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Health Workforce Innovations: A Synthesis of Four Promising Practices

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1. Introduction

The human resources challenges facing health systems in Africa are by now well described, but many remain unresolved. Skill shortages, geographic and sector maldistribution, poor morale, inadequate resources, growing demand for services due to HIV/AIDS and other factors have been outlined in the report of the Joint Learning Initiative in 2004[1] and the World Health Report 2006.[2] The World Health Report recommends that, in order to achieve the goal of getting "the right workers with the right skills in the right place doing the right things," countries should develop human resources (HR) plans that include the following:

- Acting now for workforce productivity: better working conditions for health workers, improved safety and better access to treatment and care; sustaining effective performance management and a workable incentive system
- Anticipating what lies ahead: more effective workforce planning, including a well-developed plan to train the health workforce of the future
- Acquiring critical capacity; development of leadership and management.

The challenge in implementing effective HR policies and practices in health systems in Africa and elsewhere is to develop an understanding of the context in which these policies and practices are to be applied, and to identify the strengths and weaknesses of different realistic options. There is a need to ensure that the practices "fit" the context of the system in which the interventions are to be applied. And the evidence base tells us that "bundles" of linked and coordinated HR interventions are more likely to achieve sustained improvements in organizational performance than single or uncoordinated interventions.

While publications like the World Health Report have described general approaches that can be taken to improve the human resources for health (HRH) situation at the country level, there is a relative paucity of more detailed documentation that describes promising practices that would be useful to HRH leaders and practitioners. As a result, USAID's Africa Bureau commissioned a study to identify and document promising practices in a way that takes into account the context of the practice, describes lessons learned and puts forth potential implications for replication in other countries. The intent of the promising practices study is to "serve as a practical and much needed resource for governments, partners and donors in promulgating policies and approaches that have successfully mitigated the negative effects of the health workforce crisis."[3] After consultation within USAID, it was decided that the study would focus on promising practices in four African countries:

- Task shifting: Ghana and Uganda
- Improving retention: Malawi
- Increasing recruitment and rapid deployment: Namibia.

The USAID-funded Capacity Project undertook the study and has produced full reports documenting the promising practice in each country[4] (available in the Publications and Resources section at www.capacityproject.org), as well as this synthesis paper, which briefly summarizes each of the practices, describes key findings and messages that cut across the practices and suggests a number of implications for action.

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II. Promising Practices

Task Shifting: Community Health Officers in Ghana

Context

Community health centers have had limited impact on health care priorities in the most deprived and geographically large rural districts of Ghana. Access to services is constrained by the distance of the facilities to much of the population they are designated to serve. Moreover, the availability of skilled staff is limited—as in many other countries, it is difficult to recruit health professionals to work in these rural, remote locations.

The Practice

Ghana's Community-Based Health Planning and Services (CHPS) initiative is an innovative

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approach that shifts staff from low-impact static health centers with limited outreach to high-impact mobile community-supported services. The approach relies on community health officers (CHOs), auxiliary nurses who receive two years of training to provide "doorstep" services to underserved rural populations.

The health workforce strategies for this approach include:

- Recruitment of new health workers and reorientation of existing health workers
- Efforts to improve retention
- Recruitment and orientation of two levels of health volunteers, one facility-based and the other community-based.

The key innovations are:

- The Ghana Health Service offers incentives for CHOs such as reduced time to eligibility for promotion, paid additional study and a deprived-area allowance
- Local governments are beginning to contribute resources for CHPS through their district assemblies, sponsoring students for pre-service training and funding construction of community health compounds for CHOs
- Community health volunteers assist CHOs with outreach; village health committees select these volunteers, who play a key role in conducting disease surveillance and identifying persons to whom the CHO may need to pay particular attention
- Village health committees also identify a volunteer nurse aide who helps the CHO maintain the community health compound and receive patients
- The Ghana Ministry of Health has increased the number of pre-service community health nurse training schools from four to ten in the past three years, locating them in each region to encourage local recruitment and increase retention.

Health Workforce Impact

Ghana has deployed more than 310 CHOs in 53 of the country's poorest districts. These nurses have improved access to health care services for nearly one million Ghanaians (each CHO serves an average of 4,500 people), reportedly resulting in substantial improvements in community health.

Task Shifting: Field Officers in Uganda

Context

Uganda has approximately 530,000 people infected with HIV, and 110,000 of them need antiretroviral therapy (ART). Almost nine out of ten people infected with HIV live in rural communities in extreme poverty. The poor health care infrastructure in rural areas, shortages of health workers and their inequitable deployment render traditional delivery of services inadequate for this population.

The Practice

To meet this challenge, a Ugandan NGO, the AIDS Support Organization (TASO), administers a home-based program that gives people in rural settings access to ART and services. TASO recognizes that shortages of skilled health professionals in Uganda constrain the effective delivery and expansion of services, especially to the poor. As part of its innovative approach to providing ART, TASO shifts delivery of most clients' follow-up activities at home to field officers, a new cadre of degree and diploma holders from the social sciences and education. Field officers ensure adherence to ART, refill clients' medicines and perform various activities, from voluntary counseling and testing to education to promoting family and community support. This new cadre meets the high standards demanded by this kind of program while also freeing skilled health professionals to care for clients affected by opportunistic infections or drug toxicity.

To support its field officers, TASO has introduced a range of HR initiatives, including:

- A comprehensive human resources management system
- A recruitment and selection process that matches candidates against established criteria and according to human resources needs, including the gender profile of the client base
- An intensive and tailored training program for newly appointed field officers
- Targeted continuous professional development and in-service training upgrades to strengthen field officers' skills and knowledge
- Encouraging its staff to embrace values such as obligation to people living with HIV/AIDS, equal rights, shared responsibilities and equal opportunities, human dignity, family spirit and integrity.

Health Workforce Impact

TASO's staff retention strategy has been effective, shaped by its core values that help to motivate and retain field officers. By the end of 2005, eight of the 11 TASO centers were taking part in the ART Program. The program shows promising results: the mortality rate dropped from 490/1,000 per years of observation to 59/1,000 in one TASO center. TASO's ART program comprises almost 9% of Ugandans living with HIV/AIDS who are receiving ART, reaching adherence rates over 95% and reducing mortality by almost 90% among those in the program.

Improving Retention: Nurse Tutors in Malawi

Context

Retaining nurse tutors is imperative for Malawi's health care system as they are required to train nurse technicians, who deliver essential services primarily in rural and deprived areas. Failure to retain nurse tutors can only exacerbate shortages of nurse technicians, which reportedly exceed 80% in some districts. A scarcity of nurse tutors in the late 1990s brought several training institutions run by the Christian Health Association of Malawi (CHAM) to the verge of closing. Graduates of CHAM institutions represent 80-90% of the public and private auxiliary nurse workforce in rural areas.

The Practice

Malawi's Ministry of Health (MOH) has supported a range of initiatives to retain nurse tutors. The MOH instituted a salary supplement scheme in 1997 with funding from the Interchurch Organization for Development Cooperation. This incentive program has its strengths and weaknesses, but has ultimately been deemed successful in attracting and retaining nurse tutors, particularly since 2002, building on additional support from the German Technical Cooperation.

The main elements of the incentive program are:

- Salary supplements
- Free staff housing
- Obligation to serve for a period of time in return for educational scholarships (bonding).

Some training institutions have offered additional incentives such as bonus salary supplements, transportation to work for commuting staff, transportation for home visits, training and educational opportunities and free utilities. Other factors identified as assisting to attract and retain tutors are proximity of work to home and family and promotions within institutions.

A key element in the program's success has been a public-private partnership through which government health workers are assigned to private, faith-based training institutions. This partnership helped attract faith-based donors for infrastructure development programs in many of the CHAM institutions to improve and expand training facilities and staff and student accommodations.

Health Workforce Impact

As a result of these interventions, all nurse training institutions have remained open since 2000. The number of nurse tutor and clinical instructor posts has increased and remains relatively stable. In 2000 there

were 39 tutors and 12 assistant tutors; as of September 2005 there were 71 tutors and 22 assistant tutors across the ten nurse technician training institutions operated by members of CHAM.

Rapid Recruitment and Deployment: HIV/AIDS Workers in Namibia

Context

In response to the HIV/AIDS crisis, Namibia's public health sector needed to rapidly hire and deploy professional and non-professional health workers to provide comprehensive care, counseling and testing, as well as antiretroviral therapy and prevention of mother-to-child transmission services.

Like many African countries, Namibia faced the challenge of attempting to rapidly scale-up its workforce while already experiencing a severe shortage of health professionals in its rural facilities. The Ministry of Health and Social Services (MOHSS) realized that the usual government recruitment procedure would be too slow to meet the need for urgent action, and that severe staff shortages in current positions meant that no workers were available to be redeployed.

The Practice

In collaboration with the Centers for Disease Control and Prevention (CDC) and USAID/Namibia, the MOHSS therefore initiated a mix of contractual arrangements to improve the pace and effectiveness of recruitment, employment and deployment of staff. While Namibia cannot meet its own staffing requirements internally, it can pay higher salaries than most African countries and offers a stable working environment; hence, many of the workers hired were recruited internationally.

The key innovations of this promising practice are:

- Setting up a management contract with a Namibian private-sector human resources provider for rapid health care worker recruitment and for human resources management of new staff assigned to MOHSS facilities
- Developing a variety of contracts to be used in arrangements with other health sector organizations; these include management contracts (focusing only on hiring and human resources management), service delivery contracts (which include human resources and technical work) and contracts combining management and service delivery
- Harmonizing salaries of all workers hired through the CDC and other mechanisms with MOHSS pay scales and benefits packages.

Health Workforce Impact

Close coordination between the MOHSS and donors resulted in the rapid hiring and deployment of more than 500 health workers (clinical and non-clinical) over a two-year period (2004–2006). Hiring and deploying so many staff, with minimal turnover, could not have been done so quickly through regular government recruitment practices. Even so, outsourcing for human resources for health through management contracts is regarded as a short-term solution, buying time to tackle longer-term challenges to Namibia's shortage of health workers.

III. Synthesis of Key Findings and Messages

While there are considerable differences among the four promising practices discussed in this paper (e.g., different country contexts, distinct practices, implementation of single or multiple practices), there are a number of key findings and messages that can be synthesized from the four studies. *(Quotes in this section are taken from the full reports on each practice.)*

1. Sound management and leadership must be developed and supported

The role of management and leadership is perhaps the most critical factor in achieving and sustaining the promising practices. It plays an important role in the key findings about partnership, human resources management (HRM) practices and funding. Developing a shared vision and instilling values, managing complex programs and partnerships and effective negotiation are just some of the management and leadership skills that are necessary.

In the Uganda case, TASO leaders demonstrated the ability to instill values throughout the organization, to do what was necessary to help staff live by them, and to focus on managing and infusing them throughout the chain of recruiting, hiring, orienting, deploying and supporting the lay counselors. Leadership also proved critical to establishing TASO as a learning organization in ways that had very positive practical results. In Ghana, effective management and leadership was required to manage a complex program involving various inputs from the central, regional and local levels, to interact with communities productively and to change policies regarding health care worker roles as a result of various inputs.

In Malawi and Namibia, the promising practices involved communicating with and managing a range of partners that were trying different initiatives to meet particular goals (e.g., retain nurse tutors, fill vacant positions). As part of this leadership challenge, leaders needed to be willing to assess what was happening, reflect on lessons learned with partners and either encourage or enable changes to occur.

Challenges remain in the management and leadership area—e.g., weak HR units that need strengthening, questions raised about how well the Namibian MOH will be able to manage contractors. In ministries of health, HR units typically have little influence and low priority in terms of creating establishment positions and assigning qualified personnel who can effectively address workforce issues. Overall, the number of truly professional HR leaders and practitioners is insufficient to meet the need in most countries (e.g., the Malawi HR unit is currently being managed by a controller) and this also contributes to the weak HR functions.

2. Vibrant partnerships are key

It is almost conventional wisdom that no single entity—either globally or at the country level—has the resources or leverage to address all of the significant and far-reaching HRH challenges. Complex and multi-faceted issues can only be addressed effectively by partnerships among government, educators, health professions, NGOs and others. On a micro-level, each of these four promising practices serves as an example of the necessity of partnerships to address critical issues. These partnerships included public/private partnerships, MOH and community partnerships, integrated FBO or NGO and government alliances, or some combination of all of these. For example, in Ghana it was noted that the program depended on "enthusiastic community participation." Moreover, it was stressed that the more successful districts mobilized resources and "…established partnerships with a broad range of stakeholders."

In Namibia, the core of the promising practice depended on a partnership between the government and a private recruiting firm. In addition, it was noted that "close collaboration between the government and donors to harmonize HR practices can lead to greater retention, averting 'poaching' of staff…" In Malawi, CHAM is "…seen as a key partner in the delivery of health services…[and has] developed a cooperative…relationship with the MOH to address tutor shortages." In Uganda, building alliances was seen as a

critical feature of TASO's work: "TASO has built strong alliances with key partners… The MOH is [a] key ally that sees TASO as a collaborator rather than a competitor, approving guidelines and training materials, providing free space for TASO centers inside public hospitals, and speeding up their accreditation. TASO collaborates with other NGOs by sharing strategies, methods and materials…"

It is clear that initiating and implementing a promising practice in HRH puts a premium on the ability to build and sustain alliances. This has implications for the types of core leadership competencies required to create and maintain effective partnerships among a range of partners. When a new practice is being considered, HRH leaders and practitioners should be prepared to identify appropriate partners and engage in effective partnership building.

While this seems relatively straightforward, it should be stressed that building and sustaining effective partnerships is not easy, nor are the needed skills abundantly available within the health community (which often focuses on other kinds of credentials). When leaders are chosen to take charge of new activities, these partnership competencies should be taken into consideration as part of the assignment process, and professional development opportunities should be made available to refine partnering skills.

3. *An integrated approach to HRM practices increases the value of individual strategies like incentives, supervision and career opportunities.*

Too often, interventions to improve HRM practice have relied on isolated or single strategies, which fail to take full account of the complexities of the context in which they are applied or the need to recognize the inter-relationship among different aspects of job satisfaction, motivation, recruitment and retention of staff. Effective HRM requires a broader approach, with coordinated policies and interventions, rather than "one-off" responses.

As such, it is important to be clear about how the vision and values of leadership are to be translated into the right career structure, supervisory mechanisms and incentive system. These three practical elements of HRM are critical—they provide a visible and tangible message of what the organization expects of its workers, but also of what the workers can expect from the organization. They set the tone for the contractual relationship, in its broadest sense, between the workforce and the organization. They are also inter-dependent. Effective supervision will include assessment of performance and contribution, which will enable career development opportunities to be identified and appropriate incentives to be provided. It is unlikely that an effective incentive system can be in place without good supervision. Career structures without associated incentives will be largely meaningless.

The HRM practices shown to be integral to the effectiveness of promising practices covered incentives, supportive supervision and career development (or career paths). The use of incentives was a very important part of the promising practices in Ghana and Malawi and was cited in Uganda as being under consideration to get people to work in hardship areas. While incentives are not mentioned explicitly in the Namibia report, the capacity to pay higher salaries was undoubtedly instrumental in getting outsiders to come to Namibia to work. The kinds of incentives varied from case to case. For example, the Ghana Health Service offered the following as part of their community health officers' scheme: reduced time to eligibility for promotion, paid additional study, a deprived-area allowance and (until recently) overtime pay. In Malawi, salary supplements, housing, transportation, training opportunities and free utilities were used by some or all organizations involved in the nurse tutor retention scheme.

Clearly, the use of incentives can be important, but achieving effective use can be difficult. For example, incentives can get misapplied, as was the case in Ghana: The "…40% deprived area allowances have been inconsistently applied… and sent to districts without clear guidelines… [resulting] in some staff members who are not eligible to receive the allowances, reducing the amount that CHOs should receive by up to half." Perhaps more importantly, they can gradually come to be taken for granted and turn into an entitlement: In Malawi, "given how long tutors have been receiving the monetary incentives, they may now view them as an entitlement…" and thus they may no longer have the intended impact. In both Malawi and Ghana, it was noted that it can be difficult to be clear about the purpose of a particular incentive and to continue to communicate that purpose as new health care workers come on line to receive the incentive.

It is also important that "incentives" are not viewed solely as monetary benefits. There are a broad range of financial and non-financial aspects to developing the appropriate incentive regime for individual workers or a workforce as a whole. The so-called "psychological contract" between worker and organization is rooted in mutual commitments and a recognition that value and worth do not derive from financial incentives alone. For example, it may be that personal satisfaction will be derived from being able to address the health needs of the local population and becoming a valued and respected member of the local community.

Supervision—or supportive supervision—was cited as important in Uganda, Ghana, and Malawi, as much because of problems with its absence as with positive examples of its impact. This is the case with many aspects of effective HRM—they are more evident if they are absent. If they are effective they will mesh in a supportive system that underpins the management and delivery of health services; if they are absent they will prevent effective service delivery. In Uganda, it was noted that "continuous supervision" allowed for the identification of performance and professional development needs—but as one of the areas for improvement, field officers stated that they thought supervision could be improved and supervision visits should happen more frequently. In Ghana, the lack of effective supervision "…appears to constrain the successful implementation of CHPS." In Malawi, it was also noted that supervision was a problem: "There is no systematic supervision and performance monitoring of tutors, nor is there a regular means of receiving feedback from them regarding working and living conditions" It would appear that increased attention to the provision of supportive supervision would strengthen the promising practices.

Finally, the use of career development and career paths was noted as important, both as an incentive to stay in the health care system and as a sound management practice to ensure a steady supply of increasingly experienced providers. In Ghana, the CHO scheme is based on outlining a career progression that includes educational opportunities and promotional possibilities. In Uganda, TASO reportedly does a good job of providing educational and training opportunities for professional development purposes. However, field officers still perceived a lack of "career progression and limited promotional possibilities…" and this was something TASO was working on. In Malawi, career development for nurse tutors was reportedly notable by its absence: "people do not see tutoring as an attractive career option because government-seconded tutors have no career path."

4. *In all four cases, external or donor funding was (and may remain) critical for the implementation of the promising practice.*

Introducing or altering a practice can involve a major system-wide change and will have direct and indirect cost implications. For each of the documented promising practices, a range of funding sources was used to help make the practice work. In Ghana, for example, it was "[T]he commit-

ment of resources (financial and technical) by the MOH, the GHS and donors [that] helped to rapidly increase the number of community health nursing training schools." In Uganda, the lay field officer home-based care program is based on funding from the U.S. President's Emergency Plan for AIDS Relief and TASO management has indicated that similar programs could not continue in the future without external funding support. In Namibia, the recruiting and hiring promising practice is also funded by the Emergency Plan, and there is "…uncertainty regarding the MOHSS' ability to carry the program beyond [Emergency Plan] funding." In Malawi, during various developmental stages of the promising practice, a variety of funding sources—public and private—helped to contribute to the work. And it is noted that, going forward, the MOH's program of work includes funding for the tutor retention scheme from the MOH budget, the Sector Wide Approach (SWAp), the Global Fund, and other donor funds (including FBO funding for their efforts).

Highlighting that external funding of some sort was required for each of the promising practices is not meant to discourage the search for new practices, or the replication of practices like the ones documented for this study. The opposite is intended—it may be that one of the best uses of donor funding, or of the funding that derives from public-private partnerships, is to allocate all or a certain percentage to designing, implementing and evaluating new practices that may address critical health challenges that have a workforce component. Health care system leaders need to be willing to advocate for funding in these areas, and donors need to be open to providing a certain level of support.

It is also important to acknowledge one caveat about donor or external funding: it is possible that the kinds of promising practices that tend to get identified for analysis are ones that are more easily identifiable simply because they are getting external funding or more policy attention. They may exist more readily in highly "visible" or better-funded sectors, such as can be the case with some vertical programs. The scope for any broader "roll out" of such practices to other sectors must therefore take into account any relative financial advantage benefiting better-supported sectors. It is also possible that there are promising practices within localities that are going unnoticed because they are part of the "normal" government services or programs—as such it is important to have developed a good network to ascertain where human resources development (HRD)-related innovation is occurring.

Implications for Action

In one sense any promising practice is unique—a product of inspired/inspiring leadership or good management, and reflective of a problem solving approach that has taken account of organizational priorities and context and workforce needs. However, it is imperative that policy makers, donors and governments work together to create an environment where HRH promising practices are encouraged and supported. It is their responsibility to nurture promising practices—they may not always be the instigators or sponsors, but they must sustain a system that enables practices to be implemented and tested. This paper has highlighted promising practices in only four locations; given this as a limitation, these practices still assist in identifying critical success factors for such initiatives.

Action implications drawn directly from the promising practice studies:

Build and sustain strong partnerships. Any organization involved in health systems must have some core partnership development competencies if it is to be effective. In addition, when a promising practice is scaled up or becomes a national program, it is clear that partnership mechanisms and competencies will be even more important as a greater number of stakeholders are engaged. One practical implication is that HRH leaders and practitioners need to make certain they have the necessary competencies to serve as effective alliance builders. This may be a very important place that donors could provide more explicit support.

Be creative. New solutions are required if the challenges of scaling up are to be met. Contracting out aspects of the HR function, as highlighted in the Namibia case study, was a creative solution to the identified limitations in the current system. Ghana developed a new service model to improve access.

Be flexible and adaptive—become a learning organization. New practices can have both intended and unintended consequences. Monitoring and review of implementation will highlight if the new practice is delivering on its promise—or if it needs to be amended or ended if it is not achieving its objectives. In Uganda, for example, TASO monitored turnover and discovered that the qualifications and training of their original hires made them attractive to other employers, and thus the turnover rate was high. They then acted on the lessons learned, changed the qualifications and the kind of people they hired and stabilized their lay counselor workforce.

Be clear about the nature and purpose of incentives. The common practice is to categorize items into 'financial' and 'non-financial' incentives. This may not be a helpful categorization, as real money is required to support any incentive program. A more helpful definition is to use the terms direct and indirect financial incentives, which may make it easier to identify real scale-up costs.

There are a number of other implications for action regarding incentives, including:

- Assess if investing in non-monetary incentives, such as housing and instructional facilities, is sustainable and will build institutional capacity
- Review retention schemes regularly against stated objectives and redesign if necessary to ensure they meet people's needs and achieve their intended purpose
- Ensure health workers and those being recruited know the purpose and likely lifespan of retention schemes.

Going beyond these four promising practices: related actions that will enhance the impact of promising practices:

The action implications described above derive directly from the promising practice cases used as a basis for this paper. However, since a synthesis paper drawn from only four cases cannot address all of the factors that are needed to take forward promising practices, there are some other key messages frequently recommended in the literature around strategic planning and change management that should be considered:

Involve staff in designing change. Organizational changes that underpin promising new practices will only be effective if the workforce is committed to change. Involving staff in assessing current limitations and designing solutions will improve the likelihood of designing and achieving sustainable improvements. Externally imposed "top down" solutions that are not grounded in current operational realities and that alienate or demotivate workers will not have the same potential for success.

Communicate the need for and nature of change. Organizational change should not come as a surprise to management, workforce or client groups. They should all have been either involved in the process of identifying the type of promising practice that is to be implemented, or made aware of what the impact of implementation would be on them and their situation. In almost all cases, a promising practice is a change and implementers need to use good principles of change management in order to be effective.

Visit the HRH Global Resource Center to find, share and contribute human resources for health knowledge and tools. For those working at the country or global level, the HRH Global Resource Center provides information to:

- Improve strategic planning and decision making
- Strengthen reports and presentations
- Support HRH advocacy
- Enhance professional development
- Save time.

Take the long view—but also look for "quick wins." Many aspects of HRM require a considered long-term view. Changes in HRM policy and practice may take time; their results and benefits may take longer. Vision and good management will sustain an organization through the periods of change that may be required to achieve the longer-term benefits to service effectiveness. Good managers will also be aware that early success instills confidence and boosts moral, so a program of promising practices should also give consideration to some early demonstrable improvements.

Action implications of special interest for USAID and other donors:

Provide funding for new practices. There is a relationship (or should be) between the funding necessary to start up a promising practice (which may be from existing public sources or from other sources such as venture capital) and the commitment by government or some type of public-private partnership to continue or take over the funding at a certain point. Providing the 'venture capital' for promising practice development can be an invaluable area for USAID and other donors to support.

Keep the regulatory and legislative environment under review, to remove blockages on effective practice. Health systems function within regulatory and legal frameworks that place constraints on change. These constraints can be in place for good reasons—e.g., maintaining patient safety, equality of opportunity, preventing corruption. Sometimes, however, a regulation or law will limit the scope for positive change, while no longer achieving any positive benefit. There is therefore a need to keep the regulatory and legislative environment under review to ensure that it continues to be fit for its purpose. USAID, along with other donors, can work with in-country leaders and partners to identify and remove blockages as necessary.

Strengthen the HR function in MOHs. Any type of promising practice needs competent leadership in human resources development with credibility and influence at the highest levels within government. Also needed is the associated capacity (perhaps in an HR Unit) to oversee the design, implementation and evaluation of promising practices, integrate them effectively into broader service delivery and identify practices occurring in other sectors. Generally, HR units have been woefully under-funded, and donors can provide an invaluable service by helping to fund professional development activities to produce a more professional cadre of HRD leaders, as well as advocate for a stronger, sustainable HRD function.

Consider new models of management, including contracting aspects of HR management and services. Consider the pros and cons of outsourcing government services to NGOs and the private sector when contract management capacity is weak, choices are limited and corruption may otherwise compromise the process. Identify viable options of contractual models—such as a management contract or a service delivery contract—that best fit the situation and ensure clarity of roles and accountability from all parties. Donors could help initiatives in this area by contributing to initial funding for new and innovative public-private partnerships to outsource certain kinds of services (very much like the TASO example).

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