

CHAPTER 9 HUMAN RESOURCES MODULE

9.1 Overview

9.1.1 Chapter Outline

This chapter presents the Human Resources module of the assessment. Section 9.1 defines Human Resources and its key components. Section 9.2 provides guidelines on preparing a profile of Human Resources for the country of interest. Section 9.3 presents the indicator-based assessment, including detailed descriptions of the indicators. Section 9.4 details the process for summarizing findings and developing recommendations, based on the analyses and data-gathering activities in this assessment.

Information for this assessment was based in part on the resources for Human Resource Development (HRD) Assessment Instrument for Non-governmental Organizations (NGOs) and Public Sector Health Organizations (MSH 1998) developed by the Family Planning Management Development Unit of Management Sciences for Health (MSH).

9.1.2 What Is Human Resources?

The term *human resources* refers to the people who work in an organization. The World Health Organization (WHO) uses the phrase “human resources for health” to include public and private sector nurses, doctors, midwives, and pharmacists, as well as technicians and other paraprofessional personnel. It also includes untrained and informal sector health workers, such as practitioners of traditional medicine, community health workers, and volunteers.

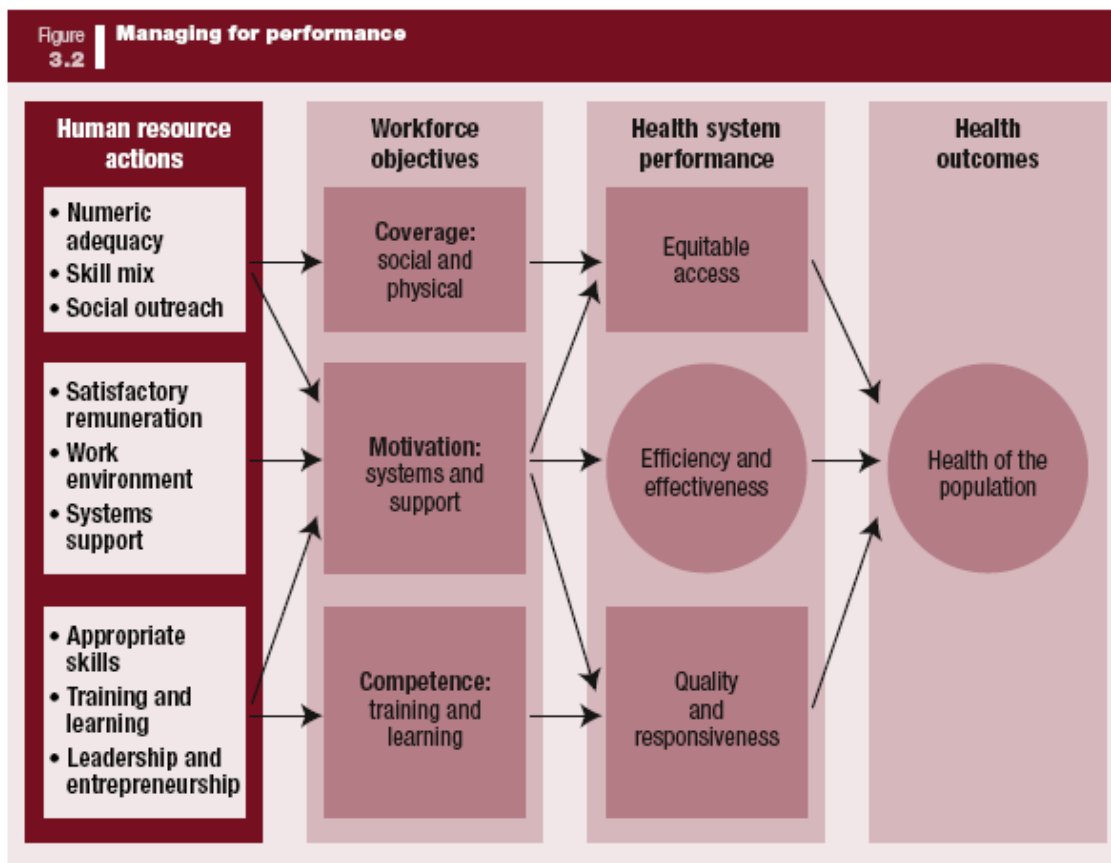
The *World Health Report 2006* (WHO 2006b) defines human resources (HR) for health, or the health workforce, as follows: “all people engaged in actions whose primary intent is to enhance health.” According to the WHO website, this includes “those who promote and preserve health as well as those who diagnose and treat disease. Also included are health management and support workers— those who help make the health system function but who do not provide health services directly.” (See also WHO 2006a.)

Regarding some of the aspects of HR for health that WHO considers to be more urgent, sub-Saharan Africa in particular has pressing issues including (1) the loss of staff due to death, burn-out, or emigration—some of these as a result of the HIV/AIDS epidemic, and (2) reduced productivity perhaps due to low motivation, poor environmental support, and lack of supervision (Dovlo 2005; WHO 2004). WHO recommends that Ministries of Health develop policies for their own HR that aim to protect health workers and focus on issues of HIV/AIDS awareness, protection from infection during their work, counseling and support, and provision of antiretroviral medications (ILO/WHO 2005; WHO n.d.). An example of a policy for protection of health workers in Tanzania is available online (United Republic of Tanzania 2001).

The Joint Learning Initiative on Human Resources for Health and Development has issued a strategy report, *Human Resources for Health: Overcoming the Crisis* (Joint Learning Initiative 2004). According to the report—

Strategic management should aim to achieve positive health outcomes from a better performing health system—and from more productive health workers. One way to consider performance and productivity is through the goals of equitable access, efficiency and effectiveness, and quality and responsiveness.... These performance parameters, in turn, are shaped by three core workforce objectives—coverage, motivation, and competence, each of them affected by workforce strategies. Coverage depends on numerically sufficient and appropriately skilled workers well distributed for physical and social access. Motivation is promoted by satisfactory remuneration, a positive work environment, and systems that support the worker. Competence requires education with an appropriate orientation and curriculum, continuing learning, and fostering innovation and leadership (Joint Learning Initiative 2004).

Figure 9.1 (Figure 3.2 in Joint Learning Initiative 2004) shows the interaction and effect of having the right number and distribution of competent, motivated, and well-supported health workers on the system performance and, ultimately, on the health outcomes of the population.



Source: Joint Learning Initiative (2004).

Figure 9.1 Managing for Performance

9.1.3 How Does HR Management Work?

HR management is an organizational function that effectively manages and uses the people who work in the organization. The HR function is important because it addresses an organization's or health system's need for a competent, stable workforce that meets its needs (i.e., having the right number of service providers with the right skills in the right locations at the right time). To retain a motivated, competent workforce, HR management must also address the needs of the workforce. The key functions of HR include recruitment, selection, performance appraisal and management, compensation, development, and other related activities such as benefits, employee relations, and labor relations.

In effective organizations, HR functions are carried out in a systematic manner using established, standardized processes by dedicated staff trained in HR management. In a large organization, the functions may be performed by many specialists; in a small one, by one or more generalists. Having standardized processes is a method of reducing unwanted variation to improve quality.

In a country where decentralization has taken place, important HR issues can emerge as a result of how the process of transferring power downward is handled (Kolehmainen-Aitken 1998). These issues include the following—

- HR data and how decentralization affects its adequacy and availability
- Transfer of HR functions and staff
- The impact of professional associations, unions, and registration bodies on HR management structures and jobs
- The morale and motivation of health workers

9.2 Developing a Profile of Human Resources

To gain an overview of the institutions and functions concerned with HR in the health sector, you will develop a profile of the HR component of the health system. The profile is an exercise to aid you, others in the assessment team, and stakeholders in conceptualizing the system.

You might choose to map the HR components of the sector using organizational charts and diagrams, or by adapting other tools that capture the HR structure and elements, including the following—

- HR policy and management units and HR functions at various levels within the Ministry of Health (MOH) and related organizations (e.g., municipal health services; professional associations; licensing councils; the private sector; schools of medicine and nursing; other ministries, such as Ministry of Labor; and trade unions)
- HR information systems and data flows

- Numbers and distribution of various categories of professionals in relation to norms and targets.

You might find the following approaches helpful.

- Obtain organizational charts of the MOH at central, regional, and district levels to ascertain where HR fits into the larger system.
- Study conceptual frameworks or analyses of HR in health if available. Review the MOH's HR establishment register or registries of health professionals.
- Prepare lists or tables that capture and synthesize key elements of the HR system, for example, categories, numbers, and distribution of health workers; levels of authority for key HR functions at various levels within the system.
- Seek existing reports or survey data with total estimates of HR including public and private sectors. Data from the World Bank, WHO, or a national statistics bureau may be useful, but use it with caution because it could be outdated or incomplete.
- Seek data from professional provider associations or other private sector entities for augmenting or cross-referencing.

9.2.1 Distribution of Personnel

Distribution of HR is important in determining access to health care. To have a more complete picture of HR, obtain the data or estimates needed to fill in the sample in Table 9.1 (you may need more personnel categories and the terminology may vary from country to country). Each cell should contain a discrete number. For example, obtain data that may be available from health provider surveys, United Nations agencies in country, the MOH, and associations of private providers to indicate the number of doctors, nurses, and other personnel that work in the public and the private sectors in both urban and rural areas. If data on the size and composition of the private health sector are lacking, identify this deficit as an opportunity for the U.S. Agency for International Development to support a survey of private providers.

Table 9.1 Country’s Human Resources (Sample Table)

Cadre	Public		Private		Totals
	Urban	Rural	Urban	Rural	
Doctors					
Nurses					
Midwives					
Traditional healer					
Other (e.g., laboratory technicians)					

9.2.2 Decentralization

In the public sector, HR may be a centralized function, with most decisions being made at the central level. In some countries, although policy is made at central level, most other functions are managed by a lower level; large municipalities often have their own HR structures. HR may be housed in the MOH, or in another ministry, such as the Ministry of Labor. In creating the profile, you should describe the relationship of the HR department to other departments, as well as the level of authority for hiring, firing, disciplining, promoting, and deploying workers (e.g., what level of authority can execute rewards and incentives or initiate disciplinary action to influence performance?).

9.3 Indicator-based Assessments

The indicators assessed in this module are organized in the two components described in Chapter 2. Component 1 has general human resource indicators, data for which can be obtained from the data file titled “Component 1 data” (available on the CD that accompanies this manual and discussed in Chapter 5.2) or from the internet if you do not have access to the CD. Component 2 combines a desk-based assessment and stakeholder interviews to collect information on additional human resource indicators. Stakeholder interviews should complement the information collected from a review of documents, as well as provide important information that may not be available through document review.

9.3.1 Topical Areas

The indicators in this module are grouped by the following topics—

- Component 1: Human Resources Data
- Component 2 topical areas—

- A. Planning
- B. Policies
- C. Performance Management
- D. Training and Education

9.3.2 Detailed Descriptions of Human Resources Indicators

Table 9.2 groups the indicators in this module by topic.

Table 9.2 Indicator Map—Human Resources

Component	Topical Area	Indicator Numbers
Component 1	Human Resources Data	1
Component 2	Planning	2–5
	Policies	6–12
	Performance Management	13–17
	Training and Education	18–20

9.3.2.1 Component 1

1. The ratio of five cadres of health care professionals to the population

Definition, rationale, and interpretation	<p>The ratio of doctors (physicians), nurses, midwives, pharmacists, and laboratory technicians, per 1,000 population</p> <p>This indicator is a necessary, but not a sufficient, measure of coverage. Adequate numbers of health care professionals and the appropriate distribution of those human resources are needed to ensure coverage.</p> <p>A low number can mean that a particular cadre does not have enough service providers. This indicator is useful for cross-country comparisons, for monitoring targets, and for comparing against international standards.</p>
Suggested data source	<p>WHO (2006b). <i>The World Health Report 2006</i>. <www.who.int> or most recent.</p> <p><i>Module links:</i> Core Module, section 5.3.4 (Structure of government and private health organizations); and Health Service Delivery, indicator 13 (ratio of health care professionals to population)</p>
Stakeholders to interview	<p>MOH central level HR or Ministry of Planning</p>
Issues to explore	<p>Examine the number of general or family practitioners (existing and/or new graduates produced) versus specialists, the migration of providers outside country (the so-called brain drain), and staffing in post-conflict settings.</p>

9.3.2.2 Component 2

A. Planning

2. The distribution of health care professionals in urban and rural areas

Definition, rationale, and interpretation	<p>Number of health personnel employed in urban areas, per 10,000 population; number of health personnel employed in rural areas, per 10,000 population</p> <p>This indicator is related to access to care. In general, urban areas may have more providers, leaving rural areas underserved. You will need to compare the distribution of personnel to the population distribution. If possible, look at the distribution by cadre, because doctors are often more likely than other cadres to be clustered in urban areas.</p> <p>In some countries, certain geographic areas are chronically underserved. When appropriate, be aware of other geographic distinctions such as states or provinces if they provide more information than the urban-rural split.</p>
Suggested data source	<p>MOH data, health provider surveys, United Nations agencies in country, the MOH, and associations of private providers</p>
Stakeholders to interview	<p>MOH central level HR or the Ministry of Planning</p>
Issues to explore	<p>In addition to the urban-rural distribution, look at numbers in hospitals versus other facilities if possible. Doctors tend to be clustered in hospitals. Also look at urban-rural distribution by state or province if certain regions pose more of an issue.</p>
Notes and caveats	<p>The split may be affected by MOH policies or incentives for newly formed providers to work in rural locations and by recent decentralization requiring local jurisdictions to recruit their own staff for health centers.</p>

3. HR data—Presence of human resources data system

Definition, rationale, and interpretation

Response: yes or no

This indicator measures the presence of an HR database in the country. (Some countries will have this database in a computerized system, which enables managers to use and share data more efficiently and effectively.)

Accessible, accurate, and timely data are essential for good planning, that is, appropriate allocation, promotion, training of staff, and tracking of personnel costs.

If this indicator is “no,” it will imply that planning is not optimal.

Suggested data source

For the public sector, central level HR, health information system. At the facility-level, HR department. These departments may be kept at more than one level (central, district, or local)

Module link: Health Information System Module, profile development (Chapter 11.2) may contain useful information on HR-specific systems

Stakeholders to interview

Central level HR or planning manager; district managers or managers within the institution (e.g., a hospital or other facility)

Issues to explore

Describe which of the above categories of data are collected systematically and whether the category is available and up to date. If data are present, are they used in planning? A good data system can exist without computers, but an electronic system is easier to search and share. Are any computers or data systems available? Maybe a country has computers but no resources to develop a data management system. Staff may not be trained to use them. Data files may be incomplete. If computerization is absent, how are records kept? At what level are data kept (national, district, or local)? Are the data available at relevant levels? Are they complete? Are they up-to-date? All these facets contribute to the overall quality of the data.

Although there is no standard minimal data set, useful information for planning should probably include a staff and record identifier; date of birth; sex; date of employment or affiliation; cadre, discipline, training, or profession; highest degree or education level; license or certification; post location; employment or affiliation status; hours typically scheduled each week within this organization; primary job function; languages other than official; participation in job-related or career-development training; income from the organization (actual or estimated income range for annual salary or reimbursement received from this organization, including overtime and bonuses, and excluding fringe benefits); fringe benefits value (include incentives for rural postings); separation date (for persons who reported HR data for a previous period or who joined or left the organization during the current reporting period); reasons for separation (e.g., attrition due to HIV/AIDS, retirement, emigration).

Other information that is important to HR may be kept in different division—for example, the number of unfilled posts.

3. HR data—Presence of human resources data system

Notes and caveats That the data exist is what is most important—can you see the data? Do a physical check by looking at the databases, if possible. Is someone managing it? Refer to the Health Information System Module (Chapter 11) for additional guidance.

In a decentralized system, the available information on HR at the central level may be more fragmented because records may come from multiple sources with different timetables for updating.

4. The existence of a functioning HR planning system

Definition, rationale, and interpretation Response: yes or no

This indicator looks for evidence of an HR plan or planning system and processes to address staff development and training, recruitment and retention policies, deployment, and staff evaluation and promotion processes.

The presence of HR planning indicates that staffing is linked to the needs of the organization.

Suggested data source For the public sector, central Level MOH

Stakeholders to interview HR staff at central level MOH

Issues to explore Review the plan. Is it based on the organizational mission or goals or staffing needs? Has it been implemented? To what extent was it used? Has it been evaluated for its effectiveness? Have professional associations, especially those that represent the private sector, been involved in developing the plan? Does it contain a staffing plan (look for job classifications, training needs)? Have long-range staffing and recruitment needs been forecast? Find out if the MOH has a written mission statement or goals. If so, are the goals linked formally to HR planning?

The country may have only an operational, or action, plan. Compare the plan with existing reports and targets; compare planned to actual. Are private sector health personnel included in national plans and targets?

Notes and caveats Although decentralized systems may still rely on national level recruitment for professionally trained providers, local jurisdictions may be responsible for hiring technical support (nurses, laboratory technicians, and pharmacies' staff).

5. HR dedicated budget	
Definition, rationale, and interpretation	<p>Response: yes or no.</p> <p>This indicator looks for the presence of a budget allocation for HR staff and related functions.</p> <p>Without a budget, HR activities cannot be assured.</p> <p>If a line item does not exist, you may find limited resources to fund HR positions or conduct HR activities—planning, training, performance planning, and monitoring.</p>
Suggested data source	<p>MOH—the level will differ between centralized and decentralized countries</p> <p><i>Module link:</i> Health Financing Module, indicator 13 (government health budget by cost category)</p>
Stakeholders to interview	<p>HR staff, MOH Planning and Budgeting Department</p>
Issues to explore	<p>Ideally, HR staff and related activities are permanent budget items, reviewed and adjusted annually. HR staff are necessary to carry out HR functions and activities. Note whether dedicated staff exist, which positions, and how many. The country may have no dedicated staff, or the staff may have only limited experience in the personnel field (recruitment, management) or have other functions to perform outside HR. There may be trained HR staff but only at a level to maintain basic procedures and record-keeping functions. The highest level would be to have experienced staff who maintain HR functions, participate in long-range planning, and are housed within the MOH.</p>
Notes and caveats	<p>The budget may vary from a one-year budget to a multiyear budget, depending on the funding cycle. Furthermore, in some countries the HR function may be situated in another ministry, such as Planning or Labor. When hiring, firing, staffing, and deployment are not inside the MOH, the country will probably have great difficulty getting the right service delivery staff with the right skills in the right place.</p>

B. Policies

6. Presence of job classification system

Definition, rationale, and interpretation

Response: yes or no

This indicator looks for a system of classifying jobs for all staff (i.e., a system of job evaluation by which jobs are classified and grouped according to a series of predetermined wage grades).

The purpose of a job classification system is to enable an organization to determine the overall worth and value of a job to that organization for the purpose of establishing a compensation system. The organization evaluates and groups its job descriptions in regard to the work to be done (for what purpose, with what methods and materials, and the required qualifications). Each job fits within a classification (e.g., medical officer, nurse) that describes duties, responsibilities, and qualifications.

The system allows organizations to standardize the jobs and types of skills required as well as salary ranges based on qualifications.

Suggested data source

Central level MOH, private hospitals, NGOs

Stakeholders to interview

HR staff at central level MOH

Issues to explore

Look for a formal classification system with job or position descriptions that contain title, qualifications, duties for various levels of staff (clinical, technical, and support staff). Qualification standards are used to set minimum requirements and guide pay grades. For example, the U.S. government personnel system has a classification called “Nurse Series.” This classification requires a minimum set of qualifications regarding education and registration. It is then further divided into pay grades depending on education or experience (those that exceed the minimum standard receive higher pay). The best case is one in which a country has a formal job classification system that is used also for other HR planning and staffing functions.

Notes and caveats

You may find that a system exists but is not used for other functions. The system may attempt to classify jobs but be incomplete (e.g., no job descriptions). Check whether salaries are based on this classification (take into consideration qualification requirements, experience, education, duties). The presence of job descriptions is an indicator (number 13) in “C. Performance Management” topic area below.

7. Compensation and benefits system that is used in a consistent manner to determine salary upgrades and merit awards

Definition, rationale, and interpretation	<p>Response: yes or no</p> <p>This indicator looks for a policy that governs compensation and benefits.</p> <p>The purpose of such a policy is to establish and authorize an equitable and market-competitive compensation and benefits system.</p> <p>A country may have no formal system to assign salary scale and benefits to each job classification or it may have a system but does not use it in a routine manner.</p>
Suggested data source	<p>Central level MOH</p>
Stakeholders to interview	<p>HR staff at central level MOH (then lower level employees to determine whether they are aware of this policy)</p>
Issues to explore	<p>Look for—</p> <ul style="list-style-type: none">• Equity• Transparency• Communication of policy to staff• Clear lines of authority
Notes and caveats	<p>The system should be understood by all employees and used consistently to determine salary upgrades and merit increases. The policy may use “differentials” to provide additional compensation for positions that may cause a hardship or inconvenience to the employee, such as working in a rural or underserved area. Compensation is not limited to salary (e.g., it could include a car allowance). Pay that is market competitive may aid in retention of staff or decrease moonlighting.</p> <p>For public sector workers, if motivation or performance is low, or moonlighting is a problem, consider innovative provider payment mechanisms, such as those related to output or quality of services, or both. Motivation is not created by a single incentive, however, and focusing solely on financial incentives is unlikely to solve motivation problems (Bennett and Franco 1999).</p>

8. Formal process for recruitment, hiring, transfer, promotion

Definition, rationale, and interpretation	<p>Response: yes or no</p> <p>This indicator looks for a formal process for recruitment, hiring, transfer, and promotion, based on established criteria.</p> <p>These functions are necessary for a fair and open process based on candidates' job qualifications.</p> <p>Lack of such functions casts doubts on issues such as fairness and whether employees are properly selected for the job.</p>
Suggested data source	Central level MOH
Stakeholders to interview	HR staff at central level MOH
Issues to explore	Note whether the process is documented and used consistently in all recruitment, hiring, transfer, and promotion decisions. Are there any policies for equity?

9. Employee conditions of service documentation (e.g., policy manual)

Definition, rationale, and interpretation	<p>Response: yes or no</p> <p>This indicator looks for an employee manual or other written documentation of the conditions of employment—the rules and regulations that govern employees' conditions of service, benefits, and related policies and procedures.</p> <p>Service documentation lets employees know what to expect in general from the organization and what rules they will be governed by.</p> <p>Lack of service documentation raises issues of fairness.</p>
Suggested data source	HR department
Stakeholders to interview	<p>HR department</p> <p>Also ask a couple of employees if they are aware of such a document or are in possession of it.</p>
Issues to explore	<p>Investigate whether documentation (or a policy manual) has been updated and made available to all employees. Does it contain policies governing work hours, discipline, grievances, benefits, travel, leave, allowances, and legal issues? Documentation may exist but not be available to all employees, may not be up-to-date, or may not include all relevant information.</p> <p>Does the policy manual contain formal discipline, termination, and grievance procedures? (Such procedures provide fair and consistent guidelines for addressing performance problems.) Find out if these procedures exist at all; if they do, they should be clearly related to performance standards, based on performance standards, known to all employees, and followed consistently.</p>

9. Employee conditions of service documentation (e.g., policy manual)

Does an overtime policy exist? Does a policy regarding moonlighting exist?

Are such issues as equity, gender discrimination, and disability addressed? Does the documentation outline a code of conduct?

Notes and caveats

A facility may have only one document for the whole facility. If so, do workers know about it, and is it available to them?

10. Presence of a formal relationship with unions (if applicable)

Definition, rationale, and interpretation

Response: yes or no

This indicator looks for the presence of a formal relationship with unions (if present). Alternately, the indicator could be the number of strikes, labor disputes, and collective grievances.

This indicator examines the country's effort to have good relations between management and labor and avoid labor strikes or disputes and adversarial relations.

The lack of a relationship could be an indication of poor management-labor relations.

Suggested data source

Central level MOH

Stakeholders to interview

Central level MOH, labor union representative

Issues to explore

Ask whether the country has experienced labor disputes, strikes, collective grievances, or other work disruptions and, if so, how they were resolved. Western countries have a history of adversarial relations between labor and management. This rift is sometimes attributed to a lack of trust and respect between the two. A well-functioning organization depends, however, on good relations between them, and those relations can and should be cultivated. By using consultative methods to develop an agenda and policy that reflect common goals of both labor and management, adversarial behavior (and outcomes) can be reduced.

Notes and caveats

Document your findings along a range from no link between HR, management, and the union to their working together to resolve issues and prevent problems.

11. Registration, certification, or licensing is required for categories of staff in order to practice

Definition, rationale, and interpretation	<p>Response: yes or no</p> <p>This indicator looks for policies in place requiring registration, licensure, or certification for cadres of staff such as doctors, nurses, midwives, pharmacists, laboratory technicians, and other personnel.</p> <p>This requirement is a mechanism for ensuring that certain professional qualifications are met upon entry to the profession and that periodic reassessments or re-qualification procedures are in place to ensure staff maintain their qualified status.</p>
Suggested data source	<p>HR central level; medical council; nursing council; professional associations; regulatory bodies</p> <p><i>Module link:</i> Governance Module, indicator 42 (accreditation and certification of providers)</p>
Stakeholders to interview	<p>HR staff at central level MOH (they will have information on requirements) and staff at medical, nursing, and other associations (they may know about enforcement)</p>
Issues to explore	<p>If certain cadres have requirements, list the cadre and the requirements. Is periodic recertification required? Review the Governance module (Chapter 6). Regulation and control of traditional and other types of providers within and outside the formal system. Some countries have formal programs in which a certain number of continuing medical education hours is required for physicians to be members in good standing or maintain their license.</p> <p>Can anyone “hang up a shingle” and practice medicine? Are the requirements monitored?</p>
Notes and caveats	<p>The country may have requirements but may not enforce them. If licensing or registration is required, find out how many individuals were registered in the past period or what the proportion of licensed or registered providers is.</p>

12. Salary

Definition, rationale, and interpretation	<p>Salaries are paid on time regularly, paid in full, and represent a viable living wage.</p>
Suggested data source	<p>MOH or Ministry of Finance; NGOs and other private providers or provider organizations</p>
Stakeholders to interview	<p>MOH or Ministry of Finance representatives; employees</p>

12. Salary

Issues to explore If salaries are not regular, how often are they late? Do employees moonlight? How prevalent is moonlighting? Is it more prevalent among certain cadres? Can employees live on what they make in compensation? Are salary surveys conducted to compare government salaries with those in the private sector, or with Social Security staff salaries?

Notes and caveats Information on moonlighting may be difficult to determine.

C. Performance Management

13. Job descriptions are present

Definition, rationale, and interpretation Response: yes or no
Job descriptions are necessary for performance management, review, and appraisal. Job descriptions, which define what employees are expected to do and how they should be prepared for their job, are necessary so that both employees and their supervisors can be held accountable for performance.
If none exist, pinning down just what exactly employees are expected to do in their job is hard; in fact, holding them accountable for doing or not doing whatever it is they are “supposed” to be doing is difficult.

Suggested data source Central level MOH

Stakeholders to interview HR staff at central level MOH; managers and employees at every level

Issues to explore Workers need job descriptions—clear information on their duties—to know what is expected of them, and their supervisors need them to evaluate performance. Investigate whether staff are aware of their job descriptions and whether they have a copy. If job descriptions exist, do all staff have them? Are they up to date? Are they specific enough in terms of duties and clear lines of supervision? Are they complete (i.e., do they contain job title, qualifications, responsibilities, supervisor)? Do they exist for every position? Are they reviewed and updated regularly? Look at a few job descriptions to get a sense of how detailed they are.

Notes and caveats In decentralized systems, job functions may differ for the same personnel category because of limited numbers of management or key staff working in rural locations.

14. Supervision (especially clinical supervision)

Definition, rationale, and interpretation

Response: yes or no

This indicator determines if supervision takes place according to a formal process.

Supervision is the most basic tool to monitor and improve quality of care, for the performance of the facility as a whole as well as for individual staff performance.

If the MOH has no method of monitoring whether supervision is conducted, then the existence of formal supervision is questionable.

Suggested data source

Interviews with managers at all levels—district, provincial, and regional. Also interview a few lower level workers to ask about their experience of being supervised.

Stakeholders to interview

Module link: Health Service Delivery Module, indicators 24–28 (quality control and supervision)

Issues to explore

Ask the following questions—

- Who is responsible for clinical supervision of primary care facilities? Central MOH? If so, from what departments? Provincial authority?
- Does each facility have a recognized *clinical* supervisor?
- How many different clinical supervisors (e.g., for different programs such as HIV, malaria, maternal health) visit a primary care facility (the more supervisors, the less integrated the system)?
- Is supervision of the supportive (i.e., modern) or the traditional surveillance and inspection type? The latter focuses on catching errors and is punitive; the former is empowering to employees.

Find out whether supervisors are prepared with supervision skills and perform their roles in monitoring and increasing employee performance, for example, meet with employees to develop workplans, evaluate performance, provide mechanism for training, recognize staff for achievement, and upgrade employee skills as needed. Clear lines of authority are needed. Explore the following—

- How many supervisors received training on how to conduct supervision in the last year?
- To what degree is supervision integrated? Do supervisory teams conduct supervisions using a single supervision tool?
- What is the frequency of supervision visits? To be conducted each month or quarter?

14. Supervision (especially clinical supervision)

- Does a document that formally defines the content of supervision or method of supervision exist? If so, describe it. Get a copy to be able to describe how supervision works.
- How do supervisors stay up-to-date with new standards of care? How many supervisors received clinical updates in the last year?
- Do supervisors have a plan and schedule, conduct joint problem solving, keep supervision records, and follow up (continuity) on issues identified in the last visit?

Notes and caveats

The quality and style of supervision can greatly influence the effectiveness of a supervision visit. Supervision visits that seem like an audit check or merely an opportunity for collecting service delivery data do not encourage the type of dialogue and feedback that help providers improve the quality of care. Do supervisors observe performance? Do they provide just-in-time training or correction? Do they practice joint problem-solving or act punitively? Do they give feedback to individuals on performance?

If there is supervision, is it on-site or from one level to the next level down (i.e., district level to facility level). “Supervision” covers a wide range of behaviors. Sometime it refers to a district level supervisor coming to inspect a health facility with a checklist, without observing or giving feedback to workers. Supervisors themselves are often service providers who rise in the ranks to supervisor with no specialized training in how to be a good supervisor.

Supportive supervision entails the supervisor working with his or her supervisees in a nonthreatening way to improve their performance by providing, for example, corrective or supportive feedback, joint problem-solving, training, incentives, consequences, tools and supplies, or other environmental or organizational support.

Especially in a decentralized system, a dual system may be in place, in which the same worker receives technical supervision (e.g., doctors supervising doctors) and administrative supervision by a local government official. This overlap can cause confusion because the line is not clear. Furthermore, administrative guidance may conflict with technical guidance and impact health care quality.

15. Percentage of supervision visits to health centers planned that were actually conducted

Definition, rationale, and interpretation

[Number of supervision visits to health centers conducted in the last year for which data are available]/[number of planned supervision visits to health centers for the same year]

A measure of frequency of supervision visits—how many planned visits (as defined by the system) actually occur

15. Percentage of supervision visits to health centers planned that were actually conducted

Suggested data source	<p>MOH central, provisional, or district level</p> <p>Private organization HQ</p> <p><i>Module link:</i> Health Service Delivery Module, indicator 27 (Percentage of supervision visits to health centers planned that were actually conducted)</p>
Stakeholders to interview	<p>Find out at the MOH or district level how many visits need to be conducted in a year, and then ask how the completion of supervision visits is monitored. Ask to see this information for the previous year to count how many planned supervision visits were actually made. Conduct interviews at the district, provincial, or regional level or MOH program level to find out where facility supervisors reside. Thus, depending on data availability, the indicator may be limited to just one program or one district, province, or region.</p>
Issues to explore	<p>Ask: What are the reasons for the discrepancy in planned versus conducted?</p> <p>If the percentage is low, probe for barriers to conducting supervision. Does the country have a national standard for the frequency of supervision visits at primary care facilities? If so, how does the system assess whether the expected number of supervisory visits is conducted?</p>
Notes and caveats	<p>In some cases, supervision visits may be conducted by national MOH staff from various programs. In such cases, identifying which national MOH program managers to interview by first interviewing supervisors at the regional level department might be more efficient.</p>

16. There is a formal mechanism for individual performance planning and review

Definition, rationale, and interpretation	<p>Response: yes or no</p> <p>This indicator looks for a formal mechanism for performance planning and review (appraisal). The planning provides expectations on performance, and the appraisal provides information to staff and organization on level of performance. The review or appraisal also serves as a basis for promotion, disciplinary action, and staff development.</p>
Suggested data source	<p>Policy manual or documentation; personnel data (individual reviews)</p>
Stakeholders to interview	<p>HR staff at central level MOH; HR department of private health institutions; supervisors and managers at all levels</p>

16. There is a formal mechanism for individual performance planning and review

Issues to explore

Ask the following questions—

- Are reviews conducted on a regular basis between personnel and their supervisors, and if so, do they jointly develop plans and goals for the employee for the coming period? Are review results documented?
- Are review results used for personnel decisions?
- Is a system of rewards and consequences for performance in place?
- Once an employee is in the government system, is he or she in “for life”?

Notes and caveats

Look for a standard personnel performance review form for various classes of employee.

Performance review and management are difficult and some (e.g., Martínez and Martineau 2002) say rare, because they require levels of local decision-making and personnel management that are lacking in most developing country health systems.

17. Incentives, monetary and non-monetary

Definition, rationale, and interpretation

Response: yes or no

Are there formal and informal methods, either monetary or non-monetary, that are used to influence, encourage, or reward worker performance or to motivate employees to work in rural or underserved (and undesirable) areas? These incentives could take the form of monetary or nonmonetary programs such as pay for performance, employee recognition programs, and incentives for distribution (e.g., to work in rural areas) and retention. When incentives take the form of provider payment, salaries are the most common method that MOHs use, although they have been deemed to provide the least incentive for performance.

Performance contracts are sometimes used in the public sector to tie health worker pay or facility recurrent budget allocations to performance (e.g., the percentage of children fully immunized, the percentage of relevant patients receiving family planning counseling, the percentage of cases with correct diagnosis). These types of contracts promote targets set by the MOH or other health services employers.

For monetary incentives, describe the payment method(s) used and whether performance contracts or other targeted incentives exist.

17. Incentives, monetary and non-monetary

Suggested data source	Key informants
Stakeholders to interview	MOH officials, supervisors, donors supporting HR, and health workers
Issues to explore in stakeholder interviews	List any programs and who can benefit. Describe how the program works and who is eligible. Ask whether workers were consulted about what they would want as an incentive. Assess with key informants whether other incentives may be needed.
Notes and caveats	You may have difficulty drawing conclusions about the effectiveness of the program. For public sector workers, if motivation or performance is low, or moonlighting is a problem, consider innovative provider payment mechanisms, such as those related to output or quality of services, or both.

D. Training and Education

18. There is a formal in-service training component for all levels of staff

Definition, rationale, and interpretation	<p>Response: yes or no</p> <p>This indicator looks for a formal training component for personnel. Such training is a cost-effective way to develop staff and organizational capacity. In its most evolved form, the training component is based on staff and organizational needs assessment and linked to organizations' priorities and changes in the health sector and health practices. More often it is ad hoc and not based on a needs assessment nor linked to the organizations' needs. Training could be continuing professional education for the various cadres of health care professionals including physicians, nurses, pharmacists, and midwives. Such a program can serve as a mechanism for professionals to receive continuing education in their technical area. Continuing education may be provided by the MOH, by donors, by professional societies, or others. A certain number of credit hours of continuing education may be required annually for membership or certification.</p> <p>Find out whether the training is available to all staff and evaluated for effectiveness, especially assessing whether employees perform better on the job, not just on how good the training was perceived to be.</p>
Suggested data source	Central level MOH, professional associations, donors supporting training, professional training institutions
Stakeholders to interview	HR staff at central level MOH; professional associations

18. There is a formal in-service training component for all levels of staff

Issues to explore Ask: Is a central training planning function in place? Continuing professional education activities, whether off site or in-service, may be sponsored by the organization or by donors. How are training needs identified? How are potential participants identified? Who develops the training materials and programs? Are the trainers specially prepared? Is there follow-up? Are there any plans or policies? Is training a permanent line item in the budget? Are private providers ever invited to updates or training programs? Do any policies govern leaving one's post to go for donor-funded training? Are training requirements enforced? If so, how?

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

19. There is a management and leadership development program

Definition, rationale, and interpretation Response: yes or no
Leadership and good management are keys to a more sustainable organization. Having a development program prepares employees to advance and provides incentives for good performance.

Suggested data source Central level MOH

Stakeholders to interview HR staff at central level MOH

Issues to explore Judge whether the country has a philosophy or policy regarding the importance of developing staff management capacity. Note whether the program allows equal opportunity to participate based on performance and other established criteria. Is the program used to develop current staff for promotion? Are promotions open to all, or are women or other groups not equally represented? To whom are these programs targeted? Who is groomed and mentored?
Do specific donors provide funds for such programs?
Are programs or courses conducted locally, regionally, or through Web-based technologies?

20. There are links and “feedback loops” between the organization and pre-service training institutions

Definition, rationale, and interpretation	Response: yes or no This indicator looks for a formal link between organizations and the pre-service training institutions that train future employees for the health sector. Pre-service training based on skills needed in the workplace is necessary so that the right numbers and cadres enter the workforce with the right skills. Note whether the organization (MOH primarily) has a systematic process for feeding its needs regarding skill sets and cadres into the pre-service curricula. Preservice training institutions can also in-service training to the MOH, and the MOH can offer practicum sites to the schools.
Suggested data source	Central level MOH
Stakeholders to interview	HR staff at central level MOH; deans and management of schools of medicine, nursing, pharmacy, and other educational institutions
Issues to explore	Ask: Does the MOH have a relationship with other related ministries, such as the Ministry of Education and the Ministry of Labor? Are the curricula of the professional and allied health sciences schools targeted toward a profile that matches the needs of the country? The numbers of graduates produced and the skills that they have should be linked to the strategic HR plans. Has an HR capacity analysis been done, aimed at determining the ability of the country to fill its HR needs in the future?
Notes and caveats	Often no real feedback loops exist to let the schools know if they are teaching the correct curricula or producing the right numbers and cadres of future staff, or whether graduates enter the profession having the right set of skills to do their jobs.

9.3.3 Summary of Issues to Address in Stakeholder Interviews

Which stakeholders are selected to interview depends on many factors, such as whether there is a centralized HR function, whether that function resides in the MOH or in another ministry, and whether it is a centralized versus decentralized system. Private sector, professional associations, donors, and academic institutions are also sources.

For some indicators, you may want to cross check the answers from managers with those of lower level employees to determine whether they are consistent (e.g., on awareness of policies). In a centralized system, much of the information for this chapter can be obtained by interviewing an HR manager.

In a decentralized system, these data may be found at district levels or in some cases at local levels.

Table 9.3 Summary of Issues to Address in Stakeholder Interviews

Profile of Stakeholder to Interview	Issues to Discuss with Stakeholder
Private provider associations, private clinics, private hospitals, NGOs	All issues where private providers are concerned— <ul style="list-style-type: none"> • Training for professionals • Salary levels • Emigration of personnel • Competition with public sector for staff • Ability to establish private practices
MOH officials	<ul style="list-style-type: none"> • Basic data • Legal and regulatory mechanisms regarding private practitioners— <ul style="list-style-type: none"> ○ Are there any? ○ Which cadres of providers are regulated? ○ Are rules and laws enforced?
Donors	Mostly issues of funding— <ul style="list-style-type: none"> • Do they support training programs? Management and leadership courses? • Do they support the salaries of health care workers?
Professional associations for physicians, nurses, midwives, and other personnel	<ul style="list-style-type: none"> • How many members do they have? • Do they have numbers of private practitioners? • Do they require continuing education for credentialing? • Do they provide continuing education?
Labor union representative	Labor relations
Educational organizations such as medical and nursing schools	Pre-service training— <ul style="list-style-type: none"> • How do they ensure that their curriculum meets the needs of the organizations where their graduates eventually work? • How do they give their graduates experience? • How often are their curricula updated? • What mechanisms are in place to monitor the needs of the workplace for which they are preparing their students?

9.4 Summarizing Findings and Developing Recommendations

Chapter 4 describes the process that the team will use to synthesize and integrate findings and prioritize recommendations across modules. To prepare for this team effort, each team member must analyze the data collected for his or her module(s) to distill findings and propose potential interventions. Each team member should be able to present findings and conclusions for his or her module(s), first to other members of the team and eventually at a stakeholders’ workshop and in the assessment report (see Chapter 3, Annex 3J for a proposed outline for the report). This process is iterative; findings and conclusions from other modules will contribute to sharpen and prioritize overall findings and recommendations. Below are some generic methods for summarizing findings and developing potential interventions for this module.

9.4.1 Summarizing Findings

Using a table that is organized by the topic areas of your module (see Table 9.4) may be the easiest way to summarize and group your findings. (This process is Phase 1 for summarizing findings as described in Chapter 4.) Note that additional rows can be added to the table if you need to include other topic areas based on your specific country context. Examples of summarized findings for system impacts on performance criteria are provided in Annex 4A of Chapter 4. In anticipation of working with other team members to put findings in the SWOT framework (strengths, weaknesses, opportunities, and threats), you can label each finding as either an S, W, O, or T (please refer to Chapter 4 for additional explanation on the SWOT framework). The “Comments” column can be used to highlight links to other modules and possible impact on health system performance in terms of equity, access, quality, efficiency, and sustainability.

Table 9.4 Summary of Findings—Human Resources Module

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

^aList impact with respect to the five health systems performance criteria (equity, access, quality, efficiency, and sustainability) and list any links to other modules.

Another way to group your findings could be a table similar to the example in Table 9.5.

Table 9.5 Human Resources Performance Criteria (Sample Table)

Human Resources Performance Criteria				
Equity: Are human resources distributed equitably or inequitably?	Access: Is access to care inhibited by lack of competent personnel in rural and distant facilities?	Efficiency: Is personnel use inefficient because of lack of HR planning and coordination?	Quality: Is the quality of care affected by access to qualified personnel, provider behavior, or incompetence?	Sustainability: Are personnel supported or given incentives (e.g., through a community financing system)?

9.4.2 Developing Recommendations

After you have summarized findings for your module (as in Section 9.4.1 above), it is now time to synthesize findings across modules and develop recommendations for health systems interventions. Phase 2 of Chapter 4 suggests an approach for doing this step with your team. Table 9.6 provides a list of common interventions seen in the area of Human Resources that you may find helpful to consider in developing your recommendations.

Key problems can be grouped by the topic areas addressed in the chapter.

When suggesting interventions, make sure that the link between the problem and the suggested intervention is direct.

Table 9.6 contains some common issues related to the topic areas of the HR chapter and some possible interventions. Keep in mind that causes of problems related to retention and motivation overlap and thus are likely to respond to similar interventions.

Table 9.6 Illustrative Recommendations for Human Resource Issues

Issue	Possible Intervention
Shortages of qualified personnel to carry out tasks	<ul style="list-style-type: none"> • Consider training lower cadres of workers and community health workers in less demanding tasks, and shift those tasks to them. • Eliminate mandatory retirement policy for public sector.
Retention	<ul style="list-style-type: none"> • Offer adequate salary. • Establish a payment schedule. • Provide extra-duty allowances. • Create a good working environment. • Expand the benefits program. <p>For example, the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) is supporting the MOH in Zambia in approaches to retain physicians. They support a scheme that provides housing, hardship allowance, transportation, and educational stipends for employees’ children for the 30 to 35 physicians who serve in rural areas throughout the country (PEPFAR 2006).</p>
Motivation	<ul style="list-style-type: none"> • Improve salary and compensation, and ensure that salary is paid on time. • Provide effective leadership and management systems. • Change existing punitive supervision practices (i.e., reducing incentives, using blame which causes fear) to supportive supervision. • Increase work-related self-efficacy—that is, workers are trained to do the tasks; clear expectations are communicated; workers receive feedback on their performance; workers are appropriately selected; job descriptions and standards are clearly communicated; and systems are established for developmental appraisals (Franco and others 2000). • Measure and share results; recognize and reward.
Unequal distribution of health workers and poor coverage in some (usually rural) areas	<ul style="list-style-type: none"> • Provide monetary incentives such as— <ul style="list-style-type: none"> ○ Incentive payments for rural hardship postings ○ Special bonuses ○ Loans ○ Vehicles ○ Scholarships ○ Promotions ○ Management responsibilities ○ Retirement benefit packages • Provide nonmonetary incentives such as— <ul style="list-style-type: none"> ○ Congratulations and thank-you notes ○ Public recognition programs • Improve intake of medical students from rural areas. • Provide training in the locations where physicians will later practice.

Issue	Possible Intervention
Graduates of professional schools lacking the skills needed in the workplace	<ul style="list-style-type: none"> • Establish feedback loops and links between the professional schools and the MOH. • Place students in facilities for practicums and clerkships using faculty or facility staff as preceptors.
Lack of feedback to employees on their performance	Strengthen supervision— <ul style="list-style-type: none"> • Provide management training for evaluators or supervisors • Define and enforce staff review cycles
No joint planning and review between employees and supervisors	Introduce a process to conduct— <ul style="list-style-type: none"> • Joint planning based on job descriptions and tied to the organization's mission and goals • Periodic employee performance reviews
Workforce at risk of HIV/AIDS	Implement HIV/AIDS programs and policies for prevention and protection of employees, for example— <ul style="list-style-type: none"> • Educate workers on how to prevent needlestick injuries and other exposure to bloodborne pathogens. • Ensure adequate follow-up of injured workers including postexposure prophylaxis. • Provide antiretroviral medicines to HIV-positive personnel. • Decrease stigma.
Punitive or controlling supervision	<ul style="list-style-type: none"> • Train supervisors in supportive supervision techniques. • Introduce self-assessment at facilities.
No regular supervision	<ul style="list-style-type: none"> • Use on-site supervisors (in-charges, peers). • Train health inspectors in supervision to support on-site supervisors.

References

- Bennett, S., and L. M. Franco. 1999. *Public Sector Health Worker Motivation and Health Sector Reform: A Conceptual Framework*. Major Applied Research 5, Technical Paper 1. Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc. <<http://www.phrplus.org/Pubs/m5tp1.pdf>> (accessed Sept. 27, 2006).
- Dovlo, D. 2005. Wastage in the Health Workforce: Some perspectives from African Countries. *Human Resources for Health* 3(6):1–9. <<http://www.human-resources-health.com/content/3/1/6>> (accessed Sept. 27, 2006).
- Franco, L. M., S. Bennett, R. Kanfer, and P. Stubblebine. 2000. *Health Worker Motivation in Jordan and Georgia: A Synthesis of Results*. Major Applied Research 5, Technical Paper 3. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc. <<http://www.phrplus.org/Pubs/m5tp3.pdf>> (accessed Sept. 27, 2006).
- ILO/WHO (International Labour Organization/World Health Organization). 2005. *Joint ILO/WHO Guidelines on Health Services and HIV/AIDS*. Geneva: ILO/WHO <http://www.who.int/hiv/pub/prev_care/who_ilo_guidelines.pdf> (accessed Sept. 27, 2006).
- Joint Learning Initiative. 2004. *Human Resources for Health. Overcoming the Crisis*. Cambridge, MA: Harvard University Press. <<http://www.globalhealthtrust.org/Report.html>> (accessed Sept. 27, 2006).
- Kolehmainen-Aitken, R. 1998. *Decentralization and Human Resources: Implications and Impact*. Cambridge, MA: Management Sciences for Health (MSH). <www.who.int/hrh/en/HRDJ_2_1_01.pdf> (accessed Sept. 27, 2006).
- Martínez, J., and T. Martineau. 2002. *Human Resources in the Health Sector: An International Perspective*. London: DFID Health Systems Resource Centre. <http://www.dfidhealthrc.org/shared/publications/Issues_papers/Human_resources.pdf> (accessed Sept. 27, 2006).
- MSH. 1998. *Human Resource Development (HRD) Assessment Instrument for Non-Governmental Organizations (NGOs) and Public Sector Health Organizations*. Cambridge, MA: MSH.
- . 2003. *Human Resource Management Rapid Assessment Tool for HIV/AIDS Environments*. Cambridge, MA: MSH. <http://erc.msh.org/newpages/english/toolkit/hr_hiv_assessment_tool.pdf> (accessed Sept. 27, 2006).
- The President's Emergency Plan for AIDS Relief (PEPFAR). 2006. *Report on Work Force Capacity and HIV/AIDS*. Washington, DC: PEPFAR. <<http://www.state.gov/documents/organization/69651.pdf>> (accessed Sept. 27, 2006).

United Republic of Tanzania, Prime Minister's Office. 2001. *National Policy on HIV/AIDS*. Dar es Salaam: United Republic of Tanzania.

<<http://www.ilo.org/public/english/protection/trav/aids/laws/tanzanianationalpolicy.pdf>>
(accessed Sept. 27, 2006).

WHO (World Health Organization). 2004. *A Guide to Rapid Assessment of Human Resources for Health*. Geneva: WHO. <http://www.who.int/hrh/tools/en/Rapid_Assessment_guide.pdf>
(accessed Sept. 27, 2006).

———. 2006a. "Human Resources for Health (HRH)." Geneva: WHO. <www.who.int/hrh/en>
(accessed Sept. 27, 2006).

———. 2006b. *The World Health Report 2006*. Geneva: WHO.
<<http://www.who.int/whr/2006/en/>> (accessed Sept. 26, 2006).

———. n.d. *Global Health-Sector Strategy for HIV/AIDS 2003–2007*. Geneva: WHO
<<http://www.who.int/hiv/pub/advocacy/ghss/en/>> (accessed Sept. 27, 2006).

