back to the Faculty after stints ranging from two to five years in the field. Out of the 110 graduates of the MSc. as of 2007, only one is not yet employed in a managerial or teaching position, though she works as a



private consultant on health projects. The graduates confirm that they have been promoted in their jobs and that they have obtained higher salaries after the training.

#### *Competence of the graduates*

Although the training was designed based on observed performance, anecdotal reports of unmet managerial expectations, and perceived upcoming challenges, it is difficult to give firm evidence of an improvement in managerial performance of individual graduates after their course. In addition, since the first evaluation of the programme in 2000 no other study, formal or informal, of the managerial performance of the graduates of the programmes has been done.

#### *Additional outputs*

Another aspect of the programme has been the publication of a scientific journal *Health Policy and Development* every four months. The journal is distributed free of charge to all hospitals, district health offices, health sub-districts and the Ministry of Health headquarters in Uganda and accessible through the internet.<sup>45</sup> The journal enables easy access to scientific material for rural health workers. It has become also a point of contact through which graduates publish their work.

The appreciation by the UCMB authorities of the FHS's work in improving the managerial situation in their health units has led them to continue to entrust FHS with key operational research assignments relevant to the provision of care within their network. The FHS has also conducted research and training on their behalf and jointly developed training programmes.<sup>46</sup> UCMB staff give the faculty advice and guidance on strategic directions.

## 7.7 Lessons learned

After nearly ten years, a couple of lessons can be learned from the training process. In no particular order, these are:

1. *Appropriate training programmes may be initiated by people outside academia such as UCMB.* Such initiators help to start courses responsive to real needs in service provision.
2. *Planning for performance-improvement training requires that reliable mechanisms for monitoring and evaluation the effects of the intervention are put in place.* It has been difficult to accurately attribute observed improved performance to the training of this programme.
3. *Partnership between prospective employers, trainers, other training institutions and donors is important.* New training programmes are costly and need to be planned well, taking into account mistakes of previous programmes. Some dangers are the recruitment of most staff from the same age bracket, and allow space to each programme to excel in a given field.

<sup>45</sup> [www.bioline.org.br/hpdjournal](http://www.bioline.org.br/hpdjournal) as an Open Access journal.

<sup>46</sup> In 2001, the Faculty was invited to conduct a situation analysis of health services in a Diocese. The students on the programme were trained for the exercise and they came up with useful information which led to the design of a project that has completely transformed the health services in the diocese from near-collapse to being model services (Santini, 2002).

4. *Financial support should come from diverse sources:* For developing countries, student fees are a weak source of financial sustainability for training programmes because of their inability to pay either on time or at all. In addition, if one source is not capable or interested in financing certain activities, another source may step in. Long-term partnership with donors is important for stability since training is quite costly and may not be a self-sustaining venture. However, transparency needs to be emphasised such that all the donors know their counterpart's areas of commitment and unfunded priorities.
5. *Ensure responsiveness to the demands of the market.* Training programmes should respond to their changing external environment through regular curriculum review and take into account the needs of the students. The faculty responds to customer demands by listening to the views of the alumni at the end of each academic year but it still needs to structure the collection of opinions to capture those of other stakeholders. However, the FHS has been slow to respond to the strong demand for undergraduate degree programmes, evening, weekend and distance learning programmes.

## 7.8 Conclusion

The training of health care managers to a Masters Degree in Health Services Management level has been largely successful. The rationale for the training was to fill a gap in the number of trained managers who could act in the face of new challenges to improve the management of health services in the country. Rapidly- changing national and international health policies dictated a new breed of managers who could help the health system meet its key objectives of efficiency, effectiveness, quality, sustainability and equity of access to health care. The health management training programme at UMU is acknowledged as one of the best in the field in Uganda in terms of content and quality of teaching. A number of circumstances clearly operated in favour of the success of the programme. Key among these are adjustment to the national and international health policy environments, high level political commitment for the course, reliable financial support, appropriate staffing, and a suitable student base.

This programme has been put in place since 1995 and demonstrates the ability of the faith-based private sector to contribute to the effective response to health needs, including “public” health goals such as equity. The experience also shows the advantage of interdependence between the various arms of the churches, such as where health and education service networks are closely related, in solving problems around service delivery in an innovative way. In Uganda, the request from one partner triggered the development of an entire service that is now meeting the needs of a wider audience.



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**IMAWORLDHEALTH**  
ADVANCING HEALTH & HEALING THE WORLD OVER

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8

## **Christian Health Associations: Joining Forces for Improving Human Resources for Health**

The previous chapters have established how the human resource crisis affects service delivery for the private-not-for-profit sector, in particular faith-based organisations which primarily work in rural, remote and underserved areas. In 2004, 14 Christian Health Associations in Africa organised a Technical Working Group for Human Resources for Health. The goal was two-fold: to share and learn from each other's experience and strategise and build a knowledge base on one hand, and on the other hand to give a voice through advocacy to the crucial role faith-based health networks play in national health sectors on the African continent. This chapter introduces the technical working group, how it operates, what its objectives are and what it has achieved in its short history.

## 8.1 History of international collaboration of Christian Health Associations

Member facilities of the CHAs in Africa have a long history of providing health care in their countries, often dating back to colonial times. Medical work had been one of the main focuses for missionary work of North American and European churches. In 1968 the Christian Medical Commission (CMC) was established by the World Council of Churches (WCC) as a response to several WCC studies, which showed the limited impact of church health care facilities on improving in a sustainable way the health of the populations they were serving. WCC had found that “95% of church-related work was curative and at least half of the hospital admissions were for easily preventable health conditions” (Litsios, 2004). WCC concluded that there was need to do more prevention and behaviour change work at the community level and decided to set up the CMC. The CMC was mandated “to enhance the quest for Christian understanding of holistic health” by promoting innovative approaches to health care and sharing of experience by networking within and between countries (Kaseje, 2006). CMC was one of the pioneers of what is now known as community-based primary health care.<sup>47</sup>

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47 See reports in the *Christian Medical Commission Journal Contact*.



The 1970s and 80s also saw the focus of mission activity shift. Hospitals, health centres and dispensaries were turned over to national church bodies by their North American and European counterparts, leading to the creation of umbrella organisations called Christian Health Associations (CHAs). Although CHAs continued to participate in CMC meetings and discussions, they increasingly came together more informally as a group at various international fora and venues to discuss common challenges, issues, strategies and solutions.

## 8.2 The creation of the Technical Working Group

Since the turn of the century, many Christian Health Associations have become more and more concerned by the lack of qualified professional health staff at all levels of health provision. Increasingly, their member facilities have been facing the challenges of the out-migration of health workers from the faith-based health care facilities to public or private facilities in the country, or to better opportunities abroad. With major donor funding and cancellation of national debts, governments have additional resources to change the personnel incentive packages in the public health care sector. These cannot be matched by the faith-based facilities whose traditional partners are no longer providing as much financial and personnel (missionary) support as in the past. Therefore, the CHAs have been working hard to develop and implement alternative retention strategies to minimise out-migration.

Various CHAs have initiated discussions on human resource (HR)-related issues on a bilateral basis for several years. In 2004, at a CHA meeting hosted by the Christian Health Association of Malawi, the extent and similarity of the HR crisis facing all CHAs became very apparent. As is clear from the case discussions gathered in this book, all CHAs face similar HR issues such as staff recruitment, retention, out-migration to public facilities and developing effective strategies for dialogue and to negotiate service agreements with their respective governments. Therefore a resolution was passed to form a Technical Working Group on Human Resources for Health (TWG HRH). By sharing and working together on common issues, the once informal networks of faith-centred health providers can learn better from each other's experiences and seek tools and approaches to address the HR crisis more meaningfully. The CHAs felt that the technical working group could become a forum for the faith-based health care community and provide a platform to share issues, knowledge and successful models for solving problems.

### BOX 1: FUNCTIONS OF THE TWG

The working group assists its members by addressing their organisational HRH issues more effectively and creatively, and by discussing experiences and solutions across the wide geographic spectrum of CHAs. In addition, the TWG enhances the visibility of the FBOs and enlarges their shared voice on HR issues within the national and international arena. It is envisioned that the TWG will enable the CHAs to raise awareness of the role FBOs play in the national health sector; how health care service is affected by the HR issues that they are facing and that both public and faith-based facilities need to be supported in order to strengthen the national health sector of any African country.

In March 2006, a framework outlining objectives, ways of collaborating and responsibilities of each member was approved and signed by the Christian Health Associations and became known as the “Nairobi Declaration” (see box 2 – TWG, 2006). The framework also serves as a call to action to address issues of human resources for health within the faith-based context. The “Technical Working Group on Human Resources for Health” was launched formally in April 2006 in Zambia during the World Health Day celebration organised by the WCC and the WHO.

## BOX 2: OBJECTIVES AND ACTIVITIES OF THE TWG

The Technical Working Group on Human Resources for Health has four main objectives:

1. To strengthen partnerships & relationship between the CHAs, the respective governments and other partners.
2. To work to increase retention of health personnel for facilities within the CHA networks.
3. To assist in advancing human resource management systems of CHA secretariats and their institutions.
4. To assist in improving human resource financing and training opportunities and practices.

Broadly, TWG strategies and activities are as follows:

- Advisory work– the TWG will function as an expert group to analyse how CHA networks are confronting HRH issues and advise individual CHAs.
- Knowledge Sharing – to serve as a clearing house for sharing information and experience about HRH practices of CHAs.
- Advocacy – to advocate both nationally and internationally for policies and resources to support the CHA networks’ ability to improve health services.

## 8.3 Running the TWG

### 8.3.1 Membership

The fourteen signatory organisations to the “Nairobi Declaration” are the Christian Health Associations of Ghana, Kenya, Lesotho, Liberia, Malawi, Nigeria, Sudan and Zambia, the Christian Social Services Commission (Tanzania), the Churches Forum on HIV/AIDS (Swaziland), the Kenya Episcopal Conference–Catholic Secretariat, the Protestant Church of the Democratic Republic of Congo, the Uganda Catholic Medical Bureau and the Uganda Protestant Medical Bureau. Each organisation serves in an umbrella capacity, representing a cross-section of faith-based health care facilities in their individual countries.

Currently, the membership of the TWG is predominately made up of organisations based in the English-speaking African countries. The sole exception is the Protestant Church of Congo.<sup>48</sup>

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<sup>48</sup> This organisation has a historical link to IMA World Health, the first Secretariat of the TWG; and has English-speaking leadership.

The stated aim is to embrace the French and Portuguese-speaking Christian Health Associations through dialogue and engagement, although linguistic constraints continue to hinder this expansion. Also, a strategy for outreach to other CHAs to expand the TWG membership and network should be developed rather than through the intermittent and unstructured method that is currently being employed.

### 8.3.2 Functioning of the TWG

The fourteen member organisations each agreed to appoint a focal person from within their structure who would be responsible for liaising with the TWG. By agreement, this person devotes 10% of his/her time to TWG activities. However, in many cases the leadership of the member CHA continues to liaise with the TWG directly and have not designated a focal person for the organisation. In other cases, individuals are asked to participate on an ad hoc basis, which affects continuity and consistency.

The reason for this is not a lack of commitment on the part of the associations, rather that many of the CHAs face longstanding and funds-limiting staffing constraints. As a result, almost all personnel wear multiple “hats” and try to respond to multiple responsibilities. Regularly, staff must set Solomon-like priorities and are forced to abandon certain parts of their portfolios as more urgent matters take precedence. This has often been the case for TWG-related activities as these tend to be perceived as more flexible, less time and finance-bound. However, this in turn created additional challenges to the smooth functioning of the TWG. For example, regular participation in longstanding planned teleconferences is difficult to arrange, as well as receiving feedback in a timely manner.

### 8.3.3 Secretariat

The members decided that the Secretariat should rotate every two years among the participating CHAs. The Secretariat of the TWG is temporarily hosted at IMA World Health, as IMA was able to provide staffing and technical assistance. At the 2007 CHA meeting in Tanzania it was agreed that a Secretariat based in Africa will facilitate smoother networking and communication between the CHAs and associated organizations (CSSC, 2007). The first rotation will occur in July 2009, when the Secretariat will transition from IMA World Health to the Christian Health Association of Kenya (CHAK).

The Secretariat has a number of essential tasks. It coordinates meetings, teleconferences, and sharing of information and assists members with specific requests on circulation of essential notices and data. In addition, the Secretariat acts as a clearing house for HR documents through a portal on the IMA World Health website. The publication and dissemination of the monthly email-newsletter, the *Hotline HRH*, is a resource which provides essential information on workshops, seminars, meetings as well as articles that may be of interest to the membership.

### 8.3.4 Communication

Early in the development of the TWG, it was implicitly understood that meetings of the group would take place annually, concurrent with other workshops or conferences, attended by a large plurality of TWG members. These meetings have proven essential to keep members engaged in the TWG. The TWG lacks the resources to organise HRH-specific meetings and this makes it difficult to organise face-to-face training/learning events for members. However, a few hours can, with good planning, be set aside within the framework of other meetings to gather the TWG for important discussions.

Communication is done predominately electronically because of the difference in location and time zones between North America and Africa. In addition, the members of the TWG felt it was important to plan on quarterly teleconferences. However, these have been difficult to organise and implement as they are potentially costly for organisations with limited resources. In April 2008 a decision was made by the TWG to try other methods of communication, such as Skype, that might be less costly.

### 8.3.5 Funding

Financial assistance to initiate the TWG was provided by USAID through The Capacity Project, which will end in June 2009. In addition Cordaid, Medicus Mundi and The Capacity Project have assisted with the organisation of CHA-wide conferences in Kenya (2006) and Tanzania (2007), which made it possible for most TWG members to gather and deliberate.

The future funding of the network is far from secure and discussions are underway with a number of potential funding sources. However, donors tend to be extremely wary of working groups and networks whose benefits are not immediately visible. The TWG needs to develop, as one of its top priorities, a strategy for ensuring sustainable funding. Resource mobilisation should include sourcing of funds for networking activities for the CHAs, internally and externally, such as participation in international conferences, meetings and multinational policy strategy sessions.

## 8.4 Achievements of the TWG

The TWG's main targeted objectives have been to contribute to increased retention of health personnel, advance HR management systems, and improve HR financing and training. The TWG also seeks to strengthen partnerships between the CHAs as well as their respective governments and other essential health actors. These are exceedingly ambitious goals for a group modestly funded and loosely managed.

What has the TWG achieved so far? To answer this question, IMA World Health developed a survey to gauge the members' own perceptions of the group's strengths and weaknesses, as well as their understanding of the challenges and achievements of the TWG and, lastly, what benefits have accrued to members as a result of this collaboration. The survey was sent to fourteen members and nine responded.<sup>49</sup>

The feedback was mainly concerned with the activities undertaken by the TWG and the following table includes a sampling of the replies of the CHAs. The TWG is generally perceived as a positive step toward more exchange of information and experiences between CHAs. Members of the TWG feel that they have become better informed on HR issues and options for addressing these, through networking and information-sharing. Members have expressed a greater realisation that all face similar problems with respect to HR and that joining forces in solidarity makes perfect sense.

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<sup>49</sup> Respondents of the surveys are the: Christian Health Associations of Kenya, Lesotho, Ghana, Malawi, Zambia, Kenya Episcopal Conference – Catholic Secretariat, Uganda Catholic Medical Bureau, Uganda Protestant Medical Bureau, Protestant Church of Congo.



TABLE 1 SAMPLE OF SURVEY RESULTS ON TWG ACTIVITIES

	Yes	No	Don't know
Participated in TWG activities	8	1	-
Received useful information through the TWG	9	-	-
TWG contributed to collaboration amongst CHA and exchange of lessons learned, documentation, etc.	6	1	2
TWG is fulfilling its objectives	5	1	3

The next sections will summarise members' detailed responses as to the main achievements of the three main activities of the TWG: advisory services, knowledge sharing and advocacy.

#### 8.4.1 Advisory services

The TWG has promoted exchanges between members on specific issues either by e-mail or by exchange visits on specific topics. All visits were organised by the associations themselves. CHAK has had the opportunity to share with the Christian Health Association of Zambia and Ghana its use of ICT in enhancing communication and motivation of health workers. In addition, the Health Management Information Systems Officer from CHAK travelled to Ghana to participate in an Human Resources Information assessment with CHAG. Another achievement in this area is the request by CHAM to TWG members for feedback on their proposed survey of the top up allowances in its facilities; the survey was amended and improved accordingly.

HR staff of the member CHAs, encouraged by the collaborative spirit of the TWG, looked for ways to interact and to share experiences and this has resulted in the organisation of exchange visits between CHAM, CHAZ, CHAK and CHALe (Christian Health Association of Lesotho). In 2007 a team from CHAK visited their counterparts in Uganda, Tanzania, Ghana, Malawi and Zambia. These visits were specifically designed to create awareness and gather tools on FBO health systems, strengthening through formal contractual relationships with host governments, human resource management and a multitude of retention strategies. In addition, CHAM has visited CHAK to gather information on strategies and implementation methodologies utilised by the Kenyan network to interact successfully with government, donors and other partners.

The TWG has inspired increased in-country collaboration in Uganda, where Catholic and Protestant medical bureaus made a strategic decision to harmonise their information systems on HR. This includes the sharing and streamlining of formats, tools and guidelines, with the ultimate goal of collecting identical and easily-shared data from their respective health facilities and institutions. This has been a step forward in reducing competitiveness and emphasising the value of collaboration at the national level.

#### 8.4.2 Knowledge sharing

The TWG has worked to increase skills and knowledge relating to human resources issues within the faith-based community. The clearinghouse for sharing of HR-related documentation through a portal on the IMA World Health website has been a success. Through membership in the TWG, a health association finds itself with the access to hundreds of foundational documents and other resources which were very expensive and time-consuming when first composed and compiled. The internet now provides in a few minutes information that once

took days of research and consumed essential funds. These documents provide an array of information and lessons learned. They also include practical tools such as forms and procedures for drafting CHA constitutions, Memorandums of Understanding, service agreements, Ministerial contracts and many others. The greatest quantity of posted and available documentation has been sourced from approximately ten TWG members; the monthly average number of those who access this wide-range of materials is about 140. The Hotline HRH, the group's monthly newsletter, is distributed throughout the Christian Health Association community, their partners, donor agencies as well as other stakeholders and has approximately 200 subscribers.

### 8.4.3 Advocacy

CHAs now have much improved access to one another's methods for gaining support from their governments such as Memorandums of Understanding with service providers and/or governments. This strengthens their strategic position in advocacy around human resources for health as well as health services delivery. Here is an example from Uganda: "[w]e have used the lessons learnt from Zambia and Tanzania CHAs and how they managed to get support from their governments as precedence for us to advocate for support from our own government."

The TWG is also working towards a unified voice on HR issues and to increase the international visibility of the work of faith-based organisations. There is a general perception within those who work in health development that FBOs were neither doing nor achieving much because so little data or information had been published or documented. In order to address this, the TWG Secretariat was tasked with collecting, organising, and making available as many FBO-related reports and documents concerning HRH as could be found. It has advocated the position that for the purposes of health service delivery definition, FBOs are a separate sector and should not be included together with private or private-not-for-profit operators.<sup>50</sup>

The Secretariat has the capacity to respond quickly to calls for input for advocacy campaigns, as it has brought together much information on the members. One example is when the HCW Network<sup>51</sup> needed information pertaining to existing health professional training capacity in Africa for their advocacy concerning the Presidents Emergency Plan for AIDS Relief (PEPFAR) reauthorisation bill. The Secretariat was able to provide valuable and timely information.

TWG members who are invited to international conferences increasingly voice the needs of other FBOs as their awareness of the commonality of their problems and the importance of joining forces has grown; this is a major achievement and one that speaks eloquently to the value of collaboration and communication. At the Human Resources for Health Action Workshop held in Accra, Ghana in 2007, six FBO representatives made significant contributions to the discussions and held an ad hoc meeting. Once again, the TWG provided the spark towards greater cooperation and solidarity.

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<sup>50</sup> As happened in Uganda with the Kampala Declaration which was the main result of the Global Forum on Human Resources for Health in 2008. [http://www.who.int/workforcealliance/forum/2\\_declaration\\_final.pdf](http://www.who.int/workforcealliance/forum/2_declaration_final.pdf) retrieved May 30, 2008.

<sup>51</sup> Listserve of the Health Workforce Advocacy Initiative which is the civil society-led network of the Global Health Workforce Alliance.

Some members feel that particularly the advocacy issues can still be strengthened. “I am yet to acknowledge the visibility of [the] TWG on advocacy,” said the Christian Health Association of Ghana. This is an example of the expectations raised by many within the TWG – it is not enough to collaborate and cooperate with one another; there must also be a very clear set of achievable priorities and objectives.

## 8.5 Conclusion

By forming the TWG the CHAs have strengthened a network of organisations with similar historical backgrounds facing similar issues. Together they are moving forward in developing recruitment and retention strategies by sharing information, learning from one another and advocating with one unified voice in the international arena on the implications HR issues have for FBOs, what this implies for service delivery and what additional support is needed.

Through the TWG, CHAs are able to share lessons learned from other CHAs, which, in its turn, avoids wasting time and resources in re-inventing what others may have already developed and tested. The future of the TWG depends on its ability to develop more efficient and effective ways of networking, communicating and coordinating and funding its activities.



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# 9

## Discussion and future directions

This chapter discusses the cases presented in the previous chapters within the context of the global health workforce crisis, and looks at common lessons learned. The HRH interventions applied by the selected FBOs are first compared with key approaches to address the health workforce crisis. Next, the process used for design, implementation, monitoring and evaluation of HRH interventions is analysed. At the end, the chapter returns to the “linking and learning experience” that is at the basis of this publication.

## 9.1 Results of HRH interventions used by FBOs

The human resources crisis for health is hitting FBOs in sub-Saharan Anglophone Africa particularly hard, and all face similar challenges. One reason FBOs are harder hit is because most of their facilities are located in remote, rural areas. These under-served areas tend to be less favoured as working and living place by health care providers. Moreover, FBOs may lose out in competition over scarce staff when they lack the financial resources to match salaries, allowances and other incentives that are offered in the public, NGO and private-for-profit sector.

FBOs run a large number of facilities, ranging from training schools, hospitals to community level health posts, and they are responsible for a considerable part of health care provision, particularly in underserved areas. It is not only important for FBO facilities but also the health sector at large that sustainable approaches are developed to address these human resource management challenges, and so that facilities can continue to operate normally and provide quality care. To keep their facilities running, FBOs have to identify creative ways of retaining and motivating their staff. These interventions need to address one or more of the following approaches for addressing HRH constraints:<sup>52</sup>

1. **Increasing the number** of health care providers by training more health workers in pre-service training, by task shifting and by enabling health care staff who are on pension to return or unemployed to work;
2. Improving **retention** of health workers by addressing reduction of recruitment of health workers by institutes in high-income countries and by developing, implementing and evaluating retention strategies in low-income countries;
3. Ensuring that **available workers are actually at work** and are **performing well** to provide quality of care.

Indeed, FBOs are very active in experimenting with different strategies. For this publication, we have purposively selected examples illustrating efforts to improve the HRH situation. The cases have been selected in line with Cordaid’s key HRH intervention levels (see table 1). All three intervention approaches (increasing the number of staff, their retention and performance) are addressed by three out of the six cases included here, but at different levels in the health system. NCHS-Ghana by implementing a comprehensive package at local service delivery level; UMU-Uganda by training health service managers for different levels in the health system and different management tasks, and TWG by enabling the sharing of experience amongst FBOs and joint advocacy. Two cases focus on the increase of staff through task shifting at local service delivery level (UCMB-Uganda), and lobbying for more resources at district and national level (CSSC-Tanzania). One case addresses improvement of management at facility level (CHAM-Malawi) to improve staff performance and service delivery.

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<sup>52</sup> This section is largely based on a document written for the WHO, which is describing published practices to improve retention and performance of health workers (Dieleman and Harnmeijer, 2006).

TABLE 1 DOCUMENTED CASE STUDIES IN RELATION TO CORDAID'S INTERVENTION AREAS

CASES STUDIES	Approach	Cordaid's intervention levels
Malawi-CHAM: Performance improvement of hospital managers and accountants	Improving management staff performance through different types of training, coaching and peer activities	<i>Local level:</i> Improvement of performance of health workers in rural areas, by direct support to pre-service training, in-service training, retention schemes, staff motivation, changes in skills mix
Uganda-UCMB: training pharmacy technicians	Increasing availability of pharmaceutical services through task shifting	Strengthening knowledge and skills of local health managers for implementing HRH policy and negotiation with other organisations and authorities on HRH policy and resource allocation
Ghana-NCHS: Comprehensive retention scheme	Integrated approach availability, retention and addressing performance	
Tanzania-CSSC: Information system on Health Services and Human Resources	Improved HR planning; Increased FBO staff availability through advocacy for more government support	<i>National/ regional level:</i> Strengthening of knowledge and skills of umbrella organisations to negotiate and discuss HRH policies with various stakeholders at different levels
Uganda-UMU: Master's training in health services management	Improved performance of faculty staff; more appropriate training programme resulting in better equipped managers	Strengthening capacity of training institutes (knowledge, skills and infrastructure) to improve training programmes and to relate these better to local needs.
TWG-international network for FBOs	Information exchange and peer support among CHAs	<i>International level:</i> Lobby/advocate with respect to HRH problems in rural areas and urban slums and exchange on knowledge and experiences regarding HRH interventions and policies

### 9.1.1 Increasing the number of health workers

The aim of strategies and guidelines developed at the global level to improve the number of health workers is to increase or improve pre-service training, introduce task-shifting and to recruit unemployed or retired workers.<sup>53</sup>

Most African countries currently lack sufficient schools and faculties, equipment and internship places to assure quality teaching. For instance, the whole of Africa has 66 medical schools whereas Europe and the Americas have respectively 412 and 441 (WHO, 2006). Many FBOs are involved in **pre-service training** to increase the number of mid-level and lower level cadres. They may have their own training institutes (UCMB in Uganda), and provide scholarships often with bonding (NCHS in Ghana). Increasing the number of health care providers by expanding pre-service training is an effective strategy, although it takes a number of years before the

<sup>53</sup> However, there is a dearth of published information on the results of these types of interventions (Gerretsen, forthcoming).

results are noticeable. For pre-service training improvements to be successful, good coordination and collaboration are required between the Ministry of Health, the Ministry of Education, the Ministry of Finance, private schools and professional associations in the field of health.

Additional to increasing teaching capacity (more schools and tutors), curriculum adaptations – both contents and teaching methods - are required in many countries to ensure that health workers are prepared better for their tasks. Good results have been obtained in high income countries with curriculum adaptation of pre-service training to rural health service delivery, and to have medical students practice in rural areas during their training (Veitch et al., 2006; Salafsky, 2005).

Attention also has to be paid to the preparation of rural students for pre-service training. They often lack sufficient qualifications to enrol in the programs of health training institutes, as was experienced by Cordaid partners in Malawi and Tanzania (van den Broek, 2009). In response to the lacking qualifications for English, some Cordaid partners in Malawi made sure that courses in English are provided, while also contacting the teachers of secondary schools on how best to assist their pupils in their preparations to enrol (ibid).

Another issue in need of attention is school fees. The experience of Cordaid partners in Tanzania has shown that fees may limit enrolment by rural students (ibid). The setting of fee levels and guidelines for subsidising students has to be done carefully to make sure that poorer students are not excluded.

Another approach to expand the number of health care providers is through **task-shifting**, which implies that some tasks are moved to less specialised health care providers (WHO, 2007)<sup>54</sup>. This type of cadre tends to be less scarce and more willing to work in rural and remote areas. Positive results have been obtained by training non-physician clinicians in diagnostic and clinical tasks that used to be part of the tasks of medical doctors (Mullan et al., 2007). Huicho et al. (2008) showed that health workers with shorter pre-service training provided the same or at times even better integrated management of childhood illness (IMCI) services compared to those with longer pre-service training. Zachariah et al. (2008) describe successful implementation of HIV and AIDS services by lower level cadres.

Several experiences in task shifting have been undertaken by FBOs in the past, although few have been documented. The case study presented by the Uganda Catholic Medical Bureau (UCMB) describes its efforts in improving pharmaceutical service delivery through task shifting. In the 1990s, a new cadre was introduced in the FBO system: the pharmacy assistant, for which a training programme was set up. However, this new cadre is still not recognised outside the FBO system.

Several important lessons can be learned from the UCMB case. New tasks for cadres need to be carefully planned and included in job descriptions, even when added to tasks of existing health professionals. As FBO facilities are more and more integrated into the national health system, new cadres need to be embedded into the existing job categories of the Ministry of Health. In this way, these new positions are incorporated into the existing salary structures and staff have

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54 [http://www.who.int/healthsystems/task\\_shifting\\_booklet.pdf](http://www.who.int/healthsystems/task_shifting_booklet.pdf).



opportunities for career development (promotion, in-service training, even mobility - see also WHO, 2007). Preparation and implementation of task shifting efforts therefore requires the involvement of other stakeholders, particularly the professional associations and the Ministry of Health, in addition to the churches.

The third way to expand the number of health workers in facilities and improve the distribution is the **use of retired or unemployed health care providers**. This may require negotiations with other ministries on adjustment of public sector budget ceilings and recruitment restrictions in order to allow the ministries of health to employ additional staff.

Over the years, FBOs have experienced a decline in donor funds and become more dependent on user fees. This decline in funding makes it difficult for FBOs to offer attractive remuneration and allowance schemes, and thus match working conditions and incentive packages offered by government and private institutions. This is leading to problems attracting new staff, high staff turnover and more work pressure on remaining employees. In response, FBOs are exploring extra funding opportunities from government and global initiatives<sup>55</sup> to hire staff, pay salaries or provide salary top-ups. The CSSC in Tanzania decided to invest in generate HR data in support of their lobby and advocacy for additional resource allocation by central and local government. CSSC has developed an information system that enables mapping of health workers' availability. These maps are used in discussions with government about the availability and distribution of cadres between health facilities and the need for more human resource allocations.

### 9.1.2 Retention

Improving health worker retention is a major goal in under-served areas and the focus of many FBOs interventions. Retention is influenced by a variety of individual and work-related factors. Financial motives are often not the only (or the main) reason why health workers decide to leave their jobs. Personal factors play a role too, such as living conditions (housing, electricity, infrastructure), opportunities for schooling for their children and the possibility to live the life style they aspire to. Work-related factors include management style, remuneration and career opportunities, working conditions, safety at work- particularly in areas with a high HIV-prevalence, and specific policies and practices that make postings in underserved areas more attractive. Preparation for work during pre-service education- such as internships in rural areas and inclusion of rural health in a curriculum- also plays an important role.

Factors influencing an individual's decision to leave are thus multiple, context-specific, change over time and are gender specific. These need to be identified prior to designing a strategy to improve retention. Lehmann et al. (2008) showed that often single strategies are used to address retention problems, whereas the underlying reasons why health care providers and managers accept and remain in a post have shown to be more complex. Comprehensive approaches (or "bundles of HR interventions") are likely to yield better results. Successful HRH interventions were multi-faceted. These addressed the preparation for rural practice during pre-service training, targeting people with a rural background for recruitment and providing professional and community support for rural health workers (Dieleman and Harnmeijer, 2006).

55 *Pepfar, GFTAM or the Bill Gates foundation.*

Interventions to improve retention thus need to address the range of influencing factors simultaneously. These could aim to:

- Improve HR and deployment policies, and develop specific policies for rural recruitment;
- Develop rural training and bonding schemes;
- Address job satisfaction by improving working conditions, HRM practices, offering financial and non-financial incentives, make possible professional development, include activities and regulations to mitigate the impact of HIV/AIDS at the workplace;
- Improve living conditions, for instance by providing housing;
- Address the needs of specific groups: allow flexible working hours for health service providers with young children or sick relatives; offer specific arrangements for HIV-positive health care providers.

The case study on Ghana presents a multi-faceted approach to staff retention. Following a baseline study, the NCHS in Ghana has developed a comprehensive retention plan and used an integrated approach for implementation, which addresses health worker availability, competence and productivity simultaneously by:

- Increasing availability of staff and services through pre-service training with bonding; on-the-job training by expats; offering an end-of-service package; improving allowances and salaries; and allocation of new staff by government through a Memorandum of Understanding with the Ministry of Health;
- Competence building of staff through in-service and post-graduate training for health workers, on-the-job-training by visiting professionals and training for managers;
- Productivity improvement by offering staff the possibility to rotate between church health facilities.

Retaining more staff contributes to building an institutional memory, which in turn is likely to positively influence productivity and responsiveness. Interventions aiming to retain staff in rural and remote areas are therefore important. Given that FBOs only have limited resources; financial incentives should be complemented with non-financial incentives such as housing, in-service training, appreciation by managers and rotation between facilities.

In areas with a high HIV prevalence, special attention needs to be paid to mainstreaming HIV/AIDS activities, such as infection control, training for dealing with HIV-positive patients and colleagues, and regulations assuring access to care and treatment of HIV-positive health care providers in workplace policies. When implemented appropriately, these can reduce stigma and discrimination of HIV-positive health care providers and fear for infection and enable HIV-positive health care providers to continue their work. Guidelines to deal with HIV/AIDS at the health workplace exist (ILO/WHO, 2005), and experiences are being gained with their implementation, including among Cordaid partners, but the results of these interventions have not yet been documented.

### **9.1.3 Improving health worker performance**

Quality of care is to a large extent determined by staff performance. This is a combination of health workers' competencies, their productivity and their responsiveness to patients' and the health system's needs. Competency, productivity and responsiveness are influenced by a number of interrelated factors, such as having appropriate knowledge, skills and attitudes, being present at work, working conditions, job satisfaction and motivation, and being accountable to management and clients.

Again, the various underlying factors for poor performance need to be identified first before designing appropriate strategies. They should be context-specific and could include:

- Addressing the living conditions of health workers in rural areas or the needs of specific groups, such as female health workers or workers in specific age groups.
- Activities at health facility level, such as specific quality assurance and performance-improvement interventions, based on local problem analysis;
- Changes in payment systems (for instance contracting-out of services), decentralisation of human resources management functions, community participation in health care management and strengthening accountability mechanisms;
- Development or improvement of human resources management activities, such as implementing performance-based incentives, conducting supportive supervision, providing in-service training and improving leadership and management.

The improvement of health facility management is important for staff performance, as has been highlighted by the case studies. Inadequate management has a negative influence on service performance and can damage health care providers' motivation and performance. UMU in Uganda, CHAM in Malawi and NCHS in Ghana all indicate that one of the main problems in the health sector is that managers of health care facilities often lack appropriate skills and knowledge. As the cases show, a major reason for this situation is that medical doctors or other health professionals often manage health facilities. Pre-service training of these professional health cadres tends not to include training in management competencies. There is thus an urgent need to create a critical mass of trained managers to assure that human resources are managed appropriately at different levels in the system. Training of managers should not only focus on management of resources, but also on policy and strategy development, lobbying and advocacy skills.

In-service training or continuing education is used mostly to improve performance of health care providers and managers. Experience elsewhere has shown, however, that in-service training itself does not guarantee improvement of performance, although it is important for updating knowledge and skills (Dieleman and Harnmeijer, 2006). Integrated approaches are likely to be more successful, which include developing procedures and tools and setting up peer support and supervision. The work of CHAM in Malawi around strengthening hospital management is an example of such a comprehensive approach. The CHAM focus is on improving the performance of hospital managers and accountants through institutional capacity building instead of just offering a one-off training course. The Financial and Material Management Improvement programme uses a combination of job aids, training, coaching and individual distant support (by e-mail and telephone exchange), peer support and supervision after training. They developed also manuals and procedures.

## 9.2 The process of developing and implementing HRH interventions

### 9.2.1 Selecting HRH interventions

Four out of the six interventions (NCHS in Ghana, CHAM in Malawi and UCMB and UMU in Uganda) have their roots in a study, set up to identify factors explaining health worker shortages and poor performance. The NCHS in Ghana interviewed staff to identify reasons for attrition and then addressed these staff concerns in their interventions. CHAM implemented a study among hospital staff prior to the development of their programme, whereas UCMB based

their programme on the results of an international study to assess pharmaceutical services in church health facilities and the outcome of a regional conference on this issue. UMU developed a Master's programme for health managers, based on an external evaluation of their existing Master's in Hospital Administration.

Interestingly, this way of working is not necessarily common practice. For instance, it was concluded that there is limited evidence of retention interventions being developed on the basis of results from a baseline study (Lehman et al., 2008). However, the use of proven success from elsewhere in the design of HRH interventions was not reported in any of the cases. Effective sharing of experiences across CHA and facilities seems not developed sufficiently, which is one reason why the TWG was set up.

### **9.2.2 Stakeholder involvement**

A crucial element of successful strategies is the involvement of all key stakeholders in the formulation and implementation of HRH interventions (Dussault and Franceschini, 2006). Stakeholders to be taken into consideration are civil society organisations and individual patients, professional associations, other health care organisations in the catchment area, local governments; different departments within the Ministry of Health, and various other ministries, such as the Ministries of Education, of Finance, of Public Service, and funding agencies. This complexity makes decision making a complex and often time-consuming process.

Generally, FBOs have to deal with an even wider range of stakeholders than public facilities. They also have to involve churches and their networks, and other faith-based funding agencies, each having their own requirements and interests. The organisations that presented these cases were all networks of facilities. Whether HRH interventions are implemented depends on the owners of the individual institutes – often churches and integrating the HRH interventions in the overall plans of the member-facilities. This makes alliance-building to support decision making in these facilities important.

All our cases show that a range of stakeholders have been involved at various stages in the process. The NCHS in Ghana asked their health care providers in a baseline study for reasons for staff attrition. CHAM in Malawi interviewed hospital managers for the baseline study, discussed the results with them, and involved hospital managers in the development of procedures and manuals. For UCMB, the pharmaceutical assistant cadre was developed in collaboration with FBOs outside Uganda and multilateral organisations, and was thus based on a broad international consultation process. However, the MoH and professional associations in Uganda were involved only to a limited extent.

In the case of UMU, both UCMB and the Ministry of Health were involved in curriculum design. In addition, staff members within MoH and health care managers conduct teaching sessions. CSSC developed the HRIS system in consultation with its partner-organisations within the CSSC network in Tanzania, in consultation with the MoH and with international partners. The international HR working group (TWG) was established during the first international meeting of Church Health Associations focussing on HRH. The leaders of different African FBOs were consulted about the interest and usefulness of an international working group.

A mapping and analysis of the interests and influence of stakeholders, and how they influenced (positively or negatively) the selection and implementation of the intervention is required.

This would help to produce a better understanding of which intervention would be acceptable for key stakeholders and therefore more likely to be feasible and sustainable. However, analysing the opinion of key stakeholders on the planned intervention and mapping their influence was not common practice among the participating FBOs. The FBOs did not sufficiently assess whether all key stakeholders were indeed consulted. The UCMB case, for example, demonstrates that regulatory bodies and the Ministry of Health were not facilitating the integration of the pharmaceutical assistant in the professional cadre of pharmaceutical personnel. This is in line with other findings and may affect institutionalisation of interventions and thus sustainability (Dussault and Franceschini, 2006). More attention for stakeholder analysis would help in developing strategies on how to better accommodate the different interests. As is suggested in the UCMB case, at times it is necessary to establish alliances with different stakeholders in order to achieve a successful HRH intervention.

The involvement of health workers in developing and implementing interventions is especially important for success. However, the group “health care providers” consists of various sub-groups with different needs (such as gender, different professional cadres, difference in age). Gender especially appeared to be a neglected issue in most cases. UMU looked at gender differences in participation in their training but seems not to have acted upon the information collected. No strategies were developed to increase enrolment of female health care providers in their courses. Some FBOs are working on making their Human Resource Management more gender-sensitive: for instance, Cordaid has promoted and supported the formulation of gender policies in CHAM (oral communication).

However, gender differences are prevalent in the workplace; gender and power relations are likely to play a role in decision-making regarding HRH issues, and it is important to gain more insight in the gender-dimension in HRH. For instance, there is a need for gender-disaggregated data in order to identify the division of labour between men and women at management level, among regions of the country, and across primary, secondary or tertiary level or in the provision of informal and formal health service provision. It is equally important to understand the difference in perceptions between female and male health care providers on location of work, motivational and discouraging factors, and required support. These insights will allow for the formulation of more gender-sensitive HRH interventions (George, 2007).

More attention also needs to be paid to the involvement of patients in interventions to improve performance of health workers. For instance, feedback from patients on the service given by health care providers can increase their responsiveness to patients’ needs, which can in turn improve motivation. Health care providers also have the obligation to provide quality services. Opportunities need be created to include communities in accountability mechanisms towards improving performance of social services in general and of health care providers and their managers in particular. Valuable experiences with accountability towards communities are gained in Mali (Lodenstein et al., 2007).

The extent to which HRH interventions can be implemented according to plan depends on the decision-making power of the organisation that developed the HRH intervention, and the influence of other stakeholders. The case studies highlight the importance of advocacy and lobbying to attract more recognition for the contribution of FBO to health services delivery, put HRH problems faced by FBOs on the agenda, and to assist FBOs to build strategic alliances for HRH solutions. Skills building among FBOs for advocacy and lobbying seems to deserve a high place on the agenda of action among FBOs.

### 9.2.3 Sustainability of the interventions

Three out of the six cases face problems regarding their sustainability. The improvement programme in Malawi depends on external funding, with donor funding not yet being secured and the Ministry of Health not yet actively engaged in providing financial support. In Uganda, the UCMB is not able to integrate the new cadre they created into the existing professional categories. The TWG does not seem to be a priority yet among the participating CHA in Africa.

FBOs have long-standing relationships with external funding agencies, which are often also faith-based. This relationship of trust can provide an opportunity to experiment with innovative approaches, as was shown in the case of CHAM with their financial improvement programme, and UMU, with the health care management training programme. This support provides the flexibility to test new ways of working. The challenge is to ensure sustainability of these interventions. This requires the alignment of FBO-initiated HRH interventions with HRH interventions of MoH and their integrating in the health system. Alignment of HRH interventions between FBOs and the MoH needs to be discussed for each intervention. Even when it is an emergency solution to an urgent problem, the risks of not aligning the intervention with the existing health system need to be analysed. Another issue is the availability of adequate financial resources for implementation (Dieleman and Harnmeijer, 2006). To avoid sudden depletion of funds, an estimation of required funding, technical support and possible commitments by partners is needed. Plans also need to be made also for future financing and capacity needs for sustaining implementation without external support.

Interventions must also be adapted to changing environments, such as in the workplace, technologies (how tasks will be implemented and who is able to do this), in the population where health workers do their work (e.g. ageing society, the AIDS epidemic), or global trends which influence the availability of resources (global health workforce crisis, the economic crisis).

Finally, achieving change requires not only sound problem analysis and a solid proposal for improving human resources management, but also thinking through the process required to arrive at lasting change. This preparation includes an analysis of the interests of each stakeholder, an identification of possible winners and losers, and an anticipating of institutional resistance. This change process may require facilitation, which includes awareness raising, the development of a joint vision, building real commitment, assuring the allocation of resources and identifying “change agents” who may be prepared to go the extra mile. It thus also requires an organisation and people that are prepared to drive a change process. This may be another area where it would be useful to share experiences and build skills among FBO management.

### 9.2.4 Monitoring and evaluation

The design of the HRH interventions discussed in this publication is based mostly on logical and pragmatic arguments to solve HRH problems, while assumptions about expected results were implicit. It is important, though, to make expected results of an HRH intervention explicit and describe these. The framework described in the second chapter might be of help. This will make it possible to develop an appropriate monitoring and evaluation system for HRH interventions, which helps to assess whether the results match expectations. Such knowledge can assist policy makers and planners in deciding on the up-scaling of interventions.

Our conclusion is that assumptions about the results were not made sufficiently explicit in our cases. Neither were monitoring and evaluation methods and indicators well defined. Consequently the FBOs have difficulties in assessing and documenting progress. Most organisations have the *impression* that their intervention worked but they cannot demonstrate clearly to what extent achievements of the various approaches are in line with expectations in terms of improving retention and motivation, availability, productivity, responsiveness and competency of health workers or managers.

A monitoring and evaluation (M&E) process is an important opportunity for learning about what works and what does not. The lack of solid M&E for HRH is a general constraint. Too often little evidence is available on what works and what does not (WHO, 2006). There is an urgent need among FBOs to build capacity on M&E for interventions addressing health workers and to exchange on tools, methods and indicators. These should form the basis of linking and learning at national and international levels. The first step for FBOs is to better monitor and evaluate progress of different HRH interventions, using indicators related to the expected results and other assumptions made from the beginning. This will require the use of qualitative and quantitative methods and appropriate record keeping at facility level.



### 9.3 Knowledge gaps

This publication shows that there is a strong need to gain more knowledge about experiences of designing HRH interventions and implementation, and the achievements and challenges. From the cases, the following knowledge gaps emerged for HRH research at country level:

- Explore differences in requirements of different sub-groups of health care providers and managers (different professional cadres, gender, age) to remain in underserved areas and to improve performance, in order to develop more appropriate HRH interventions;
- Compare and evaluate similar types of HRH interventions across different regions in-country or between different countries, test the underlying assumptions and identify the influence of context on the outcome.

Knowledge gaps related to specific HR interventions are:

- Assess results of packages of financial and non-financial incentives in terms of retention and improved productivity for different types of health care providers;
- Evaluate the effects of training programs (pre-service training and in-service) on health care provider performance;
- Assess the feasibility and ways for implementing task shifting schemes;
- Evaluate the impact of comprehensive Human Resource Management activities on health worker performance;
- Undertake policy analysis around key interventions, including analysis of stakeholder involvement and change processes to improve effectiveness of advocacy and implementation;
- Explore how civil society involvement can assist in improving HRH practices;
- Evaluate the outputs and outcome of HIV/AIDS mainstreaming in health workplace policies.

Suggested actions to be taken are to:

- Develop a decision making tool for FBO facilities on how to assess feasibility of possible interventions in their specific context;
- Organise skills building to design, implement and evaluate HRH interventions and on lobbying and advocacy for HRH;
- Enhance linking and learning efforts within and between organisations at national and international level and evaluate their results.

### 9.4 Linking and learning

This publication described and discussed some examples of the rich experiences that Cordaid's FBO partners have obtained with interventions to address health worker shortages, retention and performance. Experiences are being gained at facility level, at national level and at international level with integrated approaches or single intervention approaches.

The process used for developing this publication was an opportunity for linking and learning amongst FBOs and with Cordaid. Sharing this wide variety of experiences has allowed the writers of these cases to draw some valuable lessons learned and contributed to capacity building in HRH. Moreover, better sharing of experience may avoid wasting precious energy and time. By assisting FBOs to link, to share experience and to learn from their results, these organisations tap into the creativity and emerging practice of like-minded organisations.



Sharing of experience needs to go hand in hand with good analysis: what is the evidence that it has worked, and for whom, under what circumstances, and how sustainable is the intervention? Promoting this scrutiny is important; proposed interventions are more likely to be feasible and sustainable. But more work is needed on developing solid methods for such analysis. Equally, better use can be made of existing research and analysis on HRH issues, but these insights have to be more easily accessible to FBO-based decision makers. Improving HRH practice is not only about “evidence-based” decision making but also about thinking through the process to arrive at the needed change and keeping all stakeholders on board, such as the churches and the professional organisations, as well as developing constructive relationships with the ministries of health.

These processes of linking and learning are used in different ways: by partner organisations, to develop their policies, improve their programmes and to advocate and lobby for HRH. For both Cordaid and partners linking and learning activities enable greater quality of discussion and the development of joint advocacy activities at different levels. For Cordaid they allow the support of its partners with documentation, opportunities to exchange and when needed with technical assistance; and for the development of its own policies, planning, lobby and advocacy activities in the Netherlands. In this project the linking and learning experience focussed on the human resources for health crisis, but it can be used also for other common challenges faced by FBOs. We therefore invite our partners to continue developing and systemising ways for sharing experiences, to scrutinise, document, and disseminate good practice. In this way organisations will become stronger and continue to assist underserved groups of people with quality services.

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# Appendix

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## Glossary of acronyms and abbreviations used

AIDS	Acquired Immune Deficiency Syndrome
BAM	Business Administration and Management (Uganda)
CCT	Christian Council of Tanzania
CHA	Christian Health Association
CHAG	Christian Health Association of Ghana
CHAK	Christian Health Association of Kenya
CHALe	Christian Health Association of Lesotho
CHAM	Christian Health Association of Malawi
CMC	Christian Medical Commission
CSSC	Christian Social Services Commission
DDH	District Designated Hospital (Tanzania)
DMO	District Medical Officer (Tanzania)
ECM	Episcopal Conference of Malawi
EHP	Essential Health Package (Malawi)
EPI	Expanded Programme on Immunisation (Malawi)
FBO	Faith-based Organisation
FHS	Faculty of Health Sciences (Uganda Martyrs University)
FMIP	Financial Management Improvement Plan
GHS	Ghana Health Service
GIS	Geographic Information System
HF/HR-GIS	Health Facilities–Human Resources Geographic Information System
HMIS	Health Management Information System (Tanzania)
HR	Human Resources
HRH	Human Resources for Health
HRM	Human Resources Management
HSD	Health Sub-Districts (Uganda)
ICT	Information and Communication Technology
JLI	Joint Learning Initiative
KIT	Koninklijk Instituut voor de Tropen (Royal Tropical Institute, The Netherlands)
LMIC	Low- and Middle- Income Countries
MCC	Malawi Council of Churches
MDG	Millennium Development Goals
MoH	Ministry of Health
MoHSW	Ministry of Health and Social Welfare (Tanzania)
MoU	Memorandum of Understanding
Mtuha	Mfumo wa Taarifa za Uendeshaji wa Huduma za Afya (Tanzania)
MUIPH	Makerere University Institute of Public Health (Uganda)
NCHS	National Catholic Health Services (Ghana)
NHI	National Health Insurance Act (Ghana)
NHIS	National Health Insurance Scheme (Tanzania)
OPD	Outpatient Department Services
PA	Pharmaceutical Assistant
PAT	Pharmaceutical Assistant Training
PNFP	Private-Not-For-Profit (health providers)
RCC	Roman Catholic Church

TAG	Technical Advisory Group (Uganda)
TB	Tuberculosis
TEC	Tanzania Episcopal Conference
Tshs	Tanzanian Shilling
TWG	Technical Working Group on Human Resources for Health
UCMB	Uganda Catholic Medical Bureau
UMU	Uganda Martyrs University
UNICEF	United Nations Children's Fund
USD	United States Dollar
WCC	World Council of Churches
WHO	World Health Organization