Planning, Developing and Supporting the Health Workforce:

Human Resources for Health (HRH) Action Workshop

September 23-28, 2007
Accra, Ghana

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Planning, Developing & Supporting the Health Workforce

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Executive Summary

Overview

The Capacity Project helped to organize and facilitate a regional Human Resources for Health (HRH) Action Workshop in Accra, Ghana, September 23-28, 2007. Forty-one participants from 24 countries—Anglophone and Francophone—came together with the overall purpose of exchanging knowledge and best practices in planning, developing and supporting the health workforce in order to improve health workforce management capacity and strategic development at the country level. This was the second HRH Action Workshop, with the first one being held in South Africa in January 2006. Part of the Project's global partnering initiative, the workshop was a collaborative effort among the West African Health Organization, WHO/AFRO, the Global Health Workforce Alliance, the Capacity Project and USAID.

Workshop Description

The Action Workshop had four key objectives:

- Expand the HRH knowledge base by providing technical updates for HRH managers and practitioners, including the HRH Action Framework, latest lessons learned and promising practices
- Optimize the opportunity for south-south dialogue by creating the environment for participants to share knowledge about country-level HRH issues and their potential solutions
- Help develop a critical mass of HRH advocates (champions) and problem-solvers that will help accelerate the appropriate application of the HRH Action Framework, practices and tools in their respective countries
- Generate country-level HRH strategies for implementation of new or refined HRH practices and tools after the workshops.

The workshop included technical updates, discussions about key topics including task shifting, retention, HRH strategic plan issues and how vertical programs affect HRH, family planning (FP) and reproductive health (RH). The workshop also used the Africa Bureau-sponsored Promising Practices products to stimulate active discussions about possible replication or adaptation in other countries. Participants built networks with other HRH leaders in the region and created key strategic country-level action items that emerged from workshop deliberations.

I. Planning, Developing and Supporting the Health Workforce: HRH Action Workshop

Purpose

Facilitate the exchange of knowledge and best practices in planning, developing and supporting the health workforce in order to improve health workforce management capacity and strategic development at country level.

Objectives

- Expand the HRH knowledge base by providing technical updates for HRH managers and practitioners, including the HRH Action Framework, latest lessons learned and promising practices
- Optimize the opportunity for south-south dialogue by creating the environment for participants to share knowledge about country-level HRH issues and their potential solutions
- Help develop a critical mass of HRH advocates (champions) and problem-solvers that will help accelerate the appropriate application of the HRH Action Framework, practices and tools in their respective countries
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Agenda

Sunday, September 23
6-8 pm: Opening session and reception

Monday, September 24
Approximate time each day: 9-5pm

- Introduction
  - Opening remarks (workshop is collaborative effort involving WAHO, Capacity Project and USAID, the Global Health Workforce Alliance, and WHO/AFRO)
  - Background, objectives and agenda for the meeting
- Setting the context
  - The HRH crisis at the country level: What do we all see? Progress, challenges, obstacles, future areas of interest

- Strategic role of the HR unit: an analysis
  - Analyze strength of current HR function against 13 or 14 items; use analysis as foundation of HR unit strengthening, as well as role that this whole workshop can play in constructing a growing network of more knowledgeable and strategic HR colleagues

- Key HRH building blocks: Workforce planning, recruitment, hiring, deployment
  - Key HRH concepts, latest HRH developments: What do HR leaders need to know right now to lead an effective HR unit that is responsible for managing human resources in the health sector?

- Critical HRH topic working groups (Round one)
  - Topic-based working groups (e.g., workforce assessment and planning, recruitment, hiring and deployment, retention, task shifting—these are sample topics that may be changed or refined based on results of pre-workshop survey)

- Working group report highlights
  - Key points from working groups shared in plenary

Tuesday, September 25

- Implications of Monday's sessions
  - Discuss Monday implications for HRH in respective countries; includes discussion of possible strategic actions to consider on Friday

- Key HRH building blocks: managing for performance

- Key HRH concepts, latest HRH developments: What do HR leaders need to know right now to lead an effective HR unit that is responsible for managing human resources in the health sector?

- Key promising practice cases: presentations/discussion
  - Namibia: Private-sector recruitment of health care providers
  - Malawi: Recent findings from incentive and retention schemes

- Implications of today's sessions

Wednesday, September 26

- HRH challenges/contributions for FP/RH and HIV

    - How does HRH affect key vertical programs related to HIV and FP/RH; how can advances in HRH have a positive impact; how can we measure this impact; what ways can funding be leveraged?

- Critical HRH topic working groups (Round two)
    - Topic-based working groups (e.g., human resources strategic planning, productivity and performance management, managing absence)

- Working group report highlights
    - Key points from working groups shared in plenary
    - Discussion

- Special session: Sub-regional working groups

Thursday, September 27

- Implications of Wednesday's sessions

- Supporting HRH work at the field level: Observatories
    - Review and discuss the role that Observatories (and other stakeholder groups) play and can play in supporting HRH work at the field level

- Key promising practice cases
    - Ghana: task shifting through community health nurses
    - Uganda: lay health workers providing certain ART services

- Key HRH building blocks: Leadership and partnering for better outcomes
    - Key HRH concepts, latest HRH developments: What do HR leaders need to know right now to lead an effective HR unit that is responsible for managing human resources in the health sector?

- Critical HRH topic working groups (Round three)

Friday, September 28

- Discussion time for remaining HRH issues
    - Time allocated to place new or unplanned HRH issues that emerge from workshop discussions

- Supporting HRH work at the field level
    - Presentation and discussion on ways in which WAHO, WHO/AFRO, GHWA, Capacity Project and others that are supporting HRH work

- Developing a set of strategic actions
  - Building on "workshop implication" sessions during the week, think through and consolidate key strategic actions emerging from workshop deliberations;

- Reviewing progress/looking at next steps/workshop evaluation

II. Topics of Special Interest

Strengthening HR Units: A Strategic Priority for Effective Country-Level Actions

Professionalizing HR management (HRM) and strengthening HR units, especially in ministries of health, is becoming a priority in order to address most of the pressing HR challenges. For example, on one level, staff of the HR unit need to be competent at seeing the "big picture" and helping to provide HR advice and decisions at the strategic level. At another level, they can prove their professional credibility through careful attention to the day-to-day activities that seemingly go unnoticed. The HR unit's response time, quality and effectiveness of casual communication, fair and equitable rule enforcement and personal conduct contribute to employees' perceptions of HR's professionalism and trustworthiness.

At the workshop, the facilitators organized an extended multi-country group discussion on this topic. Many interesting ideas and strategies to strengthen HR units were generated. The following is a lightly edited summary of those group conversations:

- Develop HR policies and practices manual and orient all HR staff allocated to work in HR departments/units
- Professionalize HR functions at all levels by having adequate numbers of dedicated staff, with relevant sets of skills to carry out HR functions and duties
- Merge fragmented functions under one leader who will supervise and coordinate all units undertaking HR functions
- Introduce HRM-specific training programs in local colleges and universities (countries already offering HRM programs should market their course offerings so that neighboring countries can send their staff to pursue HRM programs [networking])
- Develop international HRM communities of practice or working groups that will address and provide evidence-based solutions to all issues of HRM including recruitment, finance, deployment, performance management and promotion

- Try to ensure that HR department/unit leaders are at a high level of Ministry of Health (MOH) management and involved in planning and decision-making; they should have authority and power to carry out HR functions
- Try to arrange for adequate resources for HR departments, so they can meaningfully undertake HR functions
- Involve HR planners directly in comprehensive ministerial planning for all HR decisions and programs
- Develop a reliable and comprehensive database on overall HR that can help the department undertake HR functions adequately (the HR information system will also help to provide the basis for evidence-based decision making in HR planning and management)
- Strategize all HR needs and functions in HR policy and demonstrate links with other health sector plans.

Other observations (with long-term implications for strengthening HR units)

1. Ironically, both Anglophone and Francophone countries represented at the workshop seemed to share a somewhat similar colonial history of HR, often characterized by centralized and fragmented structure and practice of public sector personnel management and the complicated challenges associated with that legacy. However, in most countries there is a process of evolutionary HR reform that is underway—as many governments are currently grappling with the search for a new synthesis of traditional and modern principles and techniques of HR management in the public sector. Examples that were cited include the public sector Rapid Results Initiative (RRI) in Kenya and Public Sector HR Reform Program in Senegal.
2. Any attempts to strengthen HR units within the MOH will depend on the pre-existing structure of public administration in a given country—for example, working to create fundamental changes in the HR department in MOH Uganda will need to be sanctioned and supported by the Ministry of Public Service and perhaps even the Public Service Commission. The same is true for Kenya, Malawi and most of the other countries. In all these contexts, the importance of political will and political feasibility of planned changes is particularly essential. In any event, a certain level of "strategic patience" will be required on the part of technical assistance providers, as it does take some time before you see positive changes in policy and practice.
3. The primary role of any HR unit is to create and sustain a sound system-wide approach to managing people and not paper or files—and managing people as a strategic resource requires skilled and professionally qualified HR managers with staff and budgets who utilize an integrated and holistic approach to results-oriented people management.
4. Interventions that aim to strengthen the role and functions of HR units could do well to begin from where the units are now, understanding their current needs

and developing and adjusting gradually to meet the requirements of the day rather than adopting a blueprint model drawn from an international "best practice." In some cases, a blended approach may be a more desirable route to take.

5. To succeed, an HR unit of the future must be a business-driven function with a thorough understanding of the MOH's big picture. It must be viewed as a strategic partner providing innovative solutions and influencing key HR decisions and policies. It also emerged that the HR unit cannot play this role effectively without regular access to quality HR data and analysis.

Large Vertical Program Discussion

It is clear that large, vertical "disease-focused" programs (HIV/AIDS, TB, malaria) can make a very important contribution to addressing serious health issues in many developing countries. At the same time, these programs can have a serious impact on the overall HRH situation in countries in which these systems are already fragile. The larger vertical programs may operate separately, they may solicit and organize their own corps of health workers or add new duties to already overburdened staff, their focus may overwhelm or "crowd out" less well-funded programs like FP/RH and maternal and child health (MCH), and so on. As the possibility exists that even more money will be directed to vertical programs in the future, this issue will even become more important. To determine the extent of this situation—at least as represented by participants who attended the Action Workshop—facilitators organized a focused discussion in which people were asked to address two questions:

- What is the impact of vertical programs on HRH systems in your country?
- How is this impact being addressed—or how could it be addressed?

What follows is a summary of the discussion points that emerged in plenary after the small groups had addressed the questions.

Impact and issues

There was a good deal of agreement about the following points:

- Large vertical programs do take more health workers out of the regular system. Because of the interest and extra benefits, the programs "tend to take our experts, our best staff."
- The large programs tend to create resentment because workers in such programs have a number of special benefits—they have some extra allowances

and incentives, as well as opportunities for additional training and travel. They also have better supplies and working conditions. They have so many opportunities that this tends to demoralize the "regular" workers.

- In addition, workers in large vertical programs don't work nights or weekends, so the remaining workers have to do double shifts and are called in more frequently on weekends.
- All of these diseases also have their own data collection systems (HIV/ART, malaria, PMTCT, etc.).

The result of all this is that the regular health system is overloaded and stressed, and the remaining health workers are overburdened. It also means that other important programs that used to have high priority no longer have the same influence or visibility. In fact, in regular health facilities, "we are largely attending to emergencies." Another participant said, "Unless someone is about to die, things [other programs and services] get lost."

Ideas to address the issues

However, despite the serious health-system problems caused by these vertical programs, they are clearly needed to address serious health issues. As one person said during the discussion, "We need the money, and people [donors] giving it need to be recognized." Given that reality, the following were ideas generated that might improve the HRH situation and allow the vertical programs to contribute to improved health outcomes in a more integrated manner.

- There was general agreement that it would be ideal if the large vertical programs were well integrated into the regular system. Then relevant people could meet with development partners and reach agreement on one plan and one budget, and develop one high-level reporting plan. However, participants also recognized that—in the case of some large vertical programs—there were special program-design and implementation needs as well as reporting requirements. So, maybe at the beginning of such a program, elements of it could be kept separate as they are now, but planning could be put in place from the beginning about integrating the program within the regular system in, say, three years.
- For things like data needs, indicators could be designed and used, and eventually aggregated into the regular system—but done in such a way so that data results could be disaggregated and shared with development partners as needed.

Virtual Networks and Follow-Up Discussion

After the HRH Action Workshop in Johannesburg in January 2006, the Capacity Project had a general collective commitment from all—staff and participants—that creating a virtual network would enable a substantive follow-up effort. To make this happen, Project staff tried several methods to establish this network and make it a meaningful way to share knowledge, stimulate south-south dialogue and ensure follow-up. Yet,

regardless of method, there was very little feedback from the "network." So Project staff took the opportunity of the workshop in Ghana to explore the *present viability* of using electronic means to provide follow-up support to workshop participants. People were asked to share their ideas about the challenges that existed in using computers and the Internet to support sustained learning.

E-networking and follow-up challenges

Participants cited the following as reasons that virtual follow-up and networking using computers do not work as well as everyone would like:

- Time pressure—there are so many things competing for our time. There are so many pressures and deadlines, and this makes it hard to find time to spend in our own office, so we would have a hard time sitting in front of our computers even if we do have connectivity.
- There are sporadic, slow or no office Internet connections, and we may or may not have connections at home. We then pursue some connectivity through Internet cafes, but this is not a place where we want to spend lots of time to browse, look through e-mails and send and receive documents. So, it is hard to answer e-mail in the office, and we may not have connectivity at home.
- When do get access to e-mail and the Internet, there is too much information coming in—we see it, we want to respond, but it is very difficult to come back to it. So it gets shelved, and we intend to come back to it…and we don't. Maybe we need more discipline here, so we need help to organize our time better.
- There is also an anthropological lens we should used to analyze the situation—English is not our native tongue, we are afraid we won't communicate adequately; we are people from face-to-face cultures, and we can't see people when using e-mail or checking documents. We give more priority to a real person who is in our office or down the hall, or to a meeting, than we do to electronic communication; "If we have a choice between turning to our computer or to a person, we will choose the person every time."

Overall, there was agreement that there is simply not yet a culture of using the computer as an everyday work tool.

Ideas: what might be done for effective follow-up?

Participants made the following suggestions:

- Could the Capacity Project country point persons and in-country staff follow up and help out, taking advantage of other meetings and opportunities at the country level?

- What about using mobile phones more? No matter what we are doing, we answer our mobile phones, or look for text messages. Could text messaging be used to broadcast things? This is now how we communicate, and whole families have mobile phones. We are experts at texting. Creativity is called for here as we consider how to use mobiles for follow-up.
- Do a quarterly newsletter: who is doing what, what issues are being addressed by which kind of interventions, what are the initial results. Include short, easy-to-read articles. Perhaps there could be a text message through the mobile phones announcing that the newsletter is coming.
- Arrange for "country buddies" in countries that are facing the same or similar issues. The example given is that Kenya and Ghana have much to learn from each other—would there be a way to facilitate this kind of communication?

III. The HR Scorecard: A Potential Promising Practice

It is now becoming increasingly evident that HR units or departments, where they exist, can be critical foundational agents necessary for creating and sustaining positive HR changes in the public health sector. But when one considers many of the ministries of health that work with development partners in several countries in Africa, a disturbing pattern emerges: weak and ineffective HR departments. Additionally, most senior health sector leaders do not view HR as a strategic partner or as an indispensable part of the organization. Even to a casual observer, disease-specific programs and their departments such as AIDS, malaria and TB tend to be well-resourced and enjoy some prominence. But in most places, HR tends to be either invisible or even neglected. In a way, these observations may reflect a combination of the skills and competence of HR unit staff as well as their perceived relevance by senior management.

The HR Scorecard is a simple and quick-to-administer tool that can be used with HR leaders and their colleagues in public, faith-based and private sector organizations to help them understand how they are performing on some fundamental HR functions. The tool can also serve as the basis for brainstorming, focusing discussions and even strategic planning about the areas in which organizations need to provide support to their workforce. As such, with further adaptations and continued successful application, the Scorecard can be viewed as a potential promising practice that requires very little preparation or instructions to administer and still generates extremely valuable findings and actions.

The analysis of the results of the Scorecard can also be beneficial at different levels:

- Encouraging dialogue around a topic that is ordinarily perceived to be difficult or complicated and enabling the group to reach agreement on priority areas. In other words, the group will need to decide which HR transactional weaknesses they will address and how. Some weaknesses are more serious than others and may need to be addressed first
- Facilitating creative solutions: addressing a weakness in one area may require an integrated response from other HR function areas, and if carefully planned and facilitated well, the discussions around the Scorecard can bring out these dependencies or linkages that may otherwise be difficult to see or untangle in normal conversations
- Discovering that some of the strategies (e.g., ensuring that every employee has an updated job description) required for making improvements are not necessarily costly. As such, the Scorecard provides an opportunity for HR managers to identify strategies that can be accomplished fairly quickly and with few resources
- Enabling the group to identify those areas that require improvement, but also likely to involve difficult decisions regarding the use of human and financial resources or even requiring the collaboration or approval of other government entities, especially in the case of the public sector.

Strengthening the Strategic Role and Operational Efficiency of HR Departments: Using an HR Scorecard to Rapidly Analyze Strengths and Weaknesses

Scorecard process

During the workshop, facilitators administered a simple survey with 14 short HR statements—HR Scorecard (see copy at the end of this section)—the analysis of which was used to set the stage and provide a logical link to the theme of the main HRH building block sessions covered in the workshop agenda. This activity also served as the foundation for all subsequent discussions on HR unit strengthening that took place at different points in the workshop.

The Scorecard statements ranged from descriptions of higher-level HR strategic vision and leadership factors—such as, "Our unit has a strong identity;" "We have a clear HR unit vision, and work together to achieve it"—to routine HR transactional or operational tasks—such as, "Vacant positions are advertised and filled on a timely basis;" "We handle written or phone queries from an employee in a responsive and caring manner."

The other practical and immediate purpose of this exercise was to help the participants to quickly examine the strategic and operational vitality of their HR department to single out areas of strengths as well as performance weaknesses. Initially, participants were asked to complete the survey individually—to read each statement, consider their thoughts and feelings about how their department is doing in each case and provide a score and any comments. Later, they were requested to work in pairs to review each statement and share their individual responses. They were also asked to summarize the three areas they both felt their HR unit exhibits the most strength, and three areas where it faces the most challenges.

Results and analysis

Results from the working pairs demonstrated that most HR units exhibited the most strength in the following areas covered by the statements in the Scorecard (listed in order of strength):

- We (our HR unit) know and understand the vision and mission of MOH
- HR plays a critical role in informing, advising and influencing senior management as well as communicating a strong point of view
- Our HR unit has a strong identity.

However, given what is known about the performance and effectiveness of most of the HR units of the countries represented at the workshop, the organizers were mildly surprised by these generally favorable perceptions and assessments of some of these HR strategic leadership factors. Later, the organizers thought that perhaps if they had provided an explanation of each of those statements in advance, they may have received somewhat different outcomes.

On the other hand, most of the participants reported that their HR units faced challenges in the following areas contained in the Scorecard. In other words, these statements scored lowest (and the items are listed beginning with the ones that scored lowest or in order of severity of challenge for most people):

- Departmental managers are held accountable for staff retention and development
- We have an effective performance management and support system in place
- Vacant positions are advertised and filled on a timely basis
- There are effective reward or recognition programs for employees.

In the end, all the completed survey forms were collected, results tallied, tabulated and shared back with the participants, and also used as a basis for discussion and reflections. Participants were also e-mailed blank copies of the Scorecard questionnaire so that they can share and use with their HR departmental colleagues in the future.

Other observations

1. With a bit more fine-tuning and realignment to fit specific contexts, the HR Scorecard can serve as a simple yet powerful diagnostic tool that can be administered rapidly to assess the current strategic and operational vitality of any HR unit. The results can be utilized to recalibrate an existing plan or develop a new one to strengthen the strategic and administrative capacities of these units.
2. Each of the statements in the exercise is essential in addressing contemporary challenges facing HR units in the public and FBO health sectors ("This is an extremely useful checklist," remarked a participant from Nigeria).

HR Scorecard

Instructions: Step One (10 minutes)

Please take time to complete the attached survey as an individual.

The purpose of this exercise is to help you to quickly examine the strategic and operational vitality of your HR department. Carefully consider each of the diagnostic statements below. Read each question, consider your thoughts and feelings about how your department is doing in each case and provide a score and any comments.

Instructions: Step Two (30 minutes)

- Form small groups of three people.
- Please appoint a secretary who will take notes and be prepared to report back highlights of your group's findings to the plenary.
- Please review each statement and share your individual responses.
- As you complete your group task, please summarize by choosing the **three** areas where the majority of you feel your HR unit exhibits the most **strength**, and **three** areas where it faces the most **challenges**.
- As a departmental group you decide to develop a team plan with strategies to address some of the performance weaknesses that you have identified.

HR in this survey refers to the HR Department/Unit (unless stated otherwise).

Survey questions/statements

Using the scale 1–5, please indicate the degree to which you agree or disagree with the following statements. Put a mark (X) in the appropriate box:

		1 Strongly Disagree	2 Disagree	3 Somewhat Agree	4 Agree	5 Strongly Agree	Comments
1.	Our HR unit has a strong identity.						
2.	We (our HR unit) know and understand the vision and mission of the MOH.						
3.	We have a clear HR unit vision, and work together to achieve it.						
4.	HR plays a critical role in informing, advising and influencing senior management as well as communicating a strong point of view.						
5.	The HR unit is a constant reliable information source.						
6.	We have a sound process for workforce planning and establishing staffing norms.						
7.	Current in-service training programs are effective in producing desirable results.						
8.	Departmental managers are held accountable for staff retention and development.						
9.	We have an effective performance management and support system in place.						
10.	Job descriptions and core competencies for all jobs are well defined and measurable.						
11.	There are effective reward or recognition programs for employees.						
12.	Vacant positions are advertised and filled on a timely basis.						
13.	We handle written or phone queries from an employee in a responsive and caring manner.						

		1 Strongly Disagree	2 Disagree	3 Somewhat Agree	4 Agree	5 Strongly Agree	Comments
14.	We have made investments in technology and HR information systems to plan and manage the workforce, and are using them well and monitoring results.						

HRH Action Workshop: strategic role of HR unit analysis

		1 Strongly Disagree	2 Disagree	3 Somewhat Agree	4 Agree	5 Strongly Agree	Blank	Average	Median	Median Count
1.	Our HR unit has a strong identity.	2	7	7	13	6	0	3.40	4.00	13.00
2.	We (our HR unit) know and understand the vision and mission of the MOH.	1	3	4	14	13	0	4.00	4.00	14.00
3.	We have a clear HR unit vision, and work together to achieve it.	4	6	9	9	6	1	3.21	3.00	9.00
4.	HR plays a critical role in informing, advising and influencing senior management as well as communicating a strong point of view.	0	6	12	10	5	2	3.42	3.00	12.00
5.	The HR unit is a constant reliable information source.	1	7	14	8	4	1	3.21	3.00	14.00
6.	We have a sound process for workforce planning and establishing staffing norms.	8	7	10	7	1	2	2.58	3.00	10.00
7.	Current in-service training programs are effective in producing desirable results.	4	10	14	4	2	1	2.71	3.00	14.00
8.	Departmental managers are held accountable for staff retention and development.	10	14	5	4	1	1	2.18	2.00	14.00

		1 Strongly Disagree	2 Disagree	3 Somewhat Agree	4 Agree	5 Strongly Agree	Blank	Average	Median	Median Count
9.	We have an effective performance management and support system in place.	3	8	13	6	5	0	3.06	3.00	13.00
10.	Job descriptions and core competencies for all jobs are well defined and measurable.	5	18	9	2	0	1	2.24	2.00	18.00
11.	There are effective reward or recognition programs for employees.	3	15	9	6	0	2	2.55	2.00	15.00
12.	Vacant positions are advertised and filled on a timely basis.	2	13	16	4	0	0	2.63	3.00	16.00
13.	We handle written or phone queries from an employee in a responsive and caring manner.	4	6	7	10	5	3	3.19	3.00	7.00
14.	We have made investments in technology and HR information systems to plan and manage the workforce, and are using them well and monitoring results.	4	8	14	7	1	1	2.79	3.00	14.00
Totals		**51**	**128**	**143**	**104**	**49**	**15**			

IV. Summary of Highlights from Working Groups

Just like in the first HRH Action Workshop (held in Johannesburg, January 2006), a dedicated participatory methodology was used to facilitate the accomplishment of the workshop agenda. At the beginning, as part of an introductory activity for setting the overall context for the workshop, participants were asked to work in small groups on the following three broad questions: what progress was being in their countries on HRH issues; what challenges they were still encountering; and what were some of the HRH topics or areas of interest that they would like to receive more attention in the future.

Outlined below is a bulleted general summary of the thoughts and ideas that the groups generated and reported on after working on the three questions. Actual reports from each of the groups are also listed.

Due to the complexities of the issues under discussion, differences in country-specific contexts and the fact that countries tend to differ in the way they prioritize their strategic actions, you will notice that progress may be reported in one area and the same issue may still appear under the lists of challenges (for example, the use or lack of HR research). This apparent discrepancy in responses to the same issue under discussion is completely understandable.

Key Points Summarized from Plenary Discussion

Progress

- Policies and strategic plans now mostly in place
- There is an increase in training
- There is more leadership and management training available
- "Caring for the carer"—there is greater awareness of the needs, and there are some improved conditions
- Some improved work on incentives to motivate—also, some progress on using incentives to attract people to hard-to-reach, rural areas
- HRH research—there is some increase in use of research to help (example was tracking movements of health workers, taking actions based on results of tracking)
- There is a relative increase in the workforce compared to two or three years ago

- There are more development partners willing to work on HRH issues in countries
- HRH supervision systems now are in place or are being developed
- There is an increase and improvement in public-private partnerships
- More indicators are being developed.

Challenges

- There is a high dependence on donors
- High attrition rates
- Retention is still a problem
- There is still a shortage of staff
- The purpose and position of the HR unit is not always clear
- Low productivity and poor performance is a key problem
- The future of staff hired to work in specific programs (such as ART) is unclear
- Health workers can get caught between different authorities at the central and local levels
- There is now a shift in workers who are leaving the private sector for the government sector, given that in certain countries government has raised compensation and benefits
- In some countries, there has not been sufficient attention paid to HRH research.

Areas of future HRH interest

- Staff retention, especially to get people to go to rural areas
- Increasing compensation does not necessarily lead to improved performance (why? what does?)
- Focus more on leadership and management development in the future
- Make sure there is sufficient training of HR managers—it is not enough to train health workers. We need more well-trained and professional HR managers
- Address the professional risks that health workers face; take better care of workers (safety, etc.)
- We have decentralization, but HR management has not necessarily changed to address this issue
- Pay more attention to task shifting—especially at the middle level—to assure the right skill mix

- What can African countries do to help each other?
- What is our position on migration? Do we accommodate migration from neighboring countries?

Notes from Working Group Discussions

Group 1

Botswana, Burkina Faso, DR Congo, Ghana (FBO), Rwanda, Swaziland, Tanzania (FBO), WHO

What do you see as HRH progress at country level where you work?

- *Rwanda*: 2 years HRH policy, HRH strategic plan. Expanded training of doctors and nurses. Training of HRH professionals, HRH information system being developed
- *Swaziland*: HRH information system in place, review of organization structure (developed earlier)
- *Tanzania* [CSSC]: HRH strategic plan and policies, service agreement, HRH wellness center, special salary (2006). Government recognizes role of FBOs in healthcare
- *Botswana*: HRH strategic plan, HRH policy in development (draft in place), review of structure at the district level, caring for health workers initiative
- *Burkina Faso*: Planning on recruitment, facilities (HRH planning)
- *DR Congo*: Special salary scheme
- *WHO/AFRO*: Many countries are developing HRH policies/strategies, many countries to recruit, agenda for HRH is very light from Ministerial down to all levels
- *Ghana*: strong collaboration with FBO (CHAG).

Obstacles/challenges

- *Rwanda*: Policy level—group/understaffing, high staff turnover
- *Swaziland*: Training and development
- *Tanzania*: FBO and government
- *Botswana*: Training is not available except for nurses moving to rural areas
- *Burkina Faso*: Retention of specialists in rural areas
- *DR Congo*: Salary is too low, thus workers are going to NGOs, distribution of specialists (urban vs. rural), LA vs. Central Government employment dilemma
- *WHO/AFRO*: Coexistence is a challenge—authority and power issues between Las and MOHs, structures are not changing to met the changes

- *Ghana*: Funding—incentive package is very high, however low, equitable distribution of staff, reference contract.

HRH interests needing attention

- Education, basic and post
- Wellness programs for health workers
- Decentralization of management of health workers
- Improving working conditions
- Skill unit at mid level
- Public-private partnership
- Inter-country partnership and sharing of knowledge, tools and other resources.

Group 2

What do you see as HRH progress at country level where you work?

- HR Policies, strategic plans, training of staff, development of information systems (public and private)
- Improved coordination, contractual employment to get people to rural areas
- Development of workload indicators, development of job descriptions

Obstacles/challenges

- Shortage of staff, misdistribution, poor retention
- Low training of output of HRH
- Future of staff employed for special projects uncertain
- Insufficient staff for ART programs
- Poor HR information management systems

HRH interests needing attention

- Staff retention/attraction particularly to rural and remote areas
- Finances
- Capacity building of HRH (bridging the skills gap)
- Research to build evidence for HR policy and advocacy
- Strengthening public-private partnership

Group 3

Benin, Ethiopia, Guinea Bissau, Malawi, Togo

What do you see as HRH progress at country level where you work?

- *Malawi*: Progress good since 2000; Health sector wide approach, government essential health care package includes HR development component, training more workers in government and FBO schools; Retention: incentives for tutors and workers, salary top-ups (52%), working on incentives to staff hard to reach areas
- *Benin*: Strategic plan for HR Development; how to operationalize the plan
- *Togo*: Production—addressing with help from the French, in 1992 GTZ began contracting work; now taken over by the French
- *Ethiopia*: Government is giving priority to HR management, there are seven core processes for re-engineering the public sector and HRM is no. 1; Situational analysis done—redesign underway; action begun in training with a focus on mid-level task shifting of 3,000 health officers; Incentives: salaries raised by 70-75% for health professionals, but still not competitive with private sector, NGOs, and other countries; nonfinancial incentives
- *Guinea Bissau*: 5-year government plan developed, looking at production, simple cadres and specialists are focus

Obstacles/challenges

- *Benin*: Shortage of specialized staff, no doctors in rural areas
- *Togo*: Out-migration, salaries—scheme to improve is underway, hard-to-reach areas underserved
- *Ethiopia*: Shortage/retention, out-migration
- *Guinea-Bissau*: Wide salary scale, out-migration, poor motivation, maldistribution

HRH interests needing attention

- *Malawi*: protecting workers from HIV
- *Benin*: Motivation, retention, shortage of workers—study done, task shifting approach is suggested, need to determine how to address these issues annually

Group 4

Sierra Leone, Namibia, Liberia, Gambia

What do you see as HRH progress at country level where you work?

- *Sierra Leone*: Relative increase in number of workforce (1993 had 207 doctors, 66 in 2003, and 112 in 2007; 30% moving to "green pastures," 19 doctors returned to the country); significant increase of allowances given to people going to hard/remote areas; training was only funded by government, but now a number of partners have joined hands to train (UNICEF, World Bank, ADB)—each partner assigned areas of professionals to train; training schools moved to primary education hence increasing numbers of each intake
- *Namibia*: Increasing health workforce (doctors); no training schools, so students sent to South Africa to train; training sub-professionals; nurses trained in Namibia University (more than 2,000); a pre-medical training program introduced; no brain-drain but benefitting from "brain gain" from other African countries; good working environment (good salaries, accommodation, allowances, retaining strategy, study loans and contracts); additional contribution of development work of government (partners in education and training working together, so more students can be recruited)
- *Liberia*: Set aside $1k in extra monthly pay for every doctor who accepts to work in hard-to-reach areas; 5,000 volunteers in place
- *CSSC*: FBOs integration into national HR planning
- *Gambia*: Increased training of nurses from 40 to 80 per year; convinced the government that a pediatric hospital needed to be built for training; hardship allowances—the more remote the location accepted the higher the allowance; got external expat doctors from foreign countries; donor-supported training, especially WTTO; developed HRIS

Obstacles/Challenges

- *Liberia*: Doctors are moving out of the government system to NGOs and outside the country
- *Gambia*: Financial problems, inadequate workforce data

HRH interests needing attention

- *Gambia*: Important areas of priority: Have HRIS in place, build capacity/strengthen capacity of HRM, good remunerations and incentives, research on HRM issues

V. Summary of Impact of Johannesburg Action Workshop on HRH Work in Five Countries

The Capacity Project interviewed the five participants at the Ghana workshop (representing Kenya, Namibia, Rwanda, Swaziland and Uganda) who had also attended the Johannesburg HRH Action Workshop to determine how the first workshop influenced subsequent HRH work in their countries. All five participants, who had since attended other national and international

HRH-related meetings, spoke very highly of the Johannesburg workshop. Respondents agreed that the most important component was learning from the experiences of their colleagues in tackling pressing HRH issues, and in this regard the workshop was seen as uniquely designed and effective. According to participants, the format elicited country-specific stories and encouraged networking, and the open atmosphere made it easy to share and learn lessons.

Having members of country teams together working on common issues was also cited by all respondents as very useful. Opportunities to come together in-country are rare, and the workshop helped build a common vision across diverse players and advanced progress on HRH issues when participants returned home. All five respondents reported that the participation of the Capacity Project country director significantly enhanced progress on common HRH efforts.

The actual purpose to which lessons learned were applied in-country varied widely. One way to trace this application was by examining progress on the action plans created in Johannesburg. Representatives from each country created country action plans for two priority HRH areas, including a total of 67 activities (averaging 6.7 activities per action plan). In the year and a half since the workshop, respondents reported that 60% of those activities had been completed, 33% were ongoing and 6% had not yet begun (the status of one activity was unknown). Progress on proposed activities was highest in Kenya and Uganda (86% completed).

Another indication of how countries applied lessons learned from Johannesburg is in respondents' descriptions of the type of in-country HRH activities that were impacted. For example, in Tanzania (attendees were interviewed outside of the Ghana workshop) participants used the action plan they created to write a Global Fund to Fight AIDS, TB and Malaria (GFATM) proposal for an emergency hiring plan, which was subsequently funded. In Uganda, the HRH Action Workshop itself was replicated at both the national and district level. The Uganda national workshop had the intended consequence of convening high-level country players to develop an HRH national agenda and prioritize HRH issues, and the workshop proceedings continue to lead the development of the nation's HRH strategic plan. According to the respondent, at the district level the workshop raised district planners' awareness of current HRH issues and allowed them to develop district-specific action plans for local implementation.

All five respondents expressed that their own networks for solving HRH problems had been expanded by attending the Johannesburg workshop. For example, after having heard of Zambia's HRH strategic plan, officials in Uganda contacted attendees from Zambia to obtain a copy for reference in creating Uganda's own HRH strategic plan.

Annex A:
HRH Topic Working Groups: Participant Notes

At the workshop, HRH leaders from 27 countries in East, West and Southern Africa had the opportunity to form small working groups to address HRH issues related to several "hot button" topics. Some of these topics were considered and determined through a pre-workshop survey questionnaire while a few others emerged as topics of special interest during the course of the workshop and participants were asked to discuss them in small groups.

In this section, their work is presented largely as it developed in order to retain the language, thoughts and contributions of individual participants. The contents have only been lightly copyedited and formatted.

Critical HRH Topics Working Group: Tuesday Session

1. HRH strategic planning

Countries: Benin, Ghana, Guinea, Guinea Bissau, Niger, Nigeria, Senegal, Swaziland, Tanzania, Togo

What issues are facing us around this topic?

Summary of countries' progress on strategic planning: Ghana is creating its second plan. Several countries are about to implement their plans. Several others were working on their plans.

- Confusion about clear definitions of strategic plan as against operational plan. Not enough strategic thinking
- Lack of importance and priority for development of HR strategic plan
- Inadequate and ineffective HRH information systems. But this should not stop development of HR strategic plan
- Shortage of HRH and leadership skills for planning, implementation
- Insufficient funding for creating and implementing plans. Insufficient political and financial resources
- Lack of implementation coordination between HRH divisions and other relevant departments of government. High-level group coordination can solve this problem
- Ineffective monitoring, supervision related to evaluation of HR plan implementation.

2. Task shifting

Countries included: Botswana, Ethiopia, Kenya, Swaziland, Uganda

Issues around this topic

- Resistance from professional associations and councils and providers
- Tasks shifted without job descriptions, incentives of risk allowance, without policies and procedures to support the shifting of tasks
- Lack of complementary training to prepare for task shifting
- Lack of supportive supervision
- Who regulates the health workers? Some cadres don't fall under any council, not even under any association

Issues to address and what seems to be working

- Centralized council: Ethiopia to use a centralized council to regulate all health workers; includes participation from all cadres, enhances cooperation
- Advocacy with associations and councils to see reason for task shifting that is beneficial to community health and well being, looking at the broader picture
- Open career opportunity where even the lower cadres can progress to any level as long as they have the capacity (e.g., H.O get Ph.D.)

What is working and not working?

- What works: strategic planning at government level is now taking place. Informal implementation of task shifting is already taking place in most places
- Future attention: creation of association for the health workers who currently don't belong to any association or council

3. Retention and recruitment

Countries represented: Burkina Faso, Gambia, Ivory Coast, Kenya (FBO), Liberia, Malawi (FBO), Namibia, Tanzania (FBO), Senegal, Sierra Leone, Uganda (FBO)

What are the issues around this topic?

- Urban-rural imbalances
- Hard-to-reach areas
- Political instability
- Lack of career path
- Unfair transfers and promotions

- Distortions of the existing system of recruitment
- Competition among employing bodies
- Inadequate political will to change what's not working.

What we are doing that is working

- Different types of monetary incentives
- Strengthening of public private partnerships
- Promotion, transfer and positive processes to ensure fairness and transparency
- Employee wellness centers
- Review scholarship schemes
- Working and living conditions in rural areas improved
- Rewards for best performances (motorbikes, TV sets, etc)
- Some scholarships programs

Not working

- Monetary incentives seen not to be working
- Facility conditions and working conditions are not improved
- Existing bonding schemes are not working in most of countries, and in most cases the policy is not enforced

4. HRM

Countries represented: DRC, Liberia, Kenya, Malawi, Mali, Nigeria, Rwanda, Tanzania

What are the issues around this topic?

- HRM under public service (Uganda, Rwanda, Kenya, Malawi, Mali, DRC): weak development and not placed strategically, so low status. Nigeria is different: the state health boards have hiring power and the assistant director of HR is fairly influential
- HR functions fragmented in different departments and ministries
- Status of HRD is not senior enough and preoccupied with routine administrative functions (not strategically placed or oriented)
- HRM is not systemized and therefore funds are open to manipulation by individual preferences

- People management and practices: no HR handbooks
- Induction often not structured or done
- Career paths unstructured, haphazard (Malawi)
- HRIS is weak across the board, and not connected to HMIS
- Workplace policies, occupational safety is lacking in most countries

What is working?

- Career path, attempts to develop CPD (Rwanda, Kenya, ECSA countries, DRC, Nigeria)
- HRIS in progress in a number of countries (Kenya, Rwanda, Tanzania, Liberia, Nigeria)
- Attempt to upgrade HRM (Uganda, Kenya, Mali, Liberia), placement is still a challenge
- Professional HRH systems under development (Uganda, Liberia, Nigeria, Tanzania)
- HR public service reform in Kenya, MOH selected as a pilot for citizen-centered service delivery

What needs more attention?

- Plans and policies, including management of performance
- Position more strategically and professionalize HRD people and units
- Capacity for HR funding still needs to be strengthened; there needs to be attempt in each country to do so swiftly
- Broaden scope of HRM beyond personnel administration
- Any help that can be given by WHO and Capacity Project

FBOs

- Integration into sector-wide work is a challenge
- Private sector: what are they doing with our health workers?

Critical HRH Topics Working Group: Thursday Session

I. Strategies to strengthen HR units

1. Develop HR policies and practices manual and orient all HR staff working in HR departments/units.

2. Professionalize HR functions at all levels by having adequate numbers of dedicated staff, with relevant sets of skills, to carry out HR functions and duties.
3. Merge fragmented functions under one leader who will supervise and coordinate all units undertaking HR functions.
4. Introduce HRM-specific training programs in universities. Countries already offering HRM programs should market networking so that neighboring countries can send their staff to pursue HRM programs (networking).
5. Develop international communities of practice or working groups that will address all issues of HRM including recruitment, finance, and promotion.
6. HR department/unit leaders should be at a high level of MOH management and involved in planning and decision-making, with the authority and power to carry out HR functions.
7. HR departments should have adequate resources to adequately undertake HR functions.
8. HR planners should be involved in comprehensive central-level (ministerial) HR planning.
9. Develop a reliable and comprehensive database on overall HR that can help the department undertake HR functions adequately. This will also help to provide evidence-based decision-making in HR planning and management.
10. Strategize all HR needs and functions in HR policy.

2. Implementation of HR plans (including M&E)

Participants: Ethiopia, Ghana, Malawi, Nigeria, Tanzania, UK, WAHO

1. Challenge that can be traced to the Plan Development Stage
    - Overambitious plans that are underfinanced
    - Insufficient stakeholder involvement resulting in lack of ownership when it gets to the implementation phase
    - Poor coordination and integration of related policies and plans at all levels
    - Weak risk analysis
2. Challenge: Implementation Stage
    - Plans that are not widely shared and understood
    - Lack of monitoring, evaluation and accountability
    - Lack of political will to achieve goals and results of plan

3. Financial and nonfinancial incentives

The group spent some time trying to differentiate between benefits and incentives.

Benefits:

- The rights that you get from your employer (package)
- Attached to a person for filling a certain post.

It is important that the benefits are clearly stated so that the employee knows his/her benefits.

Incentives:

- Something additional to motivate you to do more (e.g. work hours)
- A privilege, not an entitlement
- Attached to a place (e.g., hard-to-reach areas)
- Attached to an employee's performance.

Incentives need to be properly managed and monitored to determine best when to continue them, when to withdraw them and to make sure they don't continue after the person has left a particular position. The different countries have different incentives including training, promotions and allowance top-ups.

Real world example

Uganda FBO: Do the incentives work or not?

Yes. The FBO was running a facility in one of the hard-to-reach areas. They provide new staff with accommodation, send them for training overseas, set-up "borehole" [well?] in places where there is no H_2O, given 10 days per month to go home, provide transport to do shopping in town. This meant that staff could be attracted and would stay, and these are not exceedingly expensive things to do. The point was brought up as to why government could not do something similar.

4. Strengthening performance management

1. There was general agreement that performance management is essential and important.
2. There must be a system to make sure that employees' important questions are answered: is an employed treated fairly, do employees know what they are supposed to do, does an employee have means to know if he or she is doing it well, does anyone actually cares and do they have a future in the organization?

3. Staff should appreciate and know contributions to a common goal, objectives, targets and indicators set together with supervisor.
4. Enabling environment: structure, culture, tools, training, benefits and compensation, etc.
5. The process of performance management should be institutionalized with means of giving evidence-based scoring and feedback.
6. Performance management should focus on people instead of trying excessively to manage systems with their bureaucracy—although bureaucracies will always be there.
7. Performance management can be made more difficult by political interference and patronage with specially appointed people paying homage to particular people, so we need to learn how to achieve even in such circumstances.

Annex B:
List of Participants

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Mr. Christopher Beyere
Mr. Philibert Kankye, Executive Secretary, Christian Health Association of Ghana (CHAG)
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The Capacity Project is an innovative global initiative funded by the United States Agency for International Development (USAID). The Capacity Project applies proven and promising approaches to improve the quality and use of priority health care services in developing countries by:

- Improving workforce planning and leadership
- Developing better education and training programs for the workforce
- Strengthening systems to support workforce performance.

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