HRH Action Workshop
Topic Working Groups
Participant Notes

Recruitment and Deployment

Definition: Examines the process of actively seeking participants to fill vacant positions using a variety of methods – internal job postings, advertising, using search firms – and mechanisms used to find and bring on those people in a timely, open, equitable and cost-efficient way.

What issues are we facing?

Malawi (FBO perspective):
The government has provided scholarships for college, and the students who accept these scholarships are then deployed to wherever the government chooses – often the students do not want to go where they are deployed and they make many excuses as to why they shouldn't have to go. If they are forced to go, they often choose to leave for private sector. Although a legal bond is signed, compliance is very low because there is no method to ensure that they follow through on their agreement.

The demand for health professionals is more than the supply. Because of this, it is very difficult to deploy—hospitals do not get the staff that they need.

There is no collaboration with the Ministry of Education, and as a result many pre-nursing/pre-medical students do not take the required classes in secondary school that are necessary to enter nursing/medical schools.

The supply is so low and the demand is so high that everyone who is trained is hired.

Lesotho (MOHSW perspective):
The government has introduced a policy to take nursing graduates and other allied health workers directly from school straight into the work environment, which is helping to increase the numbers of people working in the country. Other medical profession positions have been more difficult to fill, as doctors are not trained in Lesotho (there are no medical schools in Lesotho) and instead go to South Africa (SA) to receive training. After training, most doctors decide to stay in South Africa or go elsewhere, and do not return to Lesotho.

SA has a policy that if a doctor is trained in South Africa and wants to obtain a South African medical license, they have to stay at least one year in South Africa after school. After that year, many doctors are well situated in South Africa, well-paid, and not willing to return to Lesotho.

As a result, Lesotho has begun hiring doctors overseas, such as India.

Nurses who received their nursing training for free (on scholarship) in Lesotho are required to work in Lesotho for two-three years in return; however, many do not follow through on those

contracts and leave the country for higher paying jobs in other countries. There is a significant lack of infrastructure in the Lesotho government to follow up on and enforce these signed contracts.

The Public Service Commission (PSC) appoints all positions within the government, even those positions in other Ministries. These Ministries, including the Ministry of Health, do not have a choice of who they hire (they are allowed to sit a representative on the hiring panel, however). The PSC tends to only look at a person's qualifications when considering them for employment/deployment, but does not necessarily look at the needs of the employing Ministry.

Swaziland (MOH perspective):
While the Ministry of Health is represented in interviews for new employees, the Public Service Commission makes all final decisions. The process can take "ages."

Promotions can take 6-12 months to occur.

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

Rwanda (Capacity Project perspective):
HR reform is occurring at the national level with the creation of an HR database.

The country does not have enough professional health workers to recruit from. Many health workers were lost during the 1994 genocide. Many nursing schools that were developed after the genocide to address the nursing shortage were never officially credentialed. As a result, many Rwandan nurses who went to those schools cannot compete on the national/world level.

Beginning this past week, decentralization has happened to the government of Rwanda, with reallocation of the central government to the district level.

The government's recruitment and retention strategy is to maintain an essential and qualified workforce with increased salaries. Some incentive strategies are to reduce unnecessary staff and consequently increase the salaries of essential staff, as well as re-examine and re-shape career paths.

NGOs in Rwanda are not allowed to hire public sector doctors; they must hire ex-pats instead. NGOs are allowed to hire all other health workers, however. Thirty to forty percent of health workers in Rwanda are employed by NGOs, as encouraged by the MOH. This is working for now, but it is not a sustainable option.

Tanzania/Zanzibar:
The academic board approves all health training.

There is a tendency of the MOH to absorb all health professional graduates.

There is competition with the Ministry of Education, which offers professionals a teaching diploma after two years of school (nursing school is three years, medical school is four years), as well as higher salaries than those offered to health workers.

The MOH reports all health professional graduates to the Civil Service Commission, and then the CSC must give their approval for the hiring of the graduate.

Salary and working conditions in Zanzibar are not as good as on mainland Tanzania.

Tanzania:
In 1994, the government was told by the World Bank/IMF to freeze employment hiring…in 1997 a health sector reform allowed a partial waiver of the freeze, which continues today.

Salary schemes are being revamped throughout the country.

Strikes often happen in health clinics among professional health workers and general health workers.

Only 30% of health care positions in Tanzania are filled.

The nursing shortage has affected even the nursing schools, causing a decrease in the number of teachers available to lead the classes.

Zambia:
The process for Zambians becoming health professionals is very much like the process in Malawi.

For non-Zambians, however, the process is much more difficult. A non-Zambian hoping to fill a health position must be recommended to at least three different levels in the Ministry of Health before they can be hired. This process can take years. There is quite a lot of bureaucracy.

For Zambians employed in the public sector, delay and bureaucracy are also major problems. People often work for three to four years without a formal appointment by the Public Service Commission, unless someone is working on their behalf within the PSC.

Kenya:
The Public Service Commission hires all public sector health workers, but has delegated lower level professional recruitment to the Ministries (however, the PSC has the final say in who gets hired).

There is a larger supply of health workers than a demand for them.

Appointments are competitive; ads are placed in newspapers.

However, before recruiting can begin for a certain position, an embargo has to be lifted (due to the ongoing hiring freeze) and to do that you need to get the permission of the DPM, located in the President's office. This process can take an average of two to three months.

Advertisements are not always useful because Kenya is a big country and the mail is not very reliable, particularly when trying to advertise in a rural area. Kenya has not been decentralized – everything is done from Nairobi. When letters are being sent out to invite people for interviews, the mail can often get lost or misdirected. Therefore, the process can be a "bit long."

There are some rural areas in Kenya where health workers just refuse to work.

Although Kenya has said that there is a surplus of nurses, they have discovered that there is a mismatch between what the MOH demands of nurses and the actual skill sets of the nurses graduating from the schools. The nursing schools do not pay attention to the secondary school grades of their entrants, but the MOH does, and that can sometimes lead to people not being hired after graduating from nursing school as a result of not having met the secondary school grade requirements of the MOH.

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

There is a great deal of regional movement among the health worker cadres (particularly in Lesotho/Swaziland/South Africa). There needs to be increased recognition of that movement by the various countries affected.

MOHSW is not adapting their job categories and skill categories for those jobs that address the TB, HIV/AIDS and other emergent needs of the communities served. They are training for a work environment that is extinct, or at the very least is focused on US/UK health needs (i.e., geriatrics), not African needs.

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

Zambia:
Issues of deployment remain a problem. The government thinks the retention scheme should be rural-based – the MOH is slated to begin examining whether to give bonuses for working in rural areas. Other incentives for health workers to serve in rural areas include the installation of solar panels in homes, and the provision of motorbikes, bikes and other forms of transportation. Individual districts have also begun to come up with their own ways to motivate their staff, with salary increases, etc.

Now the MOH is considering extending this retention plan to ALL health workers, not just those with the highest education (i.e., doctors, bachelors-prepared nurses).

Rwanda (Capacity Project perspective):
There is a career ceiling in place – the lack of career paths stunts the growth of the health worker workforce.

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

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

What is working?

Malawi (FBO perspective):
Most nursing schools in Malawi are located in rural areas. There is a tutor incentive package to entice tutors to teach in these schools.

Many nurse tutors are female and married and husbands do not want to relocate to rural areas, so the training colleges now offer great incentives, like free housing and subsidized utilities being paid for each nurse tutor.

If doctors work in a Christian Health Association of Malawi (CHAM) hospital for two to three years, CHAM will pay for them to go back to school for a higher degree and/or for specialty training.

Kenya:
A forum has been designed where stakeholders (i.e., MOE, MOH) will come together to develop a standard of education and recruitment so that there is increased harmony and decreased miscommunication and surprises.

There is a planned collaboration between the universities and the public sector to monitor how long doctors spend going back to school (and consequently leave the health workforce) to receive specialization training (right now, there is no way to know how long a doctor will be back at school, receiving training for specialization).

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

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

Tanzania/Zanzibar:
The competition between the MOE and the MOH has begun to be addressed, and will hopefully be minimized.

An HRH plan is in place, and the MOH is looking forward to sending staff for training.

Rwanda (Capacity Project perspective):
In an effort to stop donor poaching, NGOs cannot hire doctors from the public sector – the government is following through on enforcement of these rules.

A detailed retention/recruitment strategy has been proposed to the MOH.

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

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

Malawi (FBO perspective):
The establishment of the Health Service Commission has been helpful, and has helped speed up the process of recruitment, employment and deployment.

South Africa (USAID perspective):
The government is considering hiring private firms to recruit and hire health workers instead of relying on the MOH to do all the recruitment/deployment, which would ultimately speed up the employment process.