

Supporting the retention of health resources for health: SADC policy context

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1. Overview

This report has been prepared for the Health Systems Trust (HST), South Africa and the Regional Network for Equity in Health in Southern Africa (EQUINET). It presents a review of issues in the regional policy context that are of relevance to the retention of human resources for the health sector (HRH) within the region, based on a rapid appraisal in selected countries and at regional level. The terms of reference for this study are presented in Annex 1 and its methods outlined in Section 2.

This work specifically focussed on the actions needed to stem the flow of international migration by encouraging the retention of health staff within countries. A particular concern raised across countries is staff retention in the public and rural services that preferentially serve the poorest populations. Importantly, policy documents and national respondents see the problems of retaining staff in these locations (the push factors underlying migration) as linked to the factors that undermine motivation and productivity. Policies to address retention issues (and so encourage health workers to stick and stay in country settings) are, thus, also likely to address poor motivation and weak productivity. In addition, these three sets of problems often go hand in hand with poor health worker attitudes and behaviours towards patients. So tackling these problems may have double benefits for health system performance – contributing to adequate availability of competent staff, as well as enhanced staff responsiveness to patients.

The report presents the findings of this work in sections 3-5 covering:

- Review of current international and regional HRH policy initiatives of relevance to the Eastern and Southern Africa region;
- Review of national level policy environments, with specific consideration of Malawi, South Africa and Tanzania;
- Implications for the future role of EQUINET in supporting implementation of HRH policy initiatives within the region.

In summary, the report notes that:

- encouraging HRH retention requires a complex package of actions working through different entry points, rather than single policy actions;
- implementation of any HRH retention policy package is challenging because of the need to coordinate efforts across a wide range of governmental actors as well as get the support of a range of external actors;
- regional co-operation to support country level action to encourage retention appears to be, as yet, little developed, although recent discussions within the African Union and SADC, provide possible bases for such co-operation;
- current international initiatives may provide regional opportunities for addressing HRH problems (as a core constraint on health system development), but also hold the danger of over-burdening health systems, and in particular leadership and management within them

In supporting initiatives to promote HRH retention within the region we suggest that EQUINET could, in broad terms, engage with others in providing a focal point for regional networking in support of HRH policy action. Such networking could, more specifically, focus on two sets of activities (see section 5 for details).

First, analytical work could fill current gaps by supporting cross-country analysis of the implementation of financial incentives, developing ideas and proposals around how to strengthen non-financial incentives and monitoring the impact at country level

of externally driven initiatives on HR issues or initiatives (such as those for HIV/AIDS) likely to have impact on HR.

Second, dialogue and engagement with key actors (such as parliamentarians, senior health and other civil servants, professional groupings) could be supported by the development of policy briefs on key issues and collaboration with WHO AFRO, SADC, NEPAD and the AU.

2. Research strategy and methods

The work summarised in this report was conducted as a rapid appraisal in order to back up the more detailed country level analyses of HRH retention problems also supported by EQUINET. This work involved:

- the identification of key informants and selection of three countries in which to conduct national-level interviews (through discussions with EQUINET colleagues);
- a search for regional-level and country-specific documentation on policy initiatives related to retention and migration. Various internet search strategies were pursued and the authors of certain documents were also contacted for further information;
- a review of the documentation obtained to provide a context for interviews;
- e-mail dialogue and interviews with representatives of regional organisations, as well as country-level visits and interviews;
- analysis of the interview material and report writing.

The three countries selected for national-level work (Malawi, South Africa and Tanzania) were identified in part because each has given significant attention to HRH issues and has recently initiated interesting policy interventions. In addition, in each country EQUINET partners could facilitate access to interviewees.

Interviews were conducted using an interview guide drawn primarily from the study terms of reference (TORs), which was adapted as appropriate to context and respondents. Analysis of data was also undertaken by reference to the study TORs, and in recognition of the range of issues actually raised by respondents.

An important constraint on this work was the relatively limited time allocated to the task. Although we have, nonetheless, taken efforts to ensure as comprehensive a review as possible, this constraint may have led us to overlook some documentation. It also prevented us from following-up as actively as we would have wished, some of our intended respondents at regional and national level whose other commitments made it difficult for us to interview them. We note that our understanding of the Malawian context is particularly limited.

3. Regional and international policy initiatives

Regional level

Overview

Regional organisations and structures in Africa are clearly concerned about the human resource crisis as it renders acceptable health service delivery impossible or near impossible in many places on the continent. The documentary evidence paints a picture of regional discussions and actions taking place in a number of inter-related forums. Some of these forums are interconnected in the sense of sharing members or taking place under the auspices of another organisation, but there are also inter-

linkages in the ways similar ideas appear in slightly different contexts. On balance, more prominence appears to be accorded to policy actions that deal with migration out of African countries and the recruitment of health workers by developed countries. African countries have certainly made a point of putting these issues on the international political agenda. Linked to this, discussions around the policy actions needed to address the factors that impact on retention seems to be slightly more muted and less well developed. Although there clear recognition of the need to address these factors (as distinct from international actions to contain migration), the documents contain limited details particularly around how to implement proposed actions. However, the need for processes of networking and analysis to support national policy action is identified. Table 1 summarises the chronology of regional initiatives, which are then discussed in more detail below.

Table 1: Chronology of regional initiatives

Year	Migration	Retention	Processes
2005		Fourth Ordinary Session of AU, Abuja	Call for African Centres of Excellence and Knowledge Institutions
	SADC health priorities WHA resolution		
2004	MIDSA migration and health workshop	ECSA conference	
	WHA resolution		
2003	Commonwealth ethical recruitment code		
	NEPAD health strategy		
2002	WHO regional committee for Africa AU heads of state meeting, Durban WHO/World Bank consultative meeting, Addis Ababa		Call for task force on HRH development in Africa
2001			
2000	MIDSA established		
1999			
1998		WHO AFRO regional HRH development strategy	Call for national advisory committees, creation of expert advisory group at regional level

Policy initiatives

The most visible of the region’s HRH policy initiatives has been the intervention by African Ministers of Health in the 2004 World Health Assembly (WHA), calling, among other things, for strategies to address the negative consequences of migration, policies to enhance retention and bilateral agreements for the creation of exchange programmes, as a way of managing migration (WHA, 2004). They then raised the lack of action on this resolution in the 2005 WHA and supported a resolution, drafted by South Africa, calling on the director-general of the World Health Organisation to ensure the full implementation of the 2004 resolution (MOH, 2005).

This action on migration followed discussion within SADC, for example, which itself led to a strongly worded 2001 ministerial statement arguing that “the active and vigorous recruitment from developing countries...could be seen as looting from these countries and is similar to that experienced during the periods of colonisation when all resources, including minerals, were looted to developed countries”. This statement

also called for a number of actions, including prioritising South-South cooperation on HR issues, the creation of a code of conduct for Commonwealth countries, and the intensification of efforts around staff exchange initiatives in the SADC region (SADC, 2001).

Within the SADC region, the Migration Dialogue for Southern Africa (MIDSA) has also focussed regional attention on these issues. Linked to the Southern African Migration Project (SAMP), among others, its intention is to create discussion and cooperation among SADC governments on issues to do with migration. Some of its more specific goals include improving policy-makers and officials' understanding of migration and strengthening SADC countries' capacity to manage migration, including moving towards similar data collection system and harmonised policy and legislation. Since its formal establishment in 2000, it has hosted a number of events, including a workshop on migration and health in 2004. MIDSA is implemented through collaboration between SAMP, a network linking Canadian organisations with selected southern African countries, and other actors, including the SADC Secretariat and the UN High Commissioner for Refugees (SAMP, 2001 & MIDSA, 2005).

Most recently, a meeting of SADC in early 2005 also identified HRH issues as one of the top priorities for the region. This may provide a basis for future efforts around retention issues.

Two years after the strongly worded SADC ministerial statement, at a meeting in Geneva, ministers of health from the Commonwealth adopted a code of practice for the international recruitment of health workers and a companion document that fleshes out the relatively brief code of practice (Commonwealth, 2003a & Commonwealth, 2003b). Six months after this meeting, in November 2003, the East, Central and Southern African Health Community (ECSA), formerly the Commonwealth Regional Health Community Secretariat, held its 38th regional health ministers conference in Zambia, with the meeting focussing on HR issues. The resolutions adopted at this meeting related to health workers, quality of care and the retention of health workers. The issue was on the agenda again at the 40th conference that took place in Zimbabwe in 2004. On this occasion six resolutions were adopted, one of which dealt specifically with human resources for health. In this resolution member states are urged, among other things, to promote the retention of health workers through better conditions of service, addressing concerns around safety at work and health programmes for workers. Other actions touched on in the resolution include defining HR needs and setting standards for the different levels of care, establishing HR management systems, supporting career development for all health workers and the need for HR policies to take account of the macro-economic factors that influence countries' health policies (ECSA, 2004)

Retention and migration have also been considered in the context of the activities of the WHO in Africa. In 1998, WHO AFRO developed a regional HRH development strategy. This strategy emphasised the importance of human development policies in supporting overall health policy frameworks, and of developing the capacity to implement those policies. It recognised the need to generate awareness of the importance of human resource development for the health system among national policy makers and health officials. The expectation was that by 2004 countries would have developed HR development policies for health and that they would have developed the capacity to implement these policies by 2007 (WHO AFRO, 1998). The strategy allows for national advisory committees and at the regional level an expert multi-disciplinary advisory group had been created (WHO AFRO, 2002).

At the beginning of 2002, the WHO and World Bank set up a consultative meeting in Addis Ababa, “bringing together for the first time African stakeholders in the development and management of human resources for health from a wide range of interested countries represented by officials from different sectors”. This meeting stimulated further regional and international policy action on HRH, including African heads of state and government discussing human resource development issues at their summit in Durban in July 2002. At this time these government leaders decided to hold a summit on human resources in 2004 and to declare that year as the year for the development of human resources, with special focus on health workers (WHO AFRO, 2002). The executive council also used this occasion to call on member states to put together HRH development plans, motivate staff members through training and better conditions of service, and to improve the skills of those working in the health sector, as well as to put forward the idea of a code of ethics on international recruitment and the establishment of a mechanism to compensate African countries for the brain drain (AU, 2002). Flowing from the consultative meeting in early 2002, the WHO, World Bank and UNESCO also agreed to set up a task force on HRH development in Africa that would, among other things, be able to assist countries with strategy development and monitoring (WHO AFRO, 2002).

The consultative meeting in Addis Ababa had four specific objectives, one of which was proposing practices contributing to the retention and motivation of health workers. In their discussions, participants recognised the impact of pull and push factors such as poor HR planning and lack of recognition. They also considered strategies to prevent emigration and to improve retention, including better motivation and trainee selection. The meeting emphasised, among other things, the need for working conditions that would make it possible for health workers to do their work with commitment and incentives to attract health workers to underserved areas. Interestingly, evaluations at the end of the meeting indicated that only about half of the delegates felt strongly that the objective around retention and migration had been achieved, the lowest rating among the meeting’s four specific objectives. This was understood to reflect both the difficulty of the problem and participants’ sense of a crisis that required more than improved HR management practices (WHO AFRO, 2002).

In October 2002, the issue was also on the agenda of the WHO Regional Committee for Africa, again as a result of the meeting in Addis Ababa earlier that year (WHO AFRO, 2002). On this occasion, the committee adopted a number of strategy documents, including one entitled *Human Resources Development for Health: Accelerating implementation of the Regional Strategy*. This paper suggests six priorities: planning and formulation of HR policy, education, training and skills development, human resources management, managing the migration of skilled health workers, advocacy and resource allocation. The human resources resolution adopted at this meeting urged states both to prioritise the issue and to put on the international agenda the ethical and moral issues related to the recruitment of health workers by developed countries (WHO AFRO, 2002b & WHO AFRO, 2002c).

The NEPAD Health Strategy, adopted in 2003, is another focal point for regional discussions and action and identifies the need both to reverse the brain drain and to improve human resource development. The call for the development of an international agreement that would underpin an ethical recruitment approach is, thus, complemented by concern for actions to ensure availability and retention of health staff and to counter the push factors in migration. In relation to this concern, it specifically prioritises the following actions (NEPAD, 2003a & NEPAD, 2003b):

- Mobilizing more finances for human resources;

- development of policies, plans and training and development approaches relevant to countries;
- balance professional and auxiliary staff to ensure suitable skills, cost-effectiveness and availability;
- effective management of human resources through supportive management, updating policies on employment and deployment, flexible career paths, continuing education and fostering strategies for motivation and retention;
- demonstrably valuing health workers and recognising their professional worth and the difficult conditions in which many work;
- training increases
- salaries and work conditions improved.

These sorts of issues were also raised in an interim report on HIV/AIDS, TB, malaria and polio presented to the Fourth Ordinary Session of the Assembly of the African Union, held in Abuja, Nigeria, in January 2005 (AU, 2005). Recognising the need for an integrated and functional health system, the report also notes the HRH crisis facing the continent. Building on the 2002 Durban AU Summit's concern about HRH, and the NEPAD Health Strategy, the report recommended that countries should:

- determine which cadres of health workers will provide an appropriate human resource mix for their needs
- develop costed national human resources development and deployment plans, including revised packages and incentives, especially for working in disadvantaged areas;
- forward fund the establishment of the training capacity required to produce the desired number of health workers
- build a cadre of multi-purpose trained clinic staff as the nucleus of health care delivery.

In discussing health systems, this report also recommends that African Centres of Excellence and Knowledge Institutions should be established to spur African supported and driven health systems.

The 2005 Assembly ultimately re-affirmed its commitment to invest increased resources in health and to address internal obstacles impeding their utilization, calling specifically for inter-ministerial costed HRH development and deployment plans.

On a separate occasion, the African Union also endorsed the work of a programme of the International Organisation for Migration that seeks to harness the skills that Africans have acquired abroad for the benefit of the continent. Migration and Development for Africa (MIDA) encourages all those who have left the continent, including health workers, to return on a temporary or long-term basis, as well as to implement other initiatives to support home countries. The Ghana-Netherlands Healthcare project, for example, has encouraged Ghanaian health professionals to offer services, conduct research and implement projects in their country of origin (Nullis-Kapp, 2005 & Padarath et al., 2003).

International level

Overview

This review of international HRH initiatives is based on information obtained from scanning relevant documentation from key actors, as well as from opportunistic review of information generated through web-servers and from our own international

networks. As a result it is possible that some international discussions and actions of relevance have been overlooked¹.

In general, the international initiatives identified here highlight the need for action, identify a range of relevant policy options and then discuss what international strategies are required to support and sustain national action. As with regional initiatives, limited detail is given about how to implement any proposed policy change. Given the variety of policy contexts this is appropriate. Yet, as the national experiences make clear, some of the most difficult challenges in tackling HRH retention problems lie in the details of how to implement new policies and strengthen existing HR management practices. Much, thus, remains to be considered in thinking through how to tackle HRH problems.

The challenge of how to implement policy change is, instead, linked to the specific call for technical assistance to support national action. WHO has called for a global Technical Cooperation Network of experts in HRH and, talking of the need to move at 'AIDS-speed' in strengthening health systems, AIDS activities call for WHO-led country-level teams. Finally, strong emphasis is also given to the need for greater research and analytical work on HRH and health systems issues in support of national action. A challenge for regional organisations may in positioning themselves to support such country level action without being swamped by international demands or experts.

Policy initiatives

The last two years or so has seen the emergence of a massive international focus on HRH problems, encompassing but going beyond the question of international migration. Coinciding with the appointment of a new Director General of WHO, and a range of other new appointments in WHO, this focus is linked to the call to strengthen health systems in order to achieve the health MDGs. In addition it reflects recognition among international agencies² and AIDS activists that failure to address the human resource crisis will prevent the large scale implementation of existing health interventions (such as the provision of anti-retroviral therapy) necessary to meet needs, and lead to further deterioration of routine service delivery.

Nonetheless, the specific HRH focus appears to have been spearheaded by a range of prior initiatives. These include the work of the Pan American Health Organisation and its HRH observatories, as well as the African health ministers' interventions in the World Health Assembly. Also key was the analytical and networking activities of the Rockefeller Foundation's Joint Learning Initiative (JLI), whose final report was launched during the November 2004 Ministerial Summit on Health Systems held in Mexico (JLI, 2004). In parallel, the Millennium Project, coordinated by Columbia University for the United Nations, released a report on the Maternal and Child Health MDGs in 2005, which again strongly emphasises that the HRH needs of health systems must be met to sustain progress towards the MDGs (Freedman et al., 2005).

Picking up a concern initially raised in its January 2004 meeting, the African HRH crisis was specifically discussed within the High Level Forum on the health MDGs

¹ However, Dr. Evan's presentation to the HLF in December 2004 suggests that several bilateral as well as multi-lateral agencies such as the World Bank and UNDP have supported recent international initiatives outlined here. In addition, a key action of AIDS activists is also discussed here.

² Such as the Global Fund to Fight AIDS, TB and Malaria (GFATM), the Global Alliance for Vaccines and Immunization (GAVI), and the WHO 3x5 programme to expand access to HIV treatment.

held in Abuja, Nigeria in December 2004 (Box 1). Subsequent discussions have continued among a small group of actors, led by WHO and with Norwegian support, about how to take forward action on HRH.

Box 1: Presentation to the High Level Forum by Dr. Tim Evans, WHO, December 2004, on in Africa's health workforce crisis

Principles of action:

- country led action and global solidarity
- learning from experience
- looking beyond the health sector for solutions
- seizing the opportunity for action arising from concern for the MDGs
- train, retain and sustain

Policy agenda for country-led action:

- motivation and retention through specific incentives and strengthening management capacity
- recruiting already trained staff who are either unemployed or working in other jobs using the capacity available within the not-for-profit and for-profit sectors
- enhancing productivity by improving working conditions and enhancing absorptive capacity

Other supportive actions:

- overcoming macroeconomic constraints and recruitment ceilings
- exploring new international mechanisms to resource new education initiatives
- technical cooperation to support analytical and planning activities, and using international volunteers as a short term solution to the crisis
- better intelligence for HRH including strengthening health systems and HRH research

The range of other HR related processes include: the work of Northern NGOs seeking to influence high income country responses to the problem of international migration; the continuing work of the JLI, including a specific Africa network; the 2005 Montreux meeting on health systems involving WHO staff, global initiatives such as GFATM and GAVI and other groups such as the NEPAD health secretariat; and the continuing lobbying and advocacy of AIDS activities around care and treatment.

The JLI's rallying cry of a million health workers for Africa has been widely quoted and taken forward through these and other activities. At the 2005 WHA, AIDS activists, for example, specifically secured amendments to the MDG resolution (WHA58/B/Conf. Paper 6), which they are now using as the basis for a call for massive and emergency-scale action internationally and within countries to tackle HR problems and strengthen health systems to support achievement of ARV targets. They have specifically called for WHO to develop teams of technical assistants bringing together government officials with NGOs, health professional associations, donors and others, in order to work both at national level (strengthening systems and planning ahead) and district level (problem-solving).

Many of these initiatives are clearly inter-linked. There also appears to be quite widespread agreement around the types of policy actions that need to be taken (as presented at the December 2004 High Level Forum; see Box 1). These include the need for technical assistance to support national level action, and WHO headquarters and WHO AFRO are also thinking through the regional structures and processes that can support national action.

Finally, a series of forthcoming activities will add further international opportunities and pressure for action on HRH problems. These include:

- the G8 Summit in July 2005;
- the UN Summit to review progress since the 2000 Millennium Declaration;
- the next High Level Forum;
- the World Health Report 2006 and World Health Day 2006 both of which will be focussed on HRH issues.

It is noteworthy that, although at times linking to or building on regional action, these international activities are currently largely being driven from outside the region despite the strong emphasis on the particular importance of African HRH problems.

4. National policy environments

Despite country differences, this review of three national policy environments highlights some important similarities across countries in terms of HRH problems, interventions being considered and implementation challenges. Here we provide an overview of these experiences, with the more detailed analyses of each national situation presented in Annexes 2 to 4. We again note our awareness that the Malawi review is particularly limited, given our less detailed knowledge of that country and difficulties experienced in arranging interviews.

HRH problems, causes and context

Across countries it is clear that there is a new urgency about the need to address human resource problems despite their long-standing nature. These problems are important contributory factors to weak health sector performance.

Current problems identified in all countries include an absolute shortage of health personnel at least partly connected to weak production planning in the past. In Tanzania it is also linked to the public sector employment freeze of the 1990s, part of the structural adjustment programme, whereas in Malawi and South Africa current levels of international migration are identified as an important cause of shortages. However, migration clearly affects cadres differently. Although few figures are available, in Tanzania there is concern about the migration of doctors, in Malawi, of nurses, and in South Africa, of all cadres of personnel. HIV/AIDS mortality is also a problem affecting health personnel availability across countries.

The problem of retaining staff in rural areas is a second important concern in South Africa and Tanzania, but less discussed in Malawi. The movement of staff from the public to the urban-based for-profit private sector in South Africa only exacerbates the shortages in rural areas. In Malawi and Tanzania there is also concern about the proportion of health workers/doctors working privately or in managerial positions outside the health sector, although, in contrast to South Africa, there is evidence that allied health professionals and nurses working in church-run facilities in Tanzania increasingly seek public sector employment.

Overall staff shortages are generally said to exacerbate retention problems because they result in increased workloads that contribute to the demanding nature of the health workplace. At the same time, population health needs are growing and changing in ways that add to these demands, with HIV/AIDS being clearly important. The resulting skills mix problem (at individual and system level) are another HRH problem which itself contributes to low levels of motivation and productivity among staff by undermining their own confidence in their skills. One Tanzanian estimate suggests that improved management and optimized staffing levels could themselves

generate a nearly 30% productivity gain by reducing the time spent on unproductive activities.

Other than workloads, the problems of working conditions that may push staff out of rural areas/the public sector include shortages in the drugs and equipment needed to provide care (although in Tanzania improvements are noted to have resulted from the health reform programme), lack of in-service training opportunities to upgrade skills and, in rural areas specifically, the general difficulties of living conditions (poor schooling for children, poor housing, poor transport etc). Low salaries are also important in all three countries, although the problems of Malawi, particularly, are clearly of a different order of magnitude to those in South Africa. A final factor underlying retention problems and raised frequently in South Africa and Tanzania is poor people management – resulting in health worker concerns that they are neither cared for nor their hard work, recognised.

Beneath the surface of these problems and immediate causes in all countries are indications of the critical influence of contextual factors over HRH problems. Although more detailed and nuanced inquiry would be necessary to fully investigate these issues, some of the relevant contextual influences are identified here.

All countries are, for example, in socio-political transition: from authoritarian rule to democracy in Malawi, from apartheid to democracy in South Africa, and from socialism and a single party state to a more liberal philosophy and multi-partyism in Tanzania. The legacies of the past clearly influence current problems (and will pose challenges for policy implementation). The opening up of South African and Malawian societies has, for example, created opportunities for migration that did not exist before. The centralised nature of the South African bureaucracy, as inherited from the apartheid era, makes it a weak vehicle through which to manage people effectively. Societal and health system challenges to the professional status of nurses in South Africa only exacerbate their own sense of being unfairly treated by their employers and society at large. Socialist thinking and practices continue to influence public sector pay structures in Tanzania and to constrain efforts to even suggest that the health workforce should get special treatment relative to other civil servants, or to improve pay levels for middle level cadres, such as doctors.

In addition to socio-political transition, in all three countries macro-economic policy frameworks and philosophies place constraints on health system resource levels, which in turn place limits on what can be done to tackle HRH problems. But clearly, the Malawian and Tanzanian economic constraints are of a very different order of magnitude to those of South Africa.

South Africa is also unusual among the three countries in having a very strong private for profit health sector, another feature of context with direct bearing on current HRH problems. The public-private movement of staff exacerbates the difficulties the public health system faces in addressing the needs of the majority of the population with a minority of the country's total pool of health care resources. In addition, the practices of the private sector only add to the pressure for unrealistically high salary levels within the public sector. Other important HRH inefficiencies and inequities inherited from the apartheid era include the mal-distribution of health workers between rural and urban areas, an inadequate emphasis on primary health care needs in training and inequitable access to training opportunities.

Finally, the combination of wide ranging public and health sector reform programmes in South Africa and Tanzania create an uncertain and demanding environment for

health workers which is itself de-motivating. Similar concerns were hinted at in Malawi in relation to its decentralisation strategy.

HRH policy options

There are some similarities in the package of policy options being considered in each country, both within the health sector and the public sector more generally (Table 2). For example, various additional financial allowances are being considered or implemented in all countries within the context of medium term pay policy frameworks and the overall medium term expenditure framework (even the same terms are used to describe these different policies in Malawi and Tanzania). Similar types of reforms to the public sector performance appraisal system are also being considered in both South Africa and Tanzania, although with different names.

However, in comparing these countries it is clear that Malawi has taken three important and unusual actions: a donor-funded salary top up for public health staff, an emergency human resources programme and the creation of a special health commission charged with review of employment regulations for health workers. None of these Malawian actions are as yet even being contemplated in Tanzania, which is instead focussing its current efforts on improving recruitment processes and tapping into the pool of trained staff who are not currently working in the health sector. The lack of action on production in Tanzania is particularly noticeable in the face of the significant levels of staff shortages.

In contrast again, South Africa has so far focussed its policy efforts on strategies to improve HR availability in rural areas (the Cuban doctor programme and the medical internship programme) and actions to limit international migration (such as the WHA resolutions and a bilateral agreement with the UK). Within the last year it has also implemented a new financial incentive, the scarce skills and rural allowance. Unlike the Malawi health worker salary top up (but like the selective allowance in Tanzania), this South African allowance represents a small addition to existing wages for which only some staff are eligible. A third policy option receiving considerable current attention in South Africa is that of developing mid-level workers. Drawing on the past experience of other countries (such as Tanzania), the proponents of this option see it as a cost-effective strategy for ensuring the human resources needed to strengthen primary health care, with the added benefit of developing a cadre less likely to migrate. South Africa is also expanding its training of CHWs for similar reasons, and in response to the particular needs created by the HIV/AIDS epidemic.

The commonalities in discussion and action across countries include the relatively limited weight given to bonding as a mechanism of retention, the recognition but varying action to tackle skills' mix problems and the growth of dual practice arrangements (which are commonly seen to have dangers).

In addition, no country has yet finally identified a coherent package of interventions and actions to strengthen non-financial incentives and tackle the problem of poor people management within the health sector. Public service reform programmes in South Africa and Tanzania are bringing changes to performance appraisal systems, with open discussion of objectives and performance between appraiser and appraisee replacing more confidential and closed systems, but there has been little or weak implementation of them in the health sector as yet. There is also some recognition in these countries of the need to strengthen public sector management skills to allow better human resource management, as part of a wider move to transform the HR function to serve a more strategic purpose. Within the health sector there are ongoing efforts, again in South Africa and Tanzania, to strengthen supervision as part of quality assurance efforts, and in South Africa these efforts also

include implementation of the Patient's Rights Charter intended to support stronger engagement and accountability between providers and patients. However, there is little sense that any of these policy initiatives were seen by health managers as ways of addressing current HRH problems nor any sense that the range of current actions are conceptualised as an integrated package of non-financial incentives for the health sector. Nor, except in church facilities in Malawi, were specific actions being taken to address the problems of living and working in rural areas (such as allowances for school fees).

Finally, across countries there appear to have been few attempts yet to draw on new resources for HIV/AIDS in tackling HRH issues. Clearly the international recognition of this need is itself new and so unlikely as yet to be translated into country level action. However, concerns were expressed about the so far limited consideration or new thinking being given to the actions necessary to avoid treatment programmes simply escalating the demands placed on already over-burdened and de-motivated health workers.

Policy drivers and implementation challenges

What's driving which policy options are being considered or overlooked, and what factors are likely to constrain implementation?

Past experiences are one explanatory of which policy actions are prioritised at country level. For example, Tanzania was an innovator in HRH issues, introducing mid-level cadres soon after independence. Accepting their important role in the health system, its current efforts focus on strengthening skills and developing career paths for these cadres. South Africa, meanwhile, continues to debate the relevance and role of mid-level cadres, as a radical departure from the past. It has also repeatedly toyed with the idea of stronger linkages with private sector GPs given, on the one hand, past experience of contracting them to provide primary care but, on the other hand, negative experience of their attitudes and behaviour towards poor clients. The way the HRH problem is predominantly conceived also appears to have an influence over the policy action taken. The dominant focus on absolute shortages in Tanzania may explain the relatively limited attention given to efforts to improve productivity and performance, despite clear evidence of these problems. Perhaps Malawi has focused on low salaries and South Africa on international migration at least partly because these problems have been seen as most important.

Yet despite the different responses to HRH problems, some common factors appear to shape the pattern of policy (in)action across countries. International initiatives and thinking may be helping in problem recognition and in setting national policy agendas, as reflected in the commonalities of experience across countries. Earlier review of regional and international debates also indicates a fairly high level of agreement on what needs to be done. In addition, international thinking can influence national agendas by changing the common understanding of what is acceptable or feasible. Very few actors across the three countries felt that bonding was still a reasonable policy mechanism to address recruitment and retention problems³, despite its widespread use in past decades. In more liberal environments, incentives rather than compulsion are more acceptable policy interventions. Malawi's experience also demonstrates the wider problems of feasibility with this option.

³ Although the South African community internship might be seen as a form of bonding it was developed as an additional year of training rather than a requirement for subsidies received.

Table 2: HRH policy options proposed or being implemented

Category	Malawi	South Africa	Tanzania
Recruitment	<p>Being implemented: HSC speeds up recruitment and promotions. Mass promotions across cadres</p> <p>Being implemented: Bonding</p> <p>Being implemented: Bringing specialists from other countries</p>	<p>Being implemented: Cuban doctor programme</p> <p>Being implemented: community service (temporary bonding mechanism)</p> <p>Contract private GPs</p> <p>Overseas training with contractual binding or cost recovery if migrate</p> <p>Community initiatives such as career guidance & learnerships</p>	<p>Being implemented: Centralised recruitment of clinical officer cadre by MOH on behalf of Local Councils (to be followed by other cadres)</p> <p>Employ trained staff now outside health sector</p> <p>Bonding newly employed staff</p>
Financial incentives	<p>Being implemented: Salary top-ups to certain health workers</p> <p>Being implemented: Allow private practice</p> <p>Being implemented: CHAM assistance with school fees, medical expenses etc.</p>	<p>Being implemented: Scarce skills and rural allowance</p> <p>Being implemented: limited dual practice</p> <p>New remuneration structure for professionals, including health</p>	<p>Differential salary levels for health personnel relative to other civil servants, in line with MTPS</p> <p>Rural incentives</p> <p>Agreed but limited implementation: Extend (SASE) Selected Accelerated Salary Enhancement Salary scheme</p> <p>Being implemented: Dual practice in hospitals</p>
Skills' development	<p>Broader initiatives to strengthen skills to be implemented through SWAP</p>	<p>Being implemented: Management training (health and civil service)</p> <p>Being implemented: PHC skills development</p> <p>Being implemented: Continuing Professional Development (CPD) programme</p>	<p>Being implemented: Continuous education to update clinical and general management skills of existing staff through Zonal Training Centres (ZTCs)</p>

Category	Malawi	South Africa	Tanzania
		Use of skills levy funding	
Non-financial incentives	<p>Being implemented: HIV policies in workplace</p> <p>Broader initiatives to improve management and supplies to be implemented through SWAP</p>	<p>Improve working conditions (e.g. through modernisation of hospitals)</p> <p>Agreed but limited implementation: Participatory decision-making, teamwork, praise</p> <p>Agreed but limited implementation: New civil service performance appraisal system</p> <p>Being implemented: Private sector allows people to work abroad for short periods of time</p>	<p>Agreed but limited implementation: Open Performance Appraisal System (OPRAS)</p> <p>Contracts based on performance targets and flexible remuneration for most senior civil servants</p>
Production	<p>Being implemented: Emergency programme to train more health workers, including substitute cadres</p>	<p>Increased production</p> <p>Agreed but not implemented: Train mid-level workers</p> <p>Being implemented: Train Community Health Workers</p>	<p>No action yet</p> <p>Mid-level cadres already in existence</p>
Structural	<p>Being implemented: Creation of Health Services Commission (HSC)</p> <p>Being implemented: Decentralisation</p>	<p>Being implemented: Decentralisation</p>	<p>Being implemented: Decentralisation</p>
Migration	no specific action	<p>Being implemented: Bilateral agreements</p> <p>Exchange agreements (allow staff to return to same positions when come back from overseas)</p>	no specific action

Another common influence over country level action is the policy context. Malawi's unusual steps, thus, seem to reflect coordinated efforts between government and donors, particularly DFID, to take advantage of a window of opportunity for policy change. The window may have been partly opened by the broader international concerns around HRH issues and specific publicity given in Britain to the flight of Malawian nurses to the UK. Common recognition that an HR crisis exists also paved the way for action, and an important factor in relation to implementation of the salary top-ups has been the IMF's flexibility around macro-economic ceilings. Nonetheless, economic constraints do continue limit the country's ability to expand production.

Perhaps the socio-political transition in Malawi also opened up policy space more than in Tanzania - where the legacy of socialist practices is very strongly identified as, for example, restricting special treatment for one group of civil servants over another. In addition, Tanzanian macro-economic thinking seems to remain fairly firmly tied to limits on public sector expenditure and within that, public sector wage bill limits. As a result although donors do support the special allowances paid to some health staff, wider donor funding of salaries is not currently being considered. Public sector expenditure limits also appear to constrain Tanzanian thinking about the need to expand health personnel production, because such efforts would require considerable initial investment in physical infrastructure and training teaching staff. Similarly, improving rural infrastructure to address living condition problems requires considerable and very scarce capital investment. Although not needing donor support, similar constraints also limit South African policy thinking. There is, specifically, concern about treating some groups of civil servants differently from others and clear limits on public sector expenditure, including the public sector wage bill. Perhaps in both countries there is also less of a sense, than in Malawi, that the human resource problems of the health sector require emergency responses. The high level lack of awareness of current problems was certainly raised as a factor limiting policy action in Tanzania.

In all countries, the complexity of HRH issues requires that many different policy changes are considered simultaneously, and the different needs of different cadres are also recognised. Complex policy changes are always difficult to implement. The need for high level political support and coordinated action across a wide range of government departments and other actors also clearly also shapes what policy actions are even considered.

Government and donor agreement has enabled specific actions to be taken in Malawi. In Tanzania, the most urgent next step for HRH policy development is the submission of a Cabinet paper to raise awareness of the problems and garner high-level political support for action. Until now, much of the thinking about how to tackle HR problems has remained tied to training, largely in-service training, perhaps because the Ministry of Health has primary control of that function (subject to budget availability). Recent actions to fast track recruitment have only been possible as a result of high-level agreements between health, finance and public sector management officials. Similarly, the recent introduction of the scarce skills and rural allowances in South Africa was only possible because of agreement between officials of the health, treasury and public service management departments, as well with representatives of health professionals.

At the same time, the general lack of action on key retention problems (such as improving rural infrastructure, increasing production or improving management) can also be seen partly as a function of the difficulties of coordination across government. Health ministries are often quite weak players within government and health officials often fail to develop arguments that persuade other powerful government actors

(such as treasury or public service officials) to support HRH policy initiatives. The gap in mindsets between government departments is itself an important implementation barrier.

Active contestation around HRH policies is particularly evident in South Africa, where powerful actors outside government – including professional associations and trade unions, the leaders of health professional training institutions and private sector actors – also have influence over policy change. Thus, despite policy statements favouring the development of mid-level cadres, the clear opposition from the professional bodies to these cadres is likely to slow down and perhaps prevent implementation of this policy. At the same time, the need to negotiate with a wide set of actors inevitably delays decision-making processes. Implementation of the scarce skills and rural allowances was, for example, delayed by the opposition of nursing professionals and the resulting need to adapt the policy to get their support. In contrast, health professional associations and other actors are weak in both Malawi and Tanzania.

The complexity of HRH problems and the need for political sensitivity and coordination in enabling policy change places particular demands on the central HR planning and development capacity of every health ministry. The capacity needs of these units commonly include more personnel with a wider range of skills to allow them to tackle production and management issues effectively. Vital but overlooked skills are those of persuasion, negotiation and actor management, and greater political leadership and backing on HRH issues within health ministries is also required. Finally, stronger information systems also needed to support workforce planning and management. Although policy frameworks or plans are commonly understood as one function of these units, they also need to do much more and to work more quickly.

A policy document is, moreover, not enough by itself to ensure implementation. The major difficulties of implementation in a context of multiple reforms and system change were specifically noted in South Africa and Tanzania, and hinted at in Malawi. This reflects broader concern about the negative impacts of health reform programmes on the HRH function. Decentralisation in South Africa and Tanzania also means that implementing HRH policies requires coordination with the local governments engaged in primary health care delivery. More generally, managers and health workers throughout the system must also support policy change for effective implementation, yet are already over-burdened and de-motivated.

This complex implementation environment may itself help to explain why some policy actions are prioritised over others. Financial incentives, for example, may not only be seen by some as the most appropriate response to current needs, but may also, easier to implement than efforts to strengthen non-financial incentives. New allowances or improved salaries can, in theory, simply be fed through the existing payment system without much need for change in the way things the health system functions. In contrast, new performance appraisal systems, for example, require everyone within the health system to function differently, challenging existing organisational cultures. Sustaining the implementation of such policies is inevitably a complex and long process that is difficult to manage. The irony of this thinking is, however, that the 'simple policy change' of salary increases or new allowances is quite widely recognised to have potential to impact negatively staff if not well managed. In both South Africa and Tanzania strong concerns were expressed about the divisive impact of allowances paid to selected people, as they undermine the self-esteem of those not receiving them (by signalling that they are less valued than others) and so undermine the team work needed for health care delivery.

The example illustrates not only how financial incentives can incorporate non-financial incentives, but also that every policy change requires careful and active management. Although a very difficult task, strengthening management, especially people management, is always necessary in addressing HRH problems.

5. Summary and implications for regional action

The importance of HR retention to health system performance is acknowledged at all levels. Efforts to support sustainable policy action on the problem of HR retention are vital to the overall efforts to improve health system performance.

National level assessments suggest that regional and international HRH initiatives contribute to these efforts by outlining a policy agenda and provide an enabling international environment. There are, therefore, similarities in the packages of policies discussed across levels. In addition, regional policy agreements achieved through formal structures such as the AU and SADC, provide, at a minimum, repeated reminders to countries that these are critical areas for policy action – and may, over time, stimulate such action. International discussions, such as those with the High Level Forum, have in some ways a similar effect, though with little or no binding force. In addition such actions serve to remind all countries, including high income countries, as well as bilateral donors and multilateral institutions, that tackling HRH problems is a vital effort in strengthening health systems, promoting health and achieving the MDGs. Ultimately, such discussions may enable national action by, as in the Malawian context, securing additional resources and encouraging the relaxation of previously binding policy constraints.

However, it is also clear that implementation of HRH policies is always likely to be difficult. The problems are intractable and long-standing and no single policy action can by itself cut through their multi-faceted and inter-connected nature. Instead, as national level analysis indicates, a package of complementary actions is required that has the support of high level political actors. This package must then be implemented through complex governance structures, requiring coordination amongst national governmental actors and across governmental layers, as well as coordination with non-governmental actors including, at least in South Africa, powerful professional and private sector interest groups. An outline policy agenda and an enabling international environment may help to initiate action, but are not enough by themselves to sustain it.

Perhaps in recognition of these circumstances, regional and international debates strongly emphasise the need to support policy action by active processes of dialogue and engagement with a wide range of actors. International initiatives explicitly call for national action on HRH issues to be supported, and perhaps even led, by external technical assistants. The Malawian experience seems to provide a national example of joint government and donor action on HRH problems.

However, sustained implementation of any health policy change requires more than national level agreement between government and donor representatives/ technical assistants. It generally also requires widespread political and popular support, as well as the support of the health workers (managers, doctors, nurses, allied health professionals) responsible for service delivery (Walt, 1994; Walker and Gilson, 2004). The support of health workers is particularly important where they are the subjects of the policy action. A failure to gain their support for HRH policy initiatives may lead to greater problems of retention, lower motivation and weaker productivity. The cross-country concern about the unanticipated and negative impacts on health staff of

selective financial incentives reflects the dangers of poorly thought through and communicated policy change. In addition, the chances of successful policy change are enhanced with adequate recognition of the specific contextual features shaping policy agendas and patterns of policy implementation. The power of professional bodies, even at the level of resisting policy change, should not be taken lightly in South Africa. And the legacies of authoritarianism (Malawi), socialism (Tanzania) and apartheid (South Africa) have to be taken seriously in order to enable policy change and limit the dangers of unanticipated negative policy impacts. Understanding of national and health system histories and cultures is always an essential input for policy implementation.

So, whilst action on HRH problems is clearly urgent, such action must also be careful. A policy idea is not enough to generate action, it must be backed by adequate levels of political support. An implementation plan is also not enough, as all the possible problems and required responses cannot be determined in advance. In addition, sustained processes of implementation are necessary – processes that involve people across the health system as well as outside it, and that have the flexibility to change direction in response to identified problems. Regional actions to support country level policy change must, therefore, acknowledge its limits and be provided in ways that support processes of implementation and not just action on specific policy ideas.

So what future role can EQUINET, a regional network, play in supporting national action on HRH problems?

Let's first consider EQUINET's strengths and opportunities. It is a regional grouping with institutional bases in several countries. These bases are rooted in countries, rather than being external to them, with people knowledgeable about national histories, cultures and actors. It is a grouping that combines analytical/research expertise with linkages, to varying degrees across countries, to parliamentarians, civil society organisations and governmental actors. It also already has links to formal regional structures such as SADC and SATUCC, and an international reputation. In the field of HRH specifically, EQUINET is developing a body of specific analytical work and has links with interested international groups.

However, its constraints include, in particular, limited human resources as well as budgetary limits, varying levels of in-country engagement with the full set of actors relevant to HRH issues and relatively limited political clout at national level.

Nonetheless, given the needs and its bases, EQUINET could, in broad terms, **engage with others in providing a focal point for regional networking in support of HRH policy action**. Given the extent of the needs on the ground and EQUINET's own constraints, this networking could benefit from links with other civil society networks that are specifically concerned with HR issues, such as the African JLI grouping. In addition, links with formal structures, such as those of WHO, could offer opportunities for engagement with governmental groups. As NEPAD is interested in supporting regional networks EQUINET could, finally, explore a link with it as this could offer specific opportunities for engagement with the AU.

More specifically, EQUINET could support **two sets of activities** – one analytical and the second, dialogue and engagement with key actors.

Analytical work:

Current policy ideas and initiatives suggest four areas in which EQUINET could support new analytical work:

- monitoring the implementation of new financial incentives for health workers within countries, with specific respect to their impacts, the processes of implementation and the links between the two;
- developing specific ideas around, and evaluating current innovative experiences of implementing, actions intended to generate non-financial incentives – such as new performance appraisal systems, quality assurance systems, new supervision systems and practices, patient/citizen accountability mechanisms; again the most useful evaluations of current experiences would need to consider impacts, implementation processes and the links between them;
- review of the adequacy of current health management training courses offered across the region and of new approaches to support stronger management of people within health systems;
- monitoring at country level the impact of externally driven HR interventions and/or other interventions likely to impact on HR issues (such as around HIV/AIDS).

These areas are priorities because the common recognition of their importance has not yet led to clear policy ideas. More thinking needs to be given to what forms of non-financial incentives can be developed through what strategies of policy change and supported by what processes of coordination and engagement among relevant actors.

These areas of work would also tie well with wider EQUINET work on human rights and governance (for example, around accountability mechanisms), work on HIV/AIDS and Financing, and proposals to review and develop new capacity building activities (including those focussing on policy analysis),

Dialogue and engagement: However, it is clear that analytical work must be linked to, supported and extended by activities that focus on building widespread understanding and support for general HRH policy action, as well as specific policy proposals. High level political support is required within countries as well as the sustained involvement of actors across the health system.

As a starting point, there is clearly a need to disseminate existing knowledge more effectively, transforming it into policy briefs that can be made widely available and used to inform national policy debates⁴. One set of briefs might focus, for example, on the pros and cons of specific policy options (e.g. mid-level workers) as evidenced by existing experience of their implementation. Another might consider what steps need to be taken to initiate specific changes within the public sector in different countries (e.g. faster recruitment processes) or how to link wider actions to HRH problems (e.g. linking performance appraisal and supervision). And a third set might consider how different policy options could be framed and presented in ways that address the mindsets and concerns of actors whose support is needed for implementation (such as Ministries of Finance and Public Service; and professional bodies).

In addition, EQUINET could engage key actors in order to support HRH policy implementation. For example it could:

- work with regional parliamentarians to raise understanding of HRH problems and policy options – using its own and other existing HR work;
- sit down with one or two regional professional and trade union groupings to think through and make explicit their perspectives and concerns on, and approaches to implementing, specific HRH policy options, as a basis for thinking about what

⁴ This idea is already being discussed in international circles.

strategies could be used to build collaboration with them in support of policy implementation;

- provide a closed-door forum and facilitate dialogue between senior health, finance and public service officials about their different perspectives on HRH issues, in order to generate common ideas about required policy actions as well as strategies to allow implementation of a package of HRH policies, and/or specific policies;
- provide a forum in which to share current experiences of implementing policy options among senior public officials from different countries and, specifically, to generate ideas about the processes and strategies that could be used to manage key actors in support of implementation;
- seek to inform and engage African Ministers of Health and health officials in collaboration with WHO AFRO, SADC or AU, from the platform of its wider body of work;
- seek to inform international debates and initiatives about the needs and experiences of the region and opportunities for policy change.

Some of these processes would build on EQUINET's existing institutional linkages and some could be supported by new engagements with the formal structures of WHO AFRO, SADC and NEPAD.

In relation to these processes, EQUINET should be cautious of over-extending already over-worked colleagues. It would be important, therefore, to look for synergies with other initiatives, even whilst, as a regional network, seeking to maintain leadership. As noted, if and when external initiatives around HRH come to bite at country level, EQUINET could also play a role in monitoring their impacts and processes.

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ANNEX 1: TERMS OF REFERENCE

The research will focus on policy analysis at the regional and country level, and aims to strengthen the SADC Regional policy context for supporting the retention of HRH within the Region. The research will comprise two components:

1. A Document Review encompassing Regional and Country level initiatives targeting Human Resource for Health initiatives.

2. Country level research with policy makers in South Africa, Tanzania and Malawi and Regional research with SADC Policy makers.

Areas of focus for the interviews will include:

- Stemming the flow of international HR migration including consideration of:
 - what policies (including incentives, production of appropriate types of HRH and other mechanisms) are being developed to support retention and why these policies have been selected;
 - if and how the wider economic benefits of migration may have influenced policy development and content;
 - whether AIDS resources are being used to support wider HRH retention;
 - views on the pros and cons of different policy instruments and strategies, including consideration of how effective these instruments have been or may be in addressing wider constraints on public sector employment;
- Consideration of which are the most feasible options for national level implementation, and what national action would be required to implement what has been identified as feasible;
- Examining the implications of policy options for Regional Agencies, especially with regard to synergies and conflicts with other policies eg. is there now a policy synergy to strengthen HRH in order to make 3X5 possible, and what regional action would be required to implement that which has been identified as feasible at national level.
- What are the areas of concurrence and difference across countries?

3. Preparation of a report of the Research, a draft of which is to be completed by June 2005.

ANNEX 2: THE MALAWIAN EXPERIENCE

Introduction

It has been at least a decade-and-a-half or so since the first steps were taken in Malawi to tackle the problem of the retention and migration of health workers. The recollections of interviewees indicate that in this earlier period, policy-makers were concerned about retaining the country's doctors, all of whom were trained outside Malawi at that time, and that this concern was addressed in part by the establishment of the country's own medical school in 1991. While the issue has therefore been on the policy agenda for some time, there is also a sense among some that it has, of late, become more severe, occupied the minds of policy-makers more fully than at some other points in the past, become the focus for action that is in some ways more concerted and comprehensive than before.

Over the years, government, donors and civil society organisations have worked to define and highlight the HR crisis in the Malawian health sector. Recognition occurred, in part, because some donor projects found it increasingly difficult to operate effectively due to the lack of frontline staff. It seems that the process, in the late 90's, around the formulation of the country's national health plan was one of the catalysts that helped to push the HR crisis higher up the policy agenda. Prior to that, and according to some to a certain extent after that, the focus was on other priorities such as the construction of health care facilities. While other priorities may have overshadowed human resources at some points, it does not seem that a pre-occupation with the potential economic benefits of migration (such as sending remittances to family members) was one of them. Arguments such as these appear to have very little currency in Malawi, with the focus much more on addressing the crisis in health service delivery.

Problem recognition and agenda-setting have also occurred against the backdrop of initiatives and debates on the international stage, with the Joint-Learning Initiative (JLI) for example having played a part in making donors more aware of the problems in sub-Saharan Africa more generally. The work to tackle human resource issues in Malawi developed simultaneously with that of the JLI, in the context of the increasing international profile of the issue. While international debates have therefore had some impact in Malawi, there is very little in the interview data to indicate that the country is, with respect to retention and migration issues, very active on the regional and international stage. Taken together, the passing of time, significant in-country work to highlight the problem and very visible international campaigns have given rise to a situation in Malawi where, today, the problem commands the attention of a wide range of actors, including a variety of agencies in government, the Christian Health Association of Malawi (CHAM), training institutions, regulatory bodies and donors.

HR problems and immediate causes

The retention and migration issue in Malawi is understood, firstly, to have an in-country dimension, where the problems include the retention of health workers in the public sector in the face of the better prospects offered by the private or NGO sectors. Movement to CHAM facilities does not appear to be the key concern at present. It was a major concern in the past, but the current situation reflects an understanding of CHAM as more of a partner than a competitor. However, even facilities associated with CHAM have some flexibility to offer their employees benefits such as assistance with medical expenses and school fees, which are not available in the public sector. This dimension of the problem is also reflected in official documents, such as the Health Sector Human Resources Plan developed in 1999 (Ministry of Health and Population, 1999) and a more recent draft document entitled

Human Resources in the Health Sector: Toward a Solution (Ministry of Health, 2004). As indicated in interview data, there is also a need to be cognisant of health workers leaving the sector altogether, not just those moving between types of providers.

Secondly, there is a keen awareness of the international dimension of the problem, which relates to the migration of health workers to destinations such as the United Kingdom. A recent report, using requests for the validation of registration as a proxy, reports that 230 nurses left the country in 2000/1, 103 in the year thereafter and 108 in 2002/3 (World Bank, 2004). This represents about 4% of all nurses providing services in the sector, with most emigrating to the United Kingdom. There is also a sense among some that the problem is more severe among nurses than doctors and that the country's relatively good retention of doctors is partly a function of its establishing its own medical college. There appears to be some truth in this notion that Malawi has done well to retain doctors. Broadhead & Muula (2002) report that 168 doctors have graduated in Malawi since mid-1992. Of these, 112 were working in Malawi, with 43 taking part in postgraduate training programmes abroad but expected to return.

Thirdly, documentary evidence suggests that in grappling with the problem of retention in Malawi one has to think about attrition as a result of death, not least death caused by HIV/Aids. Interestingly, this dimension of the problem, while raised in selected interviews, did not emerge as a major discussion point during the in-country interviews. The Health Sector Human Resources Plan (Ministry of Health and Population, 1999) recognises that death is the biggest reason for staff losses and this issue is also picked up in later work. Amongst ministry of health staff, death accounted for 56% of staff losses and voluntary resignation for a third in 2002. Expressed in nominal terms, a total of 142 staff members were lost in 2002, 80 through death and 47 through resignation. The rest of the losses were related to abscondment (8), retirement (5) and dismissal (2) (World Bank, 2004).

Of course, the concerns over retention and migration only really become meaningful when viewed against the backdrop of the bigger picture of the human resources situation in the Malawian health sector. It is worth reflecting, for example, that there are more than 21000 established posts in the health sector, but that a third of these are vacant. Approximately two-thirds of the established nursing posts in the public sector are unfilled and among clinical officers this figure stands at about 27% (Ministry of Health, 2004). Analysts use words such as "critical" and "meltdown" (Ministry of Health, 2004). "The country's health system has become so dysfunctional," argue some, "that unless drastic measures to address human resource issues are implemented now, the country's mortality and morbidity profile is likely to get worse, making it unable to reach its Millennium Development Goals and its objective of reducing poverty through better health services for its people" (World Bank, 2004).

Information from respondents and documents therefore indicates that Malawi's retention and migration problem has a number of dimensions. Health workers are moving from the public to the private sector, from Malawi to other countries and significant numbers are dying – all within the context of an absolute shortage. The country's difficulties are furthermore seen to be related to a number of specific problems, including frustration or reduced job satisfaction caused by a lack of equipment and supplies, lack of social amenities in rural areas, demotivation associated with a lack of career and promotion opportunities, lack of opportunities for training and the improvement of qualifications, and work pressure or patient load (which is, of course, partly a function of retention and migration problems). This list of factors, a composite drawn from a range of interviews, demonstrates an

understanding of the non-monetary reasons why health workers might choose to work elsewhere, but in Malawi it is difficult to escape the near-universal mention of the problem of money.

Context

The economic situation in Malawi is important for understanding the human resources situation in the health sector. Macro-economically, Malawi's high-level of indebtedness has been of concern because it constrains expenditure on other items. The government that took office in May 2004 has achieved gains in terms of macro-economic stability and ensuring that expenditure remains within budgets. Historically, health workers' remuneration has not kept pace with increases in the cost of living. At the micro-level, the comparatively poor remuneration of individual health workers is well documented and graphically illustrated through comparisons with the levels of remuneration in other SADC countries. The median salary-earner among health workers in government employ in Malawi earns the equivalent of about \$45 per month, whereas this figure is \$251 in Tanzania, and \$857 in Botswana (World Bank 2004, citing Valentine (2003)). The salaries of the country's highest-level public servants, however, seemingly compare much more favourably to that of their regional counterparts.

Also on a societal level, the greater democratisation and opening up of Malawian society have created opportunities for the growth of the private sector and NGOs in the country, while simultaneously making it easier for health workers to go abroad.

Consideration of the human resources situation can also not be divorced from developments in the Malawian public sector. One of the issues that came up in interviews was the government's medium term pay policy, which provides a framework for the remuneration of civil servants within the broader macro-economic approach. Another was the complex institutional arrangements around human resources in the health sector. Within the ministry of health, for example, some functions are located in the planning department, while others are fulfilled from the HR management department. There is also a central HR department within government as a whole, as well as a high-level Human Resources Advisory Council where actors such as donors, key government role-players, regulatory bodies and training institutions are represented. When Malawi launched its sector-wide approach (SWAp) in the health sector towards the end of last year, this council became the human resource technical working group for the SWAp. On the positive side there is obviously an attempt to manage the issue in a way that takes account of the concerns of a range of stakeholders, but some also expressed concern over the level of funding received by these bodies, their capacity to deal with the problems at hand and the need to avoid confusion over roles and responsibilities.

Contextual issues were not explored in full, with the above essentially reflecting key issues raised during the interviews with stakeholders in Malawi.

Solutions

Malawi is tackling its problems around retention and migration from a number of angles. A summary of information on policy options, gleaned from interviews and documents, is presented in the table below.

Category	Specifics	Rationale and concerns
Financial Incentives	Being implemented: Salary top-ups to certain health workers	Keep workers in post while addressing push factors BUT taxed, sustainability concern

	<p>Being implemented: Allow private practice</p> <p>Being implemented: CHAM assistance with school fees, medical expenses etc.</p>	<p>Doctors earn more BUT drift away from public sector, resist rural work because urban private practice more lucrative</p> <p>Adds incentives to salaries BUT have had to cut back on this because of financial reasons</p>
Recruitment & Promotion	<p>Being implemented: HSC speeds up recruitment and promotions. Mass promotions across cadres</p> <p>Being implemented: Bonding</p> <p>Being implemented: Bringing specialists from other countries</p>	<p>Reduce frustration because of bureaucratic and time-consuming processes</p> <p>Ensure subsidised students fill gaps BUT huge enforcement problems, unclear how vigorously still being pursued</p> <p>Stop-gap measure to address lack of specialists BUT will it lead to high turnover, do they fit in local context?</p>
Non-financial	<p>Being implemented: HIV policies in workplace</p> <p>Broader initiatives to be implemented through SWAp</p>	<p>Workers will feel cared for</p>
Production	<p>Being implemented: Train more health workers, including substitute cadres</p>	<p>Shortages need to be addressed BUT training constrained by lack of infrastructure, lecturers, money etc.</p>
Structural	<p>Being implemented: Creation of Health Services Commission (HSC)</p> <p>Being implemented: Decentralisation</p>	<p>Separate institution to look after health workers BUT limited impact thus far, still finding its feet, small budget</p> <p>Less health worker frustration because more responsibility and control BUT don't want to report to non-medical staff</p>

Currently, the policy action with the highest profile is an initiative, implemented in April 2005 and made possible by funding from the UK's Department for International Development (DFID), to top up the salaries of key cadres of health workers by approximately 50%. The interest in this initiative should not come as a surprise, given its recent implementation and the economic context sketched in the preceding section. This intervention is, beyond the issue of remuneration, also of interest because it has, in the words of an interviewee, "changed the parameters of the debate". This understanding is also reflected in the following remark by an interviewee: "It is the first time it has happened in Malawi and in fact other sectors are wondering how this happened. Over the last few years, ever since I have been here, yes donors have been supporting us and they have said, "OK, we can give you anything except salaries".

Historically, donors have been reluctant to pay salaries and where they have done so it has not been on the scale seen in Malawi. In the past, Malawi had an arrangement whereby certain donors funded top-ups for tutors in CHAM nursing schools (World Bank, 2004; Ministry of Health, 2004). It seems that in the case of the current

initiative the scale of the emergency in Malawi was judged to override the arguments over sustainability and dependency that usually stand in the way of actions such as these and that the visit to Malawi in February 2004 of Peter Piot, executive director of UNAIDS, and Suma Chakrabarti, the permanent secretary of DFID, acted as a catalyst for this initiative. On the one hand, the government of Malawi was able to speak out on the problem and on the donor-side there was a willingness to consider options that would otherwise have been dismissed as unsustainable. In the United Kingdom, issues around human resources for health have also been subject to significant public attention. In July 2004, for example, The Daily Telegraph published an article entitled "Britain is draining Malawi of nurses" (The Daily Telegraph, 2004a). On the same day, an opinion piece in that newspaper argued that hospitals "have grown unduly dependent on foreign nursing staff, especially those coming here from Africa", again citing the Malawian example (The Daily Telegraph, 2004b). In August 2004, the recruitment of African nurses was covered in The Guardian, with Malawi being one of the cases mentioned (The Guardian, 2004).

While the focus is quite strongly on the top-ups, it is important to note that this is not an isolated initiative and that it is actually nested within a much broader, supportive policy environment. The high-level visit mentioned above placed the spotlight on Malawi's inadequate health worker staffing levels and triggered DFID's intense involvement in HR issues. DFID has supported the development of an Emergency Human Resource Programme, which includes the recruitment of external physicians, incentives for the recruitment and retention of Malawian staff and the expansion of training. This human resources support, however, is provided within the broader SWAp in terms of which donors have helped the ministry of health in the design of interventions such as an essential health package, with human resources being only one of the six pillars of the SWAp. The Health Sector Human Resources Plan, published in 1999, contains the idea of introducing a SWAp, but interview data indicates that money has only started flowing through the SWAp in the last few months. In terms of the SWAp, the World Bank, DFID, Norway and Sweden are pooling their contributions, with the Global Fund for HIV/Aids, Tuberculosis and Malaria also expected to join (DFID, 2004).

The top-ups also slot into Malawi's medium-term pay policy within which there is provision for a Selected Accelerated Salary Enhancement scheme (SASE). Through this Emergency Human Resource Programme, SASE has been implemented for certain health worker cadres. The idea is to try and keep people in their posts and to increase the number of staff while issues such as poor working environments, infrastructure and supervision and management problems are addressed through the SWAp.

In implementing this initiative there has also been a need to work with the International Monetary Fund (IMF) to ensure the macro-economic feasibility of the programme. Since mid-2004, Malawi has been on a programme to establish a macro-economic and fiscal track record for the new government. With regard to the top-ups, the IMF operated a fiscal adjustor. Since the top-ups were fully donor-funded, they were not affected by IMF ceilings.

With regard to remuneration, one potential solution is to tap into HIV/Aids-related donor funding flowing into the country and to use this in part as a source of salary support, thereby strengthening current policy directions to do with the retention of health workers. Interestingly, a select few interviewees spoke about the country's plans to include a request for salary support in its 5th round applications to the Global Fund. This request, it was said, might be tailored specifically to benefit those not included in the salary top-up programme. It has since been confirmed that the

country has submitted a proposal to the Global Fund, with this proposal including significant human resource funding. However, at the time the in-country interviews were conducted few people knew about the possibility of such a request and among those who didn't know attitudes to such a possibility ranged from scepticism over whether international donors would allow it, to questioning whether it would be a good idea to channel money intended for interventions to salaries, to questions about sustainability.

In addition to increasing salaries, part of the strategy for dealing with the HRH crisis in Malawi involved the creation of a Health Services Commission (HSC) about two years ago. In the past, health workers were employed under the Civil Service Commission and enjoyed the same conditions of service as other public servants. This was perceived as a problem because of the greater demand for health workers and the higher salaries they could command elsewhere and therefore the idea arose to create a commission for health workers, despite concerns from other government departments about matters such as costs. The idea was for the HSC to look at salaries as well as issues such as promotions. Legislation gives the HSC the authority to appoint and dismiss health workers and to set conditions of service (Muula & Maseko, 2005). It seems that the HSC has not yet had an impact in terms of altering health workers' conditions of service, but that it has made progress in speeding up recruitment and promotion processes, thereby beginning to address some of the frustrations experienced by health workers.

Bonding is a well-known strategy in the field of retention and migration, but a clear picture did not emerge from interviews on the exact status of bonding as a policy mechanism in Malawi, although it is clear it has been on the agenda. Other policies understood to be related to retention were decentralisation, in the sense of it giving health professionals more responsibilities and control thereby leading to less frustration, and the implementation of HIV/Aids policies in certain sectors, in that they put in place conditions under which health workers and their families will be cared for. In the late 1980's / early 1990's doctors were also given permission to practice privately in an attempt to retain more of them, but some argue that once they begin doing it, public sector doctors drift more and more towards their private patients, thereby casting doubt on the effectiveness of this potential retention mechanism. All in all, there appears to be comparatively little discussion around how to tackle the issue of non-financial incentives. However, one interviewee pointed out that technical support has been recruited into the Ministry of Health to help address non-financial issues such as the re-grading of staff, postings policies and in-service training.

While perhaps not strictly speaking a retention strategy, it is worth noting in the context of a consideration of retention and migration issues that Malawi is also trying to address the supply side of the HR crisis by training more health workers, including so-called substitute cadres. The country has paid a high price for some of its past training policies, for example the preference in the 1990s for the training of degree-level nurses, who turned out to be in demand in developed countries (World Bank, 2004). In terms of the Emergency Human Resource Programme, which has built on an earlier six year emergency training plan, training capacity will on average be increased by about half, and more for certain categories such as doctors and nurses (DFID, 2004). The issue of increased intakes at training institutions came up in a number of interviews. Some spoke about the increased training of medical officers, with the intake increasing from an initial figure of 25 when the medical college opened its doors to the current 60, while others described increases of around 100% for whole institutions where a range of cadres are trained. According to interviewees, attempts to train more health workers are constrained, however, by factors such as a shortage of lecturers and a lack of infrastructure, for example student

accommodation. The Emergency Human Resource Programme provides for more lectures, bigger operational budgets and infrastructure. On the supply side, the country is also exploring the use of specialists from abroad, with countries such as Russia and Egypt being mentioned. In this context it is also appropriate to take note of a Scottish initiative to give NHS staff the opportunity to volunteer in Malawi. Basically, up to ten such volunteers per year will continue to receive contributions to their pensions in their home country, while working in Malawi for two years (BBC, 2005).

Some other policy options were raised in interviews, but it is not clear how formally these are being considered. Some were raised in official contexts and might therefore find their way onto the policy agenda, but others are perhaps more accurately characterised as personal wishes or personal expressions of what might work to retain health workers in Malawi. The options mentioned included loans to assist health workers in buying cars and houses, supporting workers through establishing crèches at workplaces, paying rural allowances and better training and promotion opportunities for those working in rural areas.

Policy drivers

The perception of crisis is clearly one of the policy drivers present in the Malawian context. As discussed earlier, this has been cultivated by sources inside and outside the country. It is hard to imagine that the unusual policy intervention with regard to salary top-ups would have been instituted in the absence of such strong feeling. Having said this, there also appears to be something significant in the institutional relationships in Malawi that go beyond just a shared notion of the urgency of the situation. On the one hand, the government and donors appear to have quite a functional working relationship. Some have, with reference to the health sector SWAp, suggested an increasingly trusting and harmonised relationship between government and donors. On the other hand, there seems to be something unique about the high-level Human Resources Advisory Council mentioned earlier in that it suggests, on the face of it at least, a level of organisation and thinking across stakeholders that is quite rare. The confluence of a number of factors, then, has created the current window of policy opportunity for Malawi. In parallel to this, however, there still exist less favourable dynamics to remain cognisant of, such as the country's economic difficulties, constraints on the capacity and resources of many of the institutions charged with addressing the problems of retention and migration and the broader workings of the international labour market for health workers.

Implementation challenges

This country summary has already touched on some implementation challenges, including the downside to allowing private practice among public sector doctors, concerns about the capacities, budgets and responsibilities of the complex network of organisations involved in the human resources arena, and constraints on training more health workers. The economic context also clearly presents an implementation challenge, but as illustrated by the fiscal latitude around the top-up payments, there is also some room for manoeuvre in this setting. In conclusion, this section of the summary will build on preceding sections to outline some of the implementation challenges relevant to the key policy actions that have been taken in Malawi.

Firstly, there appears, in principle, to be solid support for the initiative to improve salaries, with interviewees recognising it as a step in the right direction and as an action that demonstrates the government's commitment to improve the situation of health workers. Critical comments centre on three issues. Firstly, some point out that the increase is built on the foundation of a very small salary and that there are, therefore, questions about the extent to which it will influence health workers and the

extent to which it really helps them to close the gap between their remuneration and historical increases in the cost of living. A second concern is about sustainability and the question of whether government will be able to shoulder the burden of these top-ups in six years' time as planned. In this regard, it is interesting to note that DFID has agreed to give two years' notice if it wants to withdraw or reduce its salary support. A third concern is about the top-ups being taxed, with some suggesting that this feature of its design might undo the positive features of the initiative. Interestingly, nurses went on strike when the top-ups were implemented. This is understood as reflecting concern about the taxation of the top-ups, but also wider issues such as communication problems between health workers and the Ministry of Health and health workers' feelings of not being valued.

The taxing of these top-up allowances is the direct opposite of what health workers are used to when it comes to allowances. However, from the perspective of those who designed and implemented the initiative, the tax issue has to be considered against the backdrop of an earlier programme to collapse allowances into basic salaries, the need not to distort what the government wants to achieve with its medium-term pay policy and broader civil service reforms, and the acceptance that money will flow back from the tax windfall to the health sector SWAp.

Secondly, it is clear that bonding has been a hugely problematic issue in Malawi, but what is less clear is its current status as a policy mechanism. The descriptions of some indicated that, since government subsidises students' training, the intention is for students to serve for a period equal to the course duration and that some students had relatively recently been asked to sign bonding agreements, although there have since been problems in enforcing those agreements. Other descriptions, also echoing the idea of enforcement problems, more strongly suggest that the idea of bonding has in fact been abandoned. It is clear, therefore, that bonding has been on the agenda and that it has proved difficult, but it is unclear to what extent it is still being pursued or whether it is being pursued in a patchy way by different institutions. The problem with bonding, however, goes beyond implementation and enforcement in that not everybody is convinced that it is a good idea to begin with. Some argue that it takes away health workers' freedom and makes them unhappy, leading to them performing their duties in a less than optimal way.

Lastly, Malawi's decentralisation policy could pose implementation challenges, although this issue was not specifically addressed in interviews. The responsibility for decentralisation rests with the Ministry of Local Government in conjunction with the relevant line ministries, with legislation giving authority over health and certain other areas to District Assemblies, which may then employ staff (Ministry of Health and Population, 1999). However, as discussed earlier, the HSC also has the power to employ and dismiss staff. Questions such as these should perhaps be considered in the context of the broader question about the variety of actors and the inter-relationships between them.

All in all, with regard to the retention and migration of health workers Malawi could be said to be climbing a mountain. The setbacks it has suffered and mistakes it has made mean that it has a long way to climb. But it has also taken some positive steps and seems currently to be capitalising on political window of opportunity that has opened up.

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Interviewees

- Prof. John Chisi, dean of undergraduate studies, College of Medicine, Blantyre
- Mr Sam Chembe, deputy secretary of the Health Services Commission, Lilongwe
- Mr Edward Kataika, deputy director of planning, Ministry of Health and Population, Lilongwe
- Dr Edgar Kuchingale, specialist in obstetrics and gynaecology, Kamuzu Central Hospital, Lilongwe
- Mr Fresier Maseko, head of the department of basic sciences, Malawi College of Health Sciences, Lilongwe
- Mr Rex Moyo, registrar of the Medical Council, Blantyre
- Prof. Boniface Msamati, professor of anatomy, College of Medicine, Blantyre
- Ms Debbie Palmer, assistant governance advisor, Department for International Development, Lilongwe
- Mr Francis Panulo, principal of the Malamulo College of Health Sciences, Makwasa

ANNEX 3: THE SOUTH AFRICAN EXPERIENCE

Introduction

Since 1994, human resource issues have been recognised as important to health system transformation in South Africa. As part of wider efforts to transform the public sector and health system, the concrete steps so far taken include the amalgamation of previous administrations into integrated HR establishments within the nine provinces created after 1994, initiatives to strengthen regulation and training of health professionals and efforts to re-orient HR competencies and approaches towards the delivery of primary health care through a District Health System. In addition, a number of initiatives have sought to tackle specific HRH problems – such as the bilateral arrangement with the Cuban government to bring Cuban doctors to South Africa to work in under-served areas and the introduction of the community service programme for a range of health professionals requiring them to work in relatively under-served areas for an initial period after completing training. A national health human resource survey was also conducted in 1999/2000 and provided the basis for developing the Health Human Resource Strategy in 2001.

However, the health policy documents of the last ten years identify a much wider range of HRH-related actions as necessary (Table 1). Perhaps not surprisingly, in the face of the enormous demands of health system transformation, less has been achieved than intended, and some of the HRH problems have got worse over time. Nonetheless, the last year or two has seen some progress. The new post of Deputy Director General: Human Resources was created in the National Department of Health (NDOH) in 2004 and a process of engagement with other stakeholders initiated. Currently, the NDOH is on the verge of releasing a much-awaited national HR plan. Although likely to include a dominant focus on health personnel production and norms and standards, this might also influence policy directions around retention and migration issues.

The South African experience to date clearly demonstrates the complexity involved in addressing these issues in that more money alone is not sufficient, the problem requires interventions in management and working conditions more broadly, and even apparently positive steps can have unintended negative consequences. Perhaps most critically, the policy terrain is contested. To implement actions intended to address HRH problems there is a need to engage a wide-range of stakeholders who, even when they have common views of problems and causes, also have particular perspectives and interests. Political sensitivity and strategic skills are essential in such a terrain.

Finally, although South Africa has had quite a visible regional and international presence in debates on migration and ethical recruitment in recent years, the extent of regional or international influence over other of its own HRH problems seems quite limited. Whilst government and other organisations have many regional and international linkages and affiliations, HRH is often not a primary concern. It was unclear from the interviews if and how international or regional HRH initiatives do or could have impact on South African policy thinking and actions. Some role players appear to have thought about the possibility of South Africa assisting neighbouring countries, for example in terms of training health workers, but these thoughts are neither fully developed nor clearly the basis of action.

Table 1: Key General Health Policy Documents since 1994

Document	HR issues raised
ANC Health Plan 1994/Reconstruction and Development Programme	<p><i>Training</i></p> <ul style="list-style-type: none"> core teams for primary care facilities increased training of community health workers and environmental health officers re-orient existing and train new staff in PHC approach transform health worker training <p><i>Retention</i></p> <ul style="list-style-type: none"> attract staff to rural and under-served areas re-distribute staff to rural areas through more appropriate training, incentives, limiting opportunities for private practice in over-served areas, contractual obligations for those receiving subsidised training attract staff back to public from private sector by strengthening public sector <p><i>Planning and management</i></p> <ul style="list-style-type: none"> improve HR planning and management systems
1997 White Paper for the Transformation of the Health System	<p><i>Training</i></p> <ul style="list-style-type: none"> national framework for training and development of health personnel emphasis on PHC training to meet needs of population appropriately upgrade clinical skills of health workers affirmative action policies to transform public health services into non-racial, non-sexist organisation <p><i>Retention</i></p> <ul style="list-style-type: none"> equitable health personnel distribution decentralise management authority to provincial and district levels participative and democratic style of management and management by objectives to be encouraged develop skills of managers throughout the system develop caring ethos <p><i>Planning and management</i></p> <ul style="list-style-type: none"> develop institutional capacity to support HR planning and management
1999-2004 Health Sector Strategic Framework	<p><i>Training</i></p> <ul style="list-style-type: none"> fast track training of primary health care nurses and community health workers transform training institutions to develop rights skills mix and apply affirmative action in recruitment <p><i>Retention</i></p> <ul style="list-style-type: none"> deploy HR equitably extend community service programme to dentists and pharmacists strengthen skills and systems of HR management use non-financial incentives to retain personnel streamline disciplinary procedures, improve supervision <p><i>Planning and management</i></p> <ul style="list-style-type: none"> develop human resource plan get support and co-operation of labour organisations for non-financial incentives
2004 Strategic priorities for health system 2004-2009	<p><i>Training</i></p> <ul style="list-style-type: none"> strengthen CHW programme and expand mid-level worker programme <p><i>Retention</i></p> <ul style="list-style-type: none"> implement plan to fast track filling of posts strengthen human resource management <p><i>Planning and management</i></p> <ul style="list-style-type: none"> implement HR plan strengthen programme of action to mainstream gender
2004 National Health Act	<p><i>Training</i></p> <ul style="list-style-type: none"> Academic Health Complexes including training institutions to cater for all levels of care (including district and primary care facilities) <p><i>Retention</i></p> <ul style="list-style-type: none"> Certificate of need to assist in equitable deployment

Document	HR issues raised
	<p><i>Planning and management</i></p> <p>National Health Council to develop policy and guidelines for and monitor provision, distribution, development, management and utilisation of HRH Forum of Statutory Health Professional Councils with wide ranging stakeholder representation to oversee policies with regard to health professionals</p> <p>Minister to ensure:</p> <ul style="list-style-type: none"> • availability of resources for and implementation of education and training of personnel • address skills shortages through measures including new categories of personnel and recruitment of foreign personnel • existence of appropriate recruitment and retention strategies • capacity existing to plan produce and manage HR

HR problems and immediate causes

The key HR problems bedevilling public health care provision, in particular, in South Africa are migration and inequitable personnel distribution (resulting in absolute shortages in some cadres and areas), inappropriate and inequitable training opportunities, low staff morale and weaknesses in skills and attitudes towards patients (Lehmann and Sanders 2004). The challenges of HIV/AIDS are also important to note, including both the increased mortality and morbidity borne by the health workforce itself and the burdens of caring for the infected and affected population.

In terms of international migration, although precise figures are not known, available data suggest that nurse emigrants in 2001 were roughly equivalent to almost 20% of the total number of nurses working within the public sector. In addition, there is a problem of HR migration from public to private sectors. In 2001, with similar figures in 2003, only 44% of professional nurses and one third of general practitioners worked in the public sector, which serves the majority of the population. In addition, the number of nurses working in the public sector fell by around 10% from 2000 to 2003 (from 120.3/100,000 population to 107.1/100,000 population) (Lehman and Sanders 2004).

In addition, health workers are inequitably allocated across provinces. In 1998, there was nearly a three-fold difference in the population per nurse between the best and worst served provinces and just under a two-fold difference in the population per public sector nurse (van Rensburg and van Rensburg 1999). Migration of health professionals from the public to the private sector only exacerbates this intra-provincial inequity given that private sector services are predominantly located in urban areas. Public sector vacancies do, however, vary even between rural provinces, ranging in 2003 around an average of 31.1%, from 13.4% in rural Limpopo to 67.4% in rural Mpumalanga (Padrath et al. 2003).

The staff shortages resulting from these various factors are perceived by health workers as causing problems such as heavy patient loads, in turn leading to poor patient care and an inability to perform all tasks (Ijumba 2003). Patients see the shortages in terms of long queues and waiting times and, in some instances, early closing (Klugman and McIntyre 2000). In addition, there has been growing documentation of, and concern about, staff discourtesy towards, and even abuse, of patients (Jewkes and Mvo 1997; Klugman and McIntyre 2000; Schneider et al., 1998; Tint et al. 1996). Such behaviour effectively creates an additional barrier to service access (Palmer et al., 2000; Gilson et al., forthcoming).

Many of the factors leading to this range of problems are rooted in the broader context (see next section). In addition, on the production side, there has so far been only limited success in bringing about the sorts of production changes envisaged in policy documents since 1994, and one respondent noted that government had actually cut back on nurse training in this period. In addition to the high international reputation of South African professional training, the pull factors associated with international migration are commonly understood as including better wages, easier working conditions, and opportunities for professional advancement. Similarly, in thinking about internal migration it is necessary to be mindful of South Africa's strong private health care sector, which is generally understood to be better staffed for its workload, better equipped and to offer better working conditions than the public sector. However, some respondents noted that the public sector as a whole has a long-standing problem of retention. Others pointed out that there are shortages of skills and personnel in the private as well as public sector and that HR is a national issue, not just a government or public sector issue.

There is also a common understanding that the push factors associated with migration and retention problems, especially in the public sector, include poor human resource management and weak support for staff, work overload and emotional burnout, training that does not adequately equip staff to work in rural and under-resourced areas, problems of working conditions, including concern about staff safety and remuneration levels (Gilson et al., 2005; Lehman and Sanders 2004). The difficulties of managing professionals is a particular demand of the health sector, and the scale of the HIV/AIDS epidemic and the resulting demands on health workers only exacerbates other problems.

Context influencing HR problems

To be fully understood, however, South Africa's HR problems must be seen in their wider context. As Pick (1995) noted, 'In South Africa, human resources for health care have developed in an ad hoc and fragmented manner. The ideology of apartheid not only compounded the inherent inequality in the provision of health care along race, gender and class lines but also entrenched the development of human resources along these lines'. Thus, locating current health HR issues in historical perspective, Lehman and Sanders (2004) link the current highly unequal distribution of health professionals to the broader patterns of spatial inequity inherited from the apartheid era, and current skills mix problems to the inadequate and inappropriate training given to health professionals in the past (with emphasis given to curative and hospital-based approaches to health care provision).

Two other important health system features inherited from the apartheid era that influence today's HR problems are, as noted, the public-private fragmentation in health care delivery and the under-funding of the public sector. Although the country's health spend is, in total, quite large (as a percent of GDP) for its level of income, nearly 60% of this is spent in the private sector that serves less than one-fifth of the population (Doherty *et al.* 2002). Respondents noted both how this distributional pattern is inevitably reflected in HR distribution and that differences in salary levels between the sectors puts unreasonable pressure on public sector salary levels, perhaps particularly as supply shortages give professionals a strong hand in negotiations. At the same time, the public sector inherited from the apartheid era an inefficient and inequitable health service, under-funded relative to the population using it after 1994. Intended to serve only a small proportion of the population (given multiple government authorities and the availability of the private sector), it now routinely serves nearly 80% of the population with less than one half of the nationally available health resources (Doherty *et al.* 2002). Yet, given overall public spending limits, the health budget has not increased considerably since 1994 despite the

increased demand associated with population growth and the changing epidemiological profile (though additional resources have been made available for HIV/AIDS care). In the post 1994 fiscal environment new policy initiatives have had to be implemented in a context of stringent budget limits (Gilson and McIntyre, 2002).

Yet the scale and pace of efforts to tackle the apartheid legacy within the health system are another important factor underlying current HRH problems. The scale of efforts encompasses the total re-structuring of the structure of the public health system, with the creation of nine provincial health departments in line with governmental re-structuring and the establishment of a District Health System as the organisational and managerial basis of the health system, as well as a vast array of efforts to improve access and strengthen the provision of care.

At one level, the resulting governance structures are simply difficult to work through in implementing policy change. National, provincial and local governments each have different responsibilities and must work together. Coordination across sectors and across governance levels is a very complex task (Blaauw et al., 2003).

At another level, the speed of transformation within the public health system has been so fast and the scale of efforts so vast, that there is now what has been termed 'transformation fatigue'. Health workers and managers are 'tired of change' and frequently complain that are never consulted or communicated with before, during or after a new policy change is announced or implemented (Leon et al., 2001; Walker and Gilson, 2004). The increasing workloads associated with access improvements, such as the removal of fees for primary care, as well as HIV/AIDS, only add to the problems experienced. The overall result has been considerable uncertainty, particularly at primary care level, about tasks, organisational structures and even job security (Klugman and McIntyre 2000). This concern is, in turn, linked to the long period of uncertainty (only resolved with passing of the 2004 National Health Act) about which level of government (provincial or local) would ultimately have responsibility for primary care. Other important influences are the lack of a supportive environment, adequate encouragement and appropriate supervision. In this environment, nurses commonly complain that they do not feel important and cared for, and admit they take their frustrations out on the patients (Gilson et al., 2005; Segall 1999).

Yet a key obstacle to treating health workers better remains the tradition of bureaucratic, rule bound and authoritarian management in the public sector. Before 1994 public servants were trained to adhere to directives, administering services rather than managing them. The 1997 White Paper on Human Resource Management provides an indication of the paradigm shift expected of the public service: from a rule-bound, centralised administrative system to one of decentralised responsibility, accompanied by accountability, in management and from obedient servant to public service provider. But the experience of working within the health system remains, for many, one of working within 'a top heavy and rigid management hierarchy that imposes multiple and often conflicting demands' (Local Government and Health Consortium, 2004). The attention paid in transformational efforts to legal frameworks, structures, organograms and technical skills development has simply not been matched by the necessary efforts to strengthen human resource management or build strong relationships between people working together (Local Government and Health Consortium, 2004).

And again, efforts to tackle wider public service problems only add to the demotivating environment within the health system. In the late 1990s, for example, the public service implemented a new job grading system that involved the calculation of

job weights and which meant that employees with the same job weights, whether they be administrators or doctors, qualified for the same salary scales. In practice, this created problems in that it did not take account of the market forces relevant to certain occupational categories. Also during the latter half of the 1990s, government offered employees voluntary severance packages, which were taken up by a sizeable proportion of mid-level personnel in the health system denuding the system of skilled and experienced managers. More recently, a new re-grading exercise for the health system has caused some health workers to fear that they are being demoted or even, that their jobs are threatened (Gilson et al. 2005).

Finally, at the societal level a range of changes have bearing on HRH issues. Several respondents noted that the attractiveness of nursing as a profession has been undermined by changes over time in its perceived societal status, as well as by the bad publicity it has received as a result of recent experiences of poor quality of care. In addition, respondents noted that the establishment of a democratic government in 1994 is a key dynamic in the current problems of retention and migration, because of the way it catapulted South Africa back into the international community and made it easier for its citizens to move around freely.

Policy options being considered

The first wave of new HR policies and interventions after 1994 included, the Cuban doctor programme and the community service programme, allowing dual practice, various training initiatives, initiatives to strengthen provider accountability to patients and, slightly more recently, bilateral agreements to limit overseas recruitment efforts in South Africa (see Table 2).

Table 2: Policy options to tackle current HR problems

Category	Specifics	Rationale and concerns (where known)
Recruitment	Being implemented: Cuban doctor programme	To increase doctor availability BUT some problems of approach and language
	Being implemented: community service (temporary bonding mechanism)	To increase pool of trained staff working in less resourced areas BUT relatively short periods, lack of supervision & only delaying eventual migration
	Contract private GPs	To counter loss of doctors and take advantage of existing resource BUT mixed past experience
	Overseas training with contractual binding or cost recovery if migrate	Seek to compel people to stay BUT difficult to monitor and enforce (easy to pay back loans once earning)
	Community initiatives such as career guidance & learnerships	Increase potential pool of recruits
Financial incentives	Being implemented: Scarce skills and rural allowance	To increase salaries and retain staff BUT concerns about divisive and limited impact
	Being implemented: limited dual practice	To increase salaries and retain staff BUT potential negative impacts
	New remuneration structure for professionals, including health	Under discussion
Skills' development	Being implemented: Management training (health and civil service)	To improve HR management BUT need to review existing health management

Category	Specifics	Rationale and concerns (where known)
	<p>Being implemented: PHC skills development</p> <p>Being implemented: Continuing Professional Development (CPD) programme</p> <p>Use of skills levy funding (linked to new labour legislation)</p>	<p>training programme first</p> <p>To train people for work required BUT need expanded efforts and to integrate with basic training rather than be an add on</p> <p>To require continuous skills' upgrading in medical profession BUT impact unclear</p> <p>To strengthen skills</p>
Non-financial incentives	<p>Being implemented: strengthening provider accountability to the patient/community (Patient's Rights Charter; clinic committees)</p> <p>Improve working conditions (e.g. through modernisation of hospitals)</p> <p>Agreed but little implementation: Participatory decision-making, teamwork, praise</p> <p>Agreed but little implementation: New civil service performance appraisal system</p> <p>Being implemented: Private sector allows people to work abroad for short periods of time</p>	<p>To encourage greater responsiveness to patient needs BUT experienced quite negatively by providers</p> <p>To attract/retain staff</p> <p>Create enabling environment for staff</p> <p>To guide and support health workers</p> <p>Promote loyalty & see profession as exciting</p>
Migration	<p>Being implemented: Bilateral agreements</p> <p>Exchange agreements (allow staff to return to same positions when come back from overseas)</p>	<p>Limit migration opportunities BUT difficult to implement & enforce</p> <p>Allows professional development & attracts staff back BUT not all agree</p>
Production	<p>Increased production</p> <p>Agreed but little implementation: Train mid-level workers</p> <p>Being implemented: Train Community Health Workers</p>	<p>To offset migration BUT difficult to implement</p> <p>To develop staff with appropriate skills who are less likely to migrate BUT need career structures and opposition from professional groups</p> <p>To develop staff with appropriate skills, less likely to migrate</p>

Reviews of experience with Cuban doctors and community service show some positive effects, particularly improving staff availability in relatively under-served areas, but also demonstrate their limited potential to tackle the scale of the problem. Evaluation of the community service programme, for example, has found that interns are unlikely to change their career plans as a result of it and experience important problems (such as weak supervision) during their placements (Lehman and Sanders 2004).

There is little discussion or data about the impacts of dual practice in the public sector, although some concern was expressed that it contributed to unrealistic views about appropriate salary levels in the public sector. Training initiatives remain poorly implemented – with, for example, little systematic assessment of managerial training needs (Lehman and Sanders 2004) and PHC training remaining an add on rather than integral element of health professional training. Efforts to strengthen accountability to patients have been more wide-ranging. However, the Patient's Rights Charter, part of the broader Batho Pele (putting people first) strategy of the public service, is experienced very negatively by providers (who see it as a means of disciplining them), and, as yet, the consequences for patients remain unclear. Finally, the effectiveness of the bilateral agreement with the United Kingdom to limit recruitment, is constrained by the fact that it is still possible for health workers to find their way into the NHS following initial recruitment by the private agencies.

The most recent and currently most widely discussed HR policy intervention is the payment of scarce skills and rural allowances to certain health workers in the public sector. These allowances were introduced in the last year and it has since also become possible for staff members in other branches of the civil service to receive the scarce skills allowance. The experience with these allowances also shows how policies that are positive, on the face of it at least, can lead to unintended negative consequences. One interviewee spoke about the divisive impact of the allowances at the level of the workplace, with for example the scarce skills allowance benefiting doctors more than nurses and the rural allowance only benefiting selected nurses, despite the fact that all categories of nurses live and work in the same difficult circumstances. Another interviewee spoke suggestively of the “albatross” of the scarce skills allowance, again referring to the perception among nurses of not being valued. However, early data on the number of health professionals in public sector employment and employment trends in rural provinces may indicate that the scarce skills and rural allowances might be having some impact although it is too soon to make a definitive judgement.

The new system of allowances bears some resemblance to the system that was in place before the introduction in 1996 of a new grading system. In the late 1980s and early 1990s, South Africa had more than 300 different career classifications, with arrangements and pay scales differing across the classes. Some categories of civil servants, for example, could advance faster up the promotional ladder and had more steps on their ladders than others, while some also received allowances, including doctors, attorneys and air traffic controllers. This system was not sustainable. The re-introduction of allowances for some cadres may also be the prelude to a separate salary structure or pay scale for at least some health professionals. The possibility of or need for a separate structure or scale, in whatever form, was mentioned in a number of interviews.

In addition to remuneration a number of policies linked to non-financial incentives are under discussion. However, the extent to which these policies are currently being implemented is unclear, and much of the impetus appears to be coming from outside the health sector.

With regard to the public service in general, for example, the Department of Public Service and Administration (DPSA) is implementing a policy aimed at repositioning human resource components and encouraging strategic human resource management, as well as working on a yet-to-be-released guide on the management of retention. The notion of improving management in general and human resource management in particular, including coming to grips with the challenge of managing professionals, is one that enjoys currency beyond the realm of the DPSA. Yet little is

being done to link the need to strengthen people management with parallel efforts to strengthen supervision, for example, or efforts to strengthen health management training (Lehman and Sanders 2004). There has also been only limited action to address the problems of working and living conditions that particularly affect rural areas. However, the programme to revitalise hospitals might address some of these concerns, at least at hospital level. A final non-financial strategy, as currently used within the private sector, is also an intervention around migration. It is understood that the province of Gauteng is working on personnel exchange agreements with the United Kingdom. The perceived advantage of exchange agreements is that they allow people to retain their pensions and to return to the same post level in the South African public health system, which would not be possible for someone who resigns and then returns after a period abroad. However, no discussions are currently underway to change the general policy on re-entry into the public service.

Other HRH policy options currently under discussion include several addressing recruitment issues. There is interest in health and broader government circles in once again exploring mixed public/private delivery arrangements, such as contracting private GPs to provide support to public services. An inherited policy from the apartheid era (in the form of District Surgeon contracts), this policy option has been on hold for most of the post-1994 period due to suspicion of the private sector and concerns about public sector management capacity. Nonetheless, picking up a key proposal of the 1995 Commission of Inquiry into Social Health Insurance, there is now renewed discussion of the potential for such arrangements to ease the public sector's burden by drawing private sector resources into serving the majority of the population. In contrast, few respondents felt that bonding mechanisms were appropriate in a liberal, globalised world, although there was some discussion of the potential to use subsidised training as a mechanism of public-sector recruitment. Although not raised in interviews, the possibility of drawing on wider policy opportunities (such as those linked to labour legislation, including learnerships to enable recruitment or using the skills levy to assist training) are raised in HR review documents (Lehman and Sanders 2004).

Finally, respondents commonly raised human resource production issues as relevant to retention and migration debates. High workloads resulting from staff shortages and weak skills, for example, add to the problems of the workplace. The first step is recognised to be a plan detailing production needs and steps to build the capacity of training institutions.

However, people hold significantly different views on the merits of so-called mid-level workers or substitute cadres, a priority of the NDOH for the 2004-9 period. On the one hand, not all role players agree that this policy option is relevant and appropriate in South Africa. From one perspective, the country needs lower-level cadres of this sort to provide services and ensure access to citizens, given the lack of higher-level professionals such as physiotherapists and pharmacists. The notion of mid-level workers also fits in well with the government's public works programme and it is understood that, in certain circles at least, there is a great willingness to fund a community health worker programme. A counter argument to this is that South Africa can give each citizen access to fully qualified professionals and that the country should therefore, given its history and resources, be exploring different options. The concern here is with the perpetuation of a dual system in which those with means have access to higher-level professionals and those without do not. One of the traditional arguments in favour of mid-level workers is that they are not internationally marketable, but there is also not complete agreement on this among role players in South Africa. One interviewee argued that they were internationally marketable and also cited the potential problem of mid-level workers moving from rural to urban

areas in countries, thereby not necessarily having the desired impact on the problem of retention and migration. It is also clear from the interviews that there are a number of other implementation challenges when it comes to mid-level health workers, including resistance from established professional categories such as doctors and nurses, the need to establish meaningful career progression opportunities, the possible need to revise existing scopes of practice and the need to create an appropriate balance between mid-level cadres and higher-level cadres able to supervise their work.

Policy drivers

Clearly the apartheid legacy remains an important influence over HRH policy in South Africa – shaping the problems and requiring the massive change that itself makes change difficult.

At the same time, new developments have shaped what policy options are deemed feasible. At one level this can be seen in the common view that policies must work more through incentives than through compulsion. In today's globalised world and given a new democratic era, it is generally seen as simply not feasible to prevent or compel people from doing things; instead the focus must be on encouraging them to do things, using incentives. The dominant interpretation of this driver is that financial incentives are important to retention, hence the emphasis on allowances and remuneration. However, no interviewee felt that the economic benefits to the country of migration were ever a factor influencing policy on this issue; instead the influence comes more from the perspective of human rights. There is also recognition of the real need for non-financial incentives, and the policy frameworks proposing new forms of public service management reflect this emphasis.

Another influence over policy development in the post apartheid era is economic policy. Not only does the country's macro-economic policy place limits on overall public sector expenditure levels but there have also been efforts to reduce the public sector wage bill. The wider re-structuring of the public service, with its de-stabilising impact on personnel, has been one result. In addition, within budget limits there is a trade-off between increases in salary (which push up unit costs) and employment levels. As a result, as wages have increased in the public health sector over the last decade, the total number of employees has declined regardless of demand. Salary increases, in effect, themselves underlie the staff availability problems of the sector. The extension of the scarce skills and rural allowance to a wider pool of people is, thus, also limited by broader budgetary constraints.

The influence of wider policies over HRH policy is reflected in the influence of central government departments over health policy, as shown in the development of the scarce skills and rural allowance. Although the health department had intended to implement a rural allowance this became a scarce skills and rural allowance in response to Treasury and DPSA's views of the primary needs of the health/public workforce. The influence of Treasury in policy development is also a function of the health department's apparent inability to develop sufficiently persuasive arguments in support of its preferred policy options or to take forward policy opportunities to address HRH needs. Similarly, whereas the Department of Public Service and Administration (DPSA) develops labour policy for the public service in its entirety, it is up to the health department to lobby for the specific needs of its sector.

Beyond government, moreover, a wide range of additional and powerful actors shape HRH policy developments. Their influence can again be seen in the scarce skills and rural allowance, which was only extended to nurses as a result of pressure from nursing representatives in the Public Service Bargaining Council. Representing both

doctors and nurses in the Chamber they refused to allow the policy to go through unless at least some nurses benefited from it. They are also currently seeking the extension of the policy to a wider pool of nurses whilst remaining very critical of its impacts on nurses. Their presence in this Chamber, and the practice of negotiating and bargaining in relation to public sector employment issues, gives them at least some power over HRH issues.

Other key actors that have to be engaged in HRH policy debates include, in relation to training matters, other government departments, such as the Department of Education, and the heads of relevant training institutions. Finally, private sector actors, both providers and insurers, are also important in health policy debates.

Implementation challenges

There is widespread recognition in South Africa that the scope and intent of policy change across the health sector is comprehensive and necessary. However, the common complaint is that implementation is weak.

A key problem for the health sector is the difficulty of coordinating policy implementation across national, provincial and local governments. Yet without such coordination one province's actions, for example, might have negative effects on another (such as if differential salary rates were introduced). Variable provincial capacity to plan and manage also means that dedicated additional support needs to be given to provinces with least capacity.

In the field of HRH policy change, the complexity of the problems and required policy actions only compounds these difficulties by also requiring coordination across a range of governmental actors at each level. The power of the Treasury and DPSA has already been highlighted, as well as the vital role of the Department of Education in relation to training matters. Coordination across such actors is, however, not as simple as getting people into the same room. Key problems for coordination are the different mindsets each actor brings to discussion of the same policy problems and issues. It is not clear, for example, how responsive the education department is to the needs of the health sector. One respondent also noted that whereas Treasury thinks about policy through the lens of value for money, DPSA thinks as an employer and the health department thinks from the perspective of health professionals. To achieve policy change these different actors have to come to some common agreement about a problem and how to address it, without one forcing their ideas on another (as this only breeds resistance).

In addition, as already noted, the professional bodies and representatives have to be considered and their support sought; requiring a further layer of negotiation. One important area of current coordination between government and professionals lies, for example, in efforts to raise the status and profile of nursing, to counteract the existing more negative image of the profession and generate support for health workers. Yet it is not always clear that professionals and government have common aims or a common understanding of the needs of the health system and the role of professionals within it.

Managing implementation in this environment requires strategic and political skills, almost more than technical skills. Yet the central HRH unit in the health department remains relatively poorly resourced, works with a weak information base and is battling to do many tasks at one time. The contested nature of policy change is well demonstrated by the recent criticisms of the process of developing the HRH plan now awaiting Cabinet approval. These criticisms include the failure to consult widely, the apparent consultation of some but not other actors, and the length of time it has

taken to put the plan together. The policy hot house of the HRH field inevitably makes implementation more difficult. One respondent, for example, noted that whilst government uses the right language towards the role players in the HRH arena, its actions are seen to be weak – this generates dis-trust between actors and so provides a weak basis for implementation. Better communication and understanding among stakeholders was noted as vital.

Another HRH management challenge is the need to take account of the contextual influences likely to influence implementation of any policy option. The unanticipated negative impacts of the Patient's Rights Charter demonstrate the problem, and may also be reflected in the negative impacts of the more recent scarce skills and rural allowance. Although intended to strengthen provider relations with patients in ways that would be mutually beneficial, the Charter has only exacerbated nurses' feelings of dis-empowerment and neglect (McIntyre and Klugman 2003; Walker and Gilson 2004). These reactions can be understood as responses to some legacies from the apartheid era. First, the patient-orientation underlying the charter goes against the grain of the apartheid system, in which patients accepted whatever service was given to them without challenge. Second, it also goes against the grain of nursing as a profession, which was linked to authoritarian attitudes towards patients and which sought to create a status difference between nurses and patients. Van der Walt (2002) notes 'Nursing was, at that time, one of the few career options that offered young coloured [and other black] women the opportunity for professional qualification. A nursing qualification, often obtained with great determination and sacrifice, represented an 'upliftment' out of the situation of the average patient ... [This] frequently manifested in a top-down relationship in which nurses would set themselves up as critical authority figures in relation to their patients'. In challenging these inherited attitudes, the Charter may threaten nurses' understanding of themselves as professionals and their perceptions of their status relative to communities, creating further uncertainty in their working lives.

The complexity of HRH policy change, particularly in a time of broader transition, requires strong human resource management and leadership across the system, not just at the top. But, as noted, this remains a key weakness of the health sector. The sort of pro-active local leadership needed to provide the non-financial incentives that can themselves sustain health worker morale is undermined by the continuing legacy of a centralised and rule-bound civil service. Respondents agreed that managers commonly wait to be told what to do, rather than taking responsibility for their own actions, and so fail to take advantage of the opportunities to reward and value staff that do exist within the current management environment.

Finally, implementation of HRH policies is inevitably constrained by the multi-faceted nature of the changes required and proposed, the fact that different people and cadres will respond differently to different sets of incentives and that new initiatives will require new skills. Effective implementation of a policy such as contracting GPs will, for example, require a whole set of new managerial skills among public sector managers. Sustaining complex policy change in a complex policy environment requires the support of monitoring and evaluation systems, as well as relevant research. Yet neither are well developed in relation to HRH issues.

Although the development of a plan and vision to guide HRH policy change is widely acknowledged to be an important first step in addressing current problems, all recognise that much more will be required.

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Interviewees

Mr Mark Bletcher, director for social services, National Treasury

Prof. Eric Buch, University of Pretoria (and health advisor, The New Partnership for Africa's Development (NEPAD))

Ms Nelouise Geyer, deputy director: professional matters, Democratic Nursing Organisation of South Africa

Dr Kgosi Letlape, chairperson, South African Medical Association

Dr Percy Mahlathi, deputy director general: human resources, National Department of Health.

Ms Thembi Mngomezulu, deputy director: industrial relations, Democratic Nursing Organisation of South Africa

Mr Floors Pelsler, specialist: general employment practices, Department of Public Service and Administration

Mr Leon Pretorius, specialist: competency modelling, Department of Public Service and Administration

ANNEX 4: THE TANZANIAN EXPERIENCE

Introduction

Human Resource issues have been a constant theme of concern in Tanzania in recent years, as reflected in the reports of the Joint Annual Health Sector Reviews (JAHSR) conducted by the Ministry of Health, other government departments and development partners (see Table 1). These review documents also chart the growing sense of crisis around HR issues and commitment to taking necessary action and, yet, limited progress in implementing identified tasks. As one respondent noted, it seems a little like 'when you come across a snake, you see the problem and then are paralysed'.

The enormous complexity of tackling HR issues requires political sensitivity and coordinated multi-sectoral action, as well as technical analysis and support. Working out what to do about HR problems and how to do it, is never easy. The nature of the problems has, largely, already been identified in Tanzania and there is emerging agreement about the actions required as first steps in addressing them. Implementation of a the necessary package of actions will, however, require sustained commitment in the face of a very complex implementation environment and the broader socio-political context.

Overall, respondents felt that there had so far been little explicit regional influence over HRH thinking and actions in Tanzania with international influences linked to macro-economic agreements and donor funding flows. The regional actions that respondents identified as useful in sustaining national action on HRH issues included: developing political and technical tools to inform and sustain policy development, such as outlines of different policy options or strategies for building engagement between health and finance officials; sharing experiences across countries among senior civil servants, perhaps through existing regional structures; building the knowledge and understanding of parliamentarians.

HR problems and immediate causes

Taken together the problems of shortages, mal-distribution, poor motivation and inadequate skills are recognised to undermine the quality and efficiency of health care provision and create a working environment that encourages poor attitudes towards patients.

Although international migration has been raised as a problem in Tanzanian HR discussions (see Table 1, 2005), respondents identified it as mostly an issue of intra-African migration and as mostly affecting medical professionals⁵. Some suggest that the post-independence Tanzanian policy of developing allied health professions (including clinicians and nursing cadres) has served the country well in this regard. As their qualifications are not transferable internationally, such cadres are simply much less likely to migrate.

The most dominant HR problems facing the Tanzanian health sector are, instead, commonly identified as an overall shortage of health staff against agreed staffing norms, which particularly affects primary care health facilities given the difficulties of retaining staff in remote, rural areas.

⁵ Despite national economic constraints, the idea that migrants' remittances might have influenced HR policy and action was also entirely dismissed by respondents. There have been no deliberate efforts to produce for export.

The 2004 Joint Annual Health review noted a 33% gap between official staffing norms and people in post (Table 1) and interviewees often quoted the figure of 22,000 vacancies. Using data from the World Development Indicators 2003, Tanzania clearly has one of the lowest personnel to population ratios in the world (at 8.5 nurses per 10,000 population 1995-2000, compared to 9 in Kenya, 21.9 in Botswana and 47.2/10,000 in South Africa). At the same time, the differences in staff availability between more and less well resourced regions of the country range from 77% for medical staff and 158% for nursing staff (Kurowski et al, 2003). There is also some evidence that shortages of doctors, specifically, are exacerbated by an overall leakage of to the private sector. One estimate, for example, suggests that as a result of external migration, migration to the private sector and moonlighting whilst employed within the public sector, only 20-40% of graduating doctors practice entirely in the public sector. However, primary care health workers are increasingly looking to move from church-managed health facilities to the public sector, due to higher salary levels and the greater availability of equipment, drugs and training opportunities (Manzi et al. 2004; interviews).

Table 1: Human Resource discussions in Joint Annual Health Sector Reviews

Year	Main issues raised and milestones established
2001	<p>Review Reflecting on 1996-2001 HRH Plan see:</p> <ul style="list-style-type: none"> • progress in training Council Health Management Teams (one year MPH course established) • training institutions re-designed – and some mid-level cadres phased out and new, higher skilled cadres introduced • establishment of private medical colleges has increased annual medical training intake • Zonal Continuing Education Centres established in all 6 zones to provide in-service training but with variable capacity and still limited progress in increasing competencies to deliver quality essential services • problems with staff distribution, and specific difficulties of attracting and retaining staff in rural areas • problems with HRH management include difficulties create by local government reform (given e.g. HR concerns about transfer to employment by local governments), lack of information for planning, need for pay reform, with specific incentives for rural areas (and the possible implementation of the Selected Accelerated Salary Enhancement (SASE) scheme)
2002	<p>Review Note existence of HR gap in relation to needs for an expanded response to HIV/AIDS Need to define areas of future action on aspects of HR for health distribution and management in line with health sector and local government reform Need for better coordination of plans between health ministry and regional and local government HRH department developing own data base SASE implementation some shortfalls initially but implementation should be deepened and extended in sector MOH agreed to review optimal skills mix requirements for cost effective service delivery in light of HIV/AIDS needs and then revise HR Policy and Plan of Action MOH agreed to review training proposals of different programmes to ensure integration in support of service provision</p> <p>Milestones for 2002/03:</p> <ul style="list-style-type: none"> • regional and local government agreed to take action to fill critical vacancies to ensure provision of essential health services • health ministry to complete studies for preparation of new HR plan
2003	<p>Review Problems well known (chronic shortages, low levels of motivation, uneven deployment of staff relative to population distribution and poverty levels, in-service training ad hoc and weakly linked to improving service delivery) Zonal Training Centre network should be expanded to cover country, short-term skills-based teaching modules developed Innovative solutions to understaffing in remote areas needed HIV/AIDS counselling requires additional personnel</p> <p>Milestones for 2003/04:</p> <ul style="list-style-type: none"> • Demonstrable progress on key HR constraints
2004 HRH major focus of one day	<p>Review No major action since last review Urgent action and high level collaboration required to scale up recruitment radically and improve HR distribution (between Ministry of Health, Finance, Office of Public Service Management, Regional Administration and Local Government, Local Councils) HR in crisis and data available to show it (gap between official staffing norms and people in post, with greater needs in under-served areas and for certain cadres;</p>

	<p>workforce ageing and leaving; production levels not matched with future needs; recruitment procedures prevent current posts from being filled, 47% of local government health posts not filled)</p> <p>Actions discussed included: potential of remote Councils to offer additional incentives & to shift balance between budget for HR and budget for other charges to allow greater recruitment, extending medical internship to regional hospitals (if adequate supervision could be identified), bonding new health trainees to serve in designated areas, collaboration health/local government to recruit for rural posts, adjust pre-service training capacity to meet medium term requirements of sector, build up capacity and curriculae of zonal training centres to offer continuous education</p> <p>Also noted that speed with which HIV care and treatment plan can be rolled out would be determined by availability of human and financial resources</p> <p>Milestones for 2004/05:</p> <ul style="list-style-type: none"> • High level decision to increase recruitment and specific targets set for next five years • Efforts to ensure that 90% of available posts with permits filled by FY2004/05 • Hiring procedures communicated to all Councils and support given to speed up recruitment procedures • Strategy for equitable deployment including incentive scheme for hardship posts agreed and applied
2005	<p>Review</p> <p>Little movement in area of HR since last year, none of established milestones achieved</p> <p>HR still in crisis, particularly in primary care facilities – chronic shortage and maldistribution of staff main priority</p> <p>Continued need for high level collaboration</p> <p>Recruitment needs can be reduced if more attention paid to retention and motivation of existing staff, including upgrading of skills</p> <p>Brain-drain is an issue and requires SADC wide action</p> <p>Shortage of scarce staff could also be addressed if hospitals provide outreach clinics and supervisory support</p> <p>Staff retention in rural areas requires that living condition problems also be addressed</p> <p>Health worker pay and incentives needs to be tackled in context of overall public sector pay reform</p> <p>Need to up production of staff</p> <p>Cost of more health workers relatively small in relation to overall resource envelope and would improve health system productivity</p> <p>MOF not fully aware of problem and happy to review budget needs</p> <p>Budget increased from previous year but still below earlier levels; increases in budget for other charges anticipated but without parallel increases for personnel; increases for central MOH and not local government</p> <p>Milestones for 2005/06:</p> <ul style="list-style-type: none"> • to develop top level commitment by submitting a Cabinet paper setting out urgency and scale of problem, possible solutions, financial implications and obstacles to be overcome • plan of action for quick wins developed and implementation started by June 2005 • fast track filling of approved vacant posts through combined action between health ministry and regional administration and local government

Staff shortages are also clearly exacerbated by low levels of productivity, in turn partly linked to low motivation. One study has suggested that improved management and optimized staffing levels could themselves generate a nearly 30% productivity gain by reducing the time spent on unproductive activities (Kurowski et al. 2003).

However, another identified HR problem is the weak available skills mix relative to health and health system needs. First, there is too little supervision of lower level cadres by the few available doctors. One respondent spoke about the need to encourage doctors to do less administrative work and more clinical work by ensuring adequate administrative support at district level. Second, changing health needs and the changing profile of health care programmes are poorly-served by the available staff and skills. Most clearly, the implementation of the care and treatment programme for HIV/AIDS will require new skills, such as those of counselling. Even more importantly, this programme seems likely to require substantial additional human resources, making the gap between availability and requirement even greater.

The current HRH shortages and overall skills mix gaps in the health workforce are largely seen as a result of the weaknesses of HRH planning in the face of the changing needs and realities of the health labour market. Shortages and skills' mix gaps also cause problems for retention and motivation because they lead to increased workloads and require health workers to do jobs for which they are neither trained nor supervised. In addition, the problems of rural retention and wider motivational weaknesses are linked to the combination of low salaries, and the lack of any additional incentive for working in rural areas, poor living environment (limited schooling opportunities, poor housing etc), poor working conditions (making it difficult to do your job) and limited in-service training opportunities for upgrading skills. Finally, many respondents pointed to the influence of weak human resource management over competency problems and low motivation levels.

Context influencing HR problems

To be fully understood, the current HR problems must be seen, first, in their economic and political context. Although we did not conduct a full review of this broader environment, some hints at key issues were provided by respondents, the 1998 Medium Term Pay Policy (MTPP) and a cross-country analysis of public sector pay reforms (Kiragu and Mukandala, 2003). Together these inputs highlight the combined influence of poor economic performance, past public sector pay policies, linked to the country's socialist traditions and values, and more recent economic reforms as factors underlying current HR problems in the health sector.

Respondents noted that the problems affecting the current HRH crisis include low salaries⁶, particularly for mid level professional staff (such as doctors), the employment freeze of the 1990s (which led to reductions in the numbers of lower level workers employed and reduced intakes at medical training institutions), and the lack of pressure from professional bodies for action to address the problems. Kiragu and Mukandala (2003) locate all these issues in the broader political context of the country and its post-independence policy drivers. In line with agreements within the structural adjustment programme of the 1990s, a 26% reduction in the public sector employment level was achieved, allowing the country to keep its aggregate wage bill within budget limits as agreed with international financial institutions. However, efforts

⁶ The low level of salaries is demonstrated by the fact that the current approved government per diem for attending workshops is half the value of an average doctor's salary, generating perverse incentives in relation to being in workplaces.

to address the low salary levels of, in particular, middle and senior public servants, including doctors, have proved more difficult.

After independence, public sector salaries were part of a broader wages and income policy which strove very explicitly to ensure that every Tanzanian had a decent living income, and which led to a significant compression of public sector salary levels. Instead, a wide range of allowances were introduced to supplement basic salary levels but, eventually, economic crisis undercut the real value of incomes to such an extent that workers sought legal and illegal additional sources of income. In the 1980s-90s, public sector employees were granted permission to secure extra incomes as a way of tackling the salary problems (the length of the working week was, for example, reduced to allow such activities). And only in the mid 1990s were the first steps made to improve salary levels: first, by consolidating the wide range of existing allowances into the basic salary package and second, by developing the medium-term pay strategy. The emphasis in this strategy, is on decompressing public sector salary ranges and, in particular, on raising the relatively low salaries of the middle and senior level public servants (including doctors). In practice, however, implementation has been weak. The wage-bill-to GDP ratio has actually fallen below the initial ceiling set within the MTSP as several recent pay rises were shelved. In addition, pay increases have been given to those at the lower end of the scales. Indeed, Kiragu and Mukandala (2003) suggest that the faltering steps taken to implement the MTSP reflect the continuing ideological commitment to equity and fairness, understood as raising the incomes of those at lower levels, as well as residual caution about addressing the particular needs of relatively privileged middle and senior public servants. As organized labour is relatively weak in Tanzania this concern for the lower paid is instead seen as a reflection of a strong political legacy and tendency, often voiced by parliament.

Other of the current HR problems are influenced by the broader governance context of the country. At national level, addressing public sector HR issues requires coordinated action between relevant sectoral ministries, the Office of Public Sector Management (OPSM), responsible for the civil service and implementation of the MTSP, and the Ministry of Finance (MOF), responsible for the medium term expenditure framework and annual budgeting. All of these actors also work within the broader macro-economic frameworks established by the Planning Commission and, in the case of the most recent framework, the national strategy for growth and reduction of poverty, Mkukuta, the Vice President's Office (responsible for poverty reduction). In addition, the decentralisation within the health system, under which local councils employ health staff working at district level and in primary care facilities, means that coordination is also required between the MOH and PO-RALG (President's Office – Regional Administration and Local government), as well as the more than 100 local councils across the country. In relation to HR issues specifically, the MOH is primarily responsible for education and training and for employment in some levels of hospital. however, even on training matters it must clearly work closely with other government agencies. Finally, overlaid on these governance structures are a range of current reform programmes which only contribute to complexity, as the structures are themselves being adapted. These reform programmes include the health sector reform programme, seeking to improve quality of care and strengthen the decentralised governance of health services, the local government reform programme, seeking to improved decentralised governance in general, and the public sector reform programme, seeking to improve public service performance.

The problem of recruitment at primary care level highlights the complexity of this governance and implementation environment. To recruit more staff to existing posts,

any government department must first get a permit from the OPSM, which, in turn, must get approval for the additional salary costs from the MOF. Then there is a period of three weeks/months in which to advertise and fill the post. If the post is not filled within that time it is possible to extend the period, subject to OPSM approval. Not all local councils are, however, aware of the procedures and even when they are, making posts known to potential recruits is difficult and attracting people to work in remote areas even more difficult. In order to prevent permits for posts being lost councils may end up filling posts with relatively unskilled people.

Policy options being considered

Drawing on interview and documentary data Table 2 summarises the range of policy options currently being implemented or under consideration in Tanzania to address HRH problems, their rationale and concerns about each identified in interviews.

Table 2: Policy options to tackle current HR problems

Category	Specifics	Rationale and concerns
Recruitment	<p>Being implemented: Centralised recruitment of clinical officer cadre by MOH on behalf of Local Councils (to be followed by other cadres)</p> <p>Employ trained staff now outside health sector</p> <p>Bonding newly employed staff</p>	<p>To fill existing gaps and provide basis for request for new posts</p> <p>To help fill existing gaps, quicker than new production BUT disagreement over size of pool</p> <p>To fill existing gaps, particularly in rural areas BUT disagreement over likely success</p>
Financial incentives	<p>Differential salary levels for health personnel relative to other civil servants, in line with MTPP Rural incentives</p> <p>Agreed but limited implementation: Extend (SASE) Selected Accelerated Salary Enhancement Salary scheme</p> <p>Being implemented: Dual practice in hospitals</p>	<p>To attract and retain staff (especially to work in rural areas) BUT difficulties of implementing differential salary levels given overall policy context and negative impacts of SASE</p> <p>To attract and retain staff BUT potential for dual practice to encourage leakage to private sector</p>
Skills' development	<p>Being implemented: Continuous education to update clinical and general management skills of existing staff through Zonal Training Centres (ZTCs)</p>	<p>To strengthen better quality of care BUT differential capacity of ZTCs to provide training</p>
Non-financial incentives	<p>Agreed but limited implementation: Open Performance Appraisal System (OPRAS)</p> <p>Contracts based on performance targets and flexible remuneration for most senior civil servants</p>	<p>To strengthen performance management of civil servants BUT little considered in health sector and will require significant change in mindset of civil service to implement</p>

Given the dominant problem of staff shortages, it is notable that strategies for increasing production levels are apparently absent from these discussions. Although it is possible that such strategies are part of the HR plan being developed, little indication was given in interviews that increased enrolment would be emphasised. Indeed, the discussions suggested that increased enrolment would be very difficult to

achieve in the short term because of past under-investment in training facilities. These facilities are generally said to have neither the infrastructure nor staff to allow rapid production of increased numbers of health workers.

Instead the main strategy identified to tackle existing shortages has been to centralise recruitment of clinical officers in the hands of the MOH for a limited period, to fast-track the filling of available posts and distribution of new staff to particularly under-resourced local councils. Although apparently against the intention to decentralise such functions this action is seen as necessary until local government and health management is sufficiently strong to do the task itself. There is also some discussion of the potential to recruit trained staff currently working outside the health sector, however the size of this potential pool of recruits is unclear. Some suggest that this pool together with the planned production of new personnel will be enough to fill the existing vacancies. Others suggest that the pool is likely to be too small or difficult to attract back to the public health system without wider action to improve financial and non-financial incentives. There are probably differences between cadres of health worker. The Muhimbili Medical College (MMC) has been unable to fill the increased number of specialist posts recently given to it. Finally, MOH officials have raised the option of bonding newly trained staff as a potential way of filling some gaps in rural areas. However, some respondents felt that it would be difficult to enforce this option if new trainees remain unwilling to work in rural areas for a broader set of reasons. Taking action to attract and retain staff is required.

The second main policy option identified in discussions is the need to improve financial incentives, particularly for staff working in rural areas. Some suggest that local councils have sufficient discretionary authority to raise their salaries if they wish, as also suggested in the 2004 JAHSR; others feel that public sector procedures do not allow such action. Many concerns were, however, raised about the SASE scheme and these may add to the wider resistance to introducing any differences in salary levels. The health sector was one of the first to implement SASE, supported by donor funding. It has, however, widely been seen as a poorly implemented and divisive intervention. One respondent noted that the provision of an individual incentive undermined the team effort needed to ensure delivery of good quality of health care, leading those not receiving it to withdraw their effort. Similar sorts of complaints have also been made in MMC in response to its application of market-related salary scales for some senior management positions (an action intended to try and attract high calibre staff to these positions). MMC has also recently revised its dual practice scheme. Instead of simply permitting dual practice by those who wish to do it, it will now be required of all doctors as a way of generating income for the hospital. Some suggest that salary improvements are particularly important in retaining doctors, whilst other cadres may be more likely to respond to a combination of lower salary increases and non-financial incentives.

A third policy option that has regularly been discussed in the JAHSRs is training to improve clinical and management skills. The Zonal Training Centres have, over time, been developed and strengthened to allow them to provide improved in-service training. Efforts have also been made to integrate the range of training activities often implemented on an ad hoc basis within the health system (see 2003 JAHSR). However, concerns continue to be expressed that most ZTCs are quite weak, with few personnel and limited experience in providing a package of training activities. More evaluation of existing activities is likely to be necessary to support further training activities. A management skills module has been developed for delivery by ZTCs and the Muhimbili College of Health Sciences offers an MPH programme including management training.

A fourth action to tackle the current problems is being initiated outside the health sector. As part of the wider public sector reform programme, the OPSM is moving towards implementation of a new performance management system (OPRAS). Although it is unclear whether this is seen by health officials as a retention strategy, such a system could provide the basis for strengthening personnel management in ways that provide non-financial incentives to staff. Funding is available through the OPSM for training to support its implementation.

The apparent lack of consideration of OPRAS as a strategy for tackling retention and motivation problems reflects the broader gap in thinking on non-financial incentives. Improvements in some aspects of working conditions were noted as resulting from the overall health sector reform programme and as attracting health personnel back to the public sector. More generally, however, respondents felt that there was no coherent approach around non-financial incentives. A few options for strengthening non-financial incentives were, nonetheless, raised in interviews. These included: attracting newly trained personnel to work in rural areas for short periods of time by promising upgrading opportunities; linking the new performance management system to improved health system supervision practices (being considered within the MOH's new quality assurance framework); strengthening local council human resource management capacity through the local government reform programme; improving living conditions in rural areas by improving roads or housing, for example; specific incentives to tackle the living condition situation of rural areas such as car loans; targeted investment in selected rural areas, perhaps those which are least well resourced, to improve living conditions and for a cross-sectoral rural incentive to attract a range of staff to these areas.

Other policy options that were raised in interviews as relevant to consider in addressing the HR problems, but that appear to be rarely discussed, included:

- engaging private training institutions in increasing production;
- de-linking health staff from broader civil service to permit e.g. differential salary rates;
- strengthening the engagement between health staff and the local community in order to create incentives to retain staff;
- local recruitment and support of health workers through training to create moral commitment to return to rural areas.

Policy drivers

The three primary influences driving the HR policy options under consideration appear to be the dominant concern for HR shortages, the need to work within overarching economic and policy frameworks, and the associated socio-political realities, as well as the immense complexities of working through existing governance structures to address the problems.

The focus on shortages has led to the strong emphasis on recruitment in policy options and may, by itself, help to explain the limited attention given to considering what package of strategies, including non-financial incentives, might improve productivity and performance.

Overarching policy frameworks, particularly the medium term expenditure framework (MTEF) and MTPP, both set limits on what actions can be taken to tackle current problems and give power to the MOF and OPSM in relation to HR matters. Although the MOF apparently feels that there is some budgetary room for responding to HR needs, it has publicly stated that existing posts must be filled before new posts can be considered and has expressed reservations about whether there is a large

enough pool of trained people to allow increased recruitment. This is a key driver of current efforts to improve recruitment, which is seen as providing a first step for wider action.

In addition, budget levels, based on weak overall macroeconomic performance, place constraints on efforts to address the HR crisis. Despite the priority given to health services within the macro-economic frameworks of the late 1990s-2000s, budget increases to the sector are only now creeping back up to their 2001 levels – and as these increases are primarily going to the central MOH they do not allow increased employment by the local councils responsible for primary care provision. Budget constraints also limit broader efforts to improve service delivery and have a strong influence on the potential of the sector to increase enrolment given past under-investment in training institutions and the fear of the potential future costs of employing new graduates. Similarly, budget constraints act as a brake on salary increases as even donor-funded initiatives must fall within the overall guidelines of the MTPS.

Yet economic and other policy frameworks are themselves both rooted in and constrained by the broader socio-political context. As already noted, any special allowances or pay awards for health staff will have to address the continued concern for ensuring fair treatment for all public servants, and especially the lower paid. Although moves towards public sector salary decompression are identified as a sign that this mindset is weakening, the generally low level of salaries still makes it difficult to favour one group of civil servants over another. The socio-political context was also widely raised by respondents as a challenge to implementing new performance management systems. OPRAS will be based on an open approach to setting objectives and reviewing performance between appraiser and appraisee, in contrast to the previous approach in which appraiser made confidential reports on the appraisee. New mindsets will be required to support the implementation of OPRAS, as well as new skills.

Economic frameworks are also, partly, rooted in agreements with international agencies. However, Kiragu and Mukandala (2003) note that donors only have influence in Tanzania when their preferences coincide with those of government. On HR issues, donors are generally described as acting in harmony with the MOH even if pushing for faster implementation. Two exceptions to this may be, first, the strengthening relationship of some donors with the MOF as a result of the move to budget support and, second, the influence of donors and international agencies over the care and treatment plan for HIV/AIDS. As a result of the first, one respondent noted that the MOH now needs donors to intercede on its behalf with the MOF. However, there also appear to be moves to strengthen internal government interaction around health budget and financing issues. In relation to the second, some respondents expressed concern that the HR needs of the plan are unrealistic in the face of existing HR constraints and, together with the increased expenditure required for drugs, threaten to overwhelm other health system priorities.

Finally, the immense complexities of the Tanzanian governance structures have already been raised as an influence over HR problems. Addressing any single issue is difficult in this environment, never mind the set of inter-locking HR problems. This environment also seems to shape what policy options are being taken forward. The need for coordination across government may, for example, itself explain the limited consideration given to the broader management actions required to strengthen non-financial incentives. The re-centralisation of recruitment to the MOH is seen as a temporary move to unlock one problem of the environment, based on a precedent set by the Ministry of Education. Some respondents also felt that the MOH's emphasis

on continuous education as a response to skills' mix problems was a reflection of the fact that it continues to have primary responsibility for this training function. It does not need to coordinate with other parts of government to take action in this area. The emphasis appears likely to be reinforced by the HIV/AIDS care and treatment plans of various agencies which, as several respondents noted, focus on skills' development to develop the HR capacity required to implement them, largely ignoring the broader problems of sectoral shortages and weak incentives.

Implementation challenges

The difficulties of taking forward any action to tackle HR problems appears to be signalled by the apparent inability to reach the HR milestones set through the JAHSRs (Table 1). This failure to take action has led to the current dual emphasis on, first, the need to submit a Cabinet paper to raise awareness of severity of the problem and gain approval for a package of actions (Table 1), and, second, strengthening the capacity of the central MOH to conduct HR planning and support implementation (interviews).

The proposal of a Cabinet paper reflects the concern that key actors inside government, such as the MOF, remain relatively poorly informed about HRH problems and their impacts on service delivery⁷, and so reluctant to support necessary action. As policy options to tackle the HR crisis will touch on politically sensitive issues it is necessary to ensure adequate political awareness of the problems, and backing for the sorts of measures required to address them. This will then provide the basis for implementing the overall HRH plan, currently under development.

The parallel focus on developing the HR capacity of the central MOH reflects the need to manage a politically and technically difficult area. More staff will be required and a wider range of technical skills; the existing separation of HRH development and management functions must be tackled; stronger routine information systems must be developed. In addition, a specific implementation challenge will be the need to bridge the gap in approach between the health sector and central ministries such as Finance and OPSM. Several respondents felt that the health sector had particular problems communicating with other government departments in ways that would be persuasive and lead to support for the necessary actions. In addition, the existing resistance to developing special packages of incentives for certain groups of civil servants will require skilful development of strong arguments around the particular problems and needs of the health sector in relation to the country's overall development. Recognising that such arguments can be made, several respondents nonetheless felt that new skills and approaches would be required to develop sufficiently persuasive arguments. One suggested that the language of security and emergency should be used to emphasise the severity of the problems. Others felt that a group of HRH policy champions extending beyond those specifically tasked with HRH issues within the MOH would be needed to gain and sustain the high level political support required to take forward action.

Another central level implementation challenge appears to be the need to think laterally about how to address the existing problems. The relatively limited weight given to non-financial incentives is, for some respondents, a missed opportunity to achieve quick wins that can both relieve the shortage problem and enable performance improvements. Consideration of the OPRAS system, its links to supervision, the option of team incentives or the importance of health

⁷ One respondent posed the rhetorical question, 'do they know that patients are being seen by health attendants (untrained staff)?'

staff/community engagement are all beyond the current mainstream of HRH policy debates. However, strengthening non-financial incentives across the health system clearly also requires co-ordinated action across government which will, in turn, require a difficult change of mindset about its role in the central MOH. It also requires that there is a common understanding of problems across government agencies – yet some suggest that PO-RALG, for example, is also not yet fully persuaded of the particular problems of health care delivery (given the broader set of problems every Local Council faces). However, other respondents noted that the growing closeness between MOH and PO-RALG as a result of the health reform programme would provide a basis for co-ordinated action between these agencies.

Ultimately, however, sustained implementation of any incentive or other performance management system will require better management across the health and local government system. Being able to manage technical issues of health service delivery is not enough, also important is leadership and people and money management. Although this is a clear aim of the existing health and local government reform programmes, and of some health training initiatives, it may also be threatened by these initiatives. One respondent suggested that the pace and scope of change was itself weakening PO-RALG, for example. Another noted that creative training strategies were needed to develop the capacity of Local Councils to do what is expected of them. A third suggested that, in its wide-ranging efforts to improve service delivery, the MOH resorted to issuing too many guidelines to districts, demanding too much and creating confusion about what to implement next – especially given the existing weaknesses of supervision. Weak management may only get weaker in this environment. In the rush to do something, HR needs may only get worse; whilst in the attempt to do too much, little may be achieved.

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Interviewees

Ms. A. Dominick, Ifakara Health and Research Development Centre
Mr. Kanyase, Local Government
Dr. Hingora, Health Sector Programme Support
Mr. Magambo, Commissioner of Budget, Ministry of Finance
Mr. M. Mapunda, WHO country office
Dr. H. Mshinda, Ifakara Health and Research Development Centre
Mrs. Mwakalaka, HR Planning Officer, Ministry of Health
Dr. E. Nangawe, WHO Country office
Dr. Nyaywa, Health Sector Programme Support
Dr. Bergis Schmidt-Ehry, Programme Manager, German Programme to Support Health
Prof. A. Swai, Head, Clinical services, Muhimbili Medical College
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