# Creating an Enabling Environment for Human Resources for Health Program Implementation in Three African Countries

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# List of Acronyms

| | |
|---|---|
| CHAK | Christian Health Association of Kenya |
| DHO | district health officer |
| EHP | emergency hiring plan |
| FBO | faith-based organization |
| FP/RH | family planning/reproductive health |
| HAF | HRH Action Framework |
| HRH | human resources for health |
| HRIS | human resources information system |
| HRM | human resources management |
| IT | information technology |
| KEC | Kenya Episcopal Conference |
| KMTC | Kenya Medical Training College |
| M&E | monitoring and evaluation |
| MOF | Ministry of Finance |
| MOH | Ministry of Health |
| MOHSW | Ministry of Health and Social Welfare |
| MVC | most vulnerable children |
| NGO | nongovernmental organization |
| PNA | performance needs assessment |
| PSW | parasocial worker |
| PMO-RALG | Prime Minister's Office of Regional Administration and Local Government |
| POPSM | President's Office of Public Service Management |
| RHP | Rapid Hiring Program |
| SLG | stakeholder leadership group |
| UCP | Uganda Capacity Program |
| THRP | Tanzania Human Resource Capacity Project |
| WHO | World Health Organization |

# Executive Summary

Despite their constituting one of the most essential elements of any health system, there is a critical shortage of more than four million health workers worldwide (World Health Organization 2006), leaving nearly one billion people without access to health care (Global Health Workforce Alliance 2011a). Achieving universal health coverage will require significant scale up of human resources for health (HRH) interventions, including strengthening health workforce policy, planning, and financing; improving health workforce management, preservice education, and in-service training; and increasing health workforce deployment, retention, and productivity.

Over the past decade, global health leaders have increasingly recognized the importance of HRH in meeting the Millennium Development Goals, resulting in increased attention to and funding for HRH. Despite this increase, insufficient progress has been made globally in implementing HRH interventions. The reasons for this lack of progress are not well documented or understood, and the literature regarding factors that facilitate and hinder the implementation of HRH interventions is very limited.

Thus the principal objective of this qualitative study was to determine the factors that define the enabling environment for successful implementation of HRH interventions in three countries: Kenya, Tanzania, and Uganda. These three countries were selected because Capacity*Plus* lead partner IntraHealth International has been working in partnership with their national governments for five years or longer implementing USAID-funded HRH projects. Given that HRH objectives and programs varied greatly across the three countries, the research intentionally focused on key challenges and facilitating factors that were identified across HRH intervention categories and countries, rather than focusing on specific program activities in the individual countries. As a result, many of the findings, lessons learned, and recommendations can be applied in similar settings by health workforce planners, managers, educators, and other stakeholders.

In-depth interviews were conducted with 32 field- and US-based project staff members who previously worked or are currently working on USAID-funded HRH projects led by IntraHealth in Kenya, Tanzania, and/or Uganda. Participants were selected based on their experience and expertise in identified HRH intervention areas. The purpose of interviewing HRH implementers based in the US, as well as in the field, was to obtain a broader range of perspectives. The majority of the participants were field-based, but on average, the US-based participants in the sample had been working on HRH program implementation for a longer duration of time. A limitation of this study is the restriction of the sample to project staff. However, it is hoped that the next phase of this research on HRH implementation will take the findings of this study and expand the analysis to government partners and other key stakeholders, including health workers themselves.

Each interview focused on one or more HRH intervention areas, depending upon the expertise and experience of the participant(s). Detailed notes were taken during all interviews and most interviews were audio-recorded. The data from the transcripts and notes were analyzed using qualitative data analysis software. Emerging themes and patterns were identified and further explored.

Overall, remarkable similarities in the types of implementation challenges and strategies for success within and across the three countries were identified. Three key themes emerged as critical factors in the successful implementation of HRH interventions: 1) advocacy, 2) partnerships, and 3) technical expertise.

## Advocacy: Perception, Evidence, Data Use, and Champions

HRH does not generate the same immediate sense of urgency for decision-makers as do many other competing health sector needs, and thus many participants described the importance of incorporating advocacy efforts into activities to influence decision-makers' **perception** of and support for HRH investments. Data generated from human resources information systems (HRIS) and other studies are needed to develop effective advocacy messages that are based on **evidence** and facts; however, several participants described these data sources as weak, limited, or nonexistent. Even when data exist, participants noted the difficulty in, but also the importance of, identifying staff and partners with adequate skills for **data analysis and use**. In advocacy, the messengers are often as important as the message; thus, identifying **champions** who are able to inspire and engage other stakeholders was described as a critical step for gaining support for HRH.

## Partnerships: Identification, Representation, Coordination, and Government

Strong partnerships facilitate the successful collaboration and coordination across multiple ministries, cadres, and sectors that are often needed for HRH activities. **Identifying** partners and ensuring **representation** across various levels were described as key factors in successful HRH program implementation. Given the multitude of players involved with, invested in, or affected by an HRH intervention, attentive **coordination** is needed, especially when partnering with the **government**. Participants discussed the many challenges they face in coordinating stakeholder engagement as well as strategies they have used to address these challenges. Careful coordination and communication, strong networks, and a certain degree of flexibility were all highlighted as important for creating and maintaining valuable partnerships.

## Technical Expertise: Recruitment, Capacity-Building, and Retention

Successful implementation of HRH interventions requires a diverse set of skills among program staff, government, managers, and other key stakeholders. In relatively new fields such as HRH, technical expertise is scarce, and identifying individuals with previous HRH experience can be challenging. Further, the multidisciplinary nature of HRH

interventions often requires implementers to have additional skills in areas such as information technology (IT), monitoring and evaluation (M&E), and gender analysis. Participants stated that **recruiting** staff and identifying implementing partners with the right set of skills are key challenges. To address these challenges, participants indicated that a priority must be placed on building the **capacity** of HRH program staff, local partners, and ministries. For a variety of reasons—including the scarcity of professionals with HRH expertise, as well as pay differentials—**retaining** staff in the public and private sector with specialized skills in HRH can be difficult. Participants noted that the high turnover of HRH staff observed across the board among nongovernmental organizations (NGOs), partner organizations, and government agencies slowed implementation.

While numerous factors were cited that have either hindered or facilitated implementation of HRH interventions, those related to advocacy, partnerships, and technical expertise were the most salient across countries and intervention areas. The following recommendations, informed by the findings from this study, highlight key actions that national governments, NGOs, communities, and other HRH stakeholders should consider when preparing to implement a single HRH intervention or comprehensive HRH program.

## Advocacy

- Allocate time and resources to influence the perception of the impact of HRH investments.
- Identify, generate, and use data and evidence to strengthen advocacy messages.
- Identify and support HRH advocacy champions early in the implementation process and on an ongoing basis.

## Partnerships

- Conduct an initial environmental analysis to identify potential stakeholders and their priority implementation agendas.
- Ensure comprehensive representation of and address potential conflict between different stakeholder groups.
- Develop systematic and efficient coordination mechanisms.
- Build strong relationships across government stakeholders.

## Expertise

- Recruit staff with skills and knowledge in HRH and related areas such as advocacy, IT, M&E, and gender.
- To improve sustainability, incorporate capacity-building activities for stakeholders into implementation plans for HRH interventions.
- Develop a strategy to improve retention of staff, such as providing a competitive incentive package to employees.

# INTRODUCTION

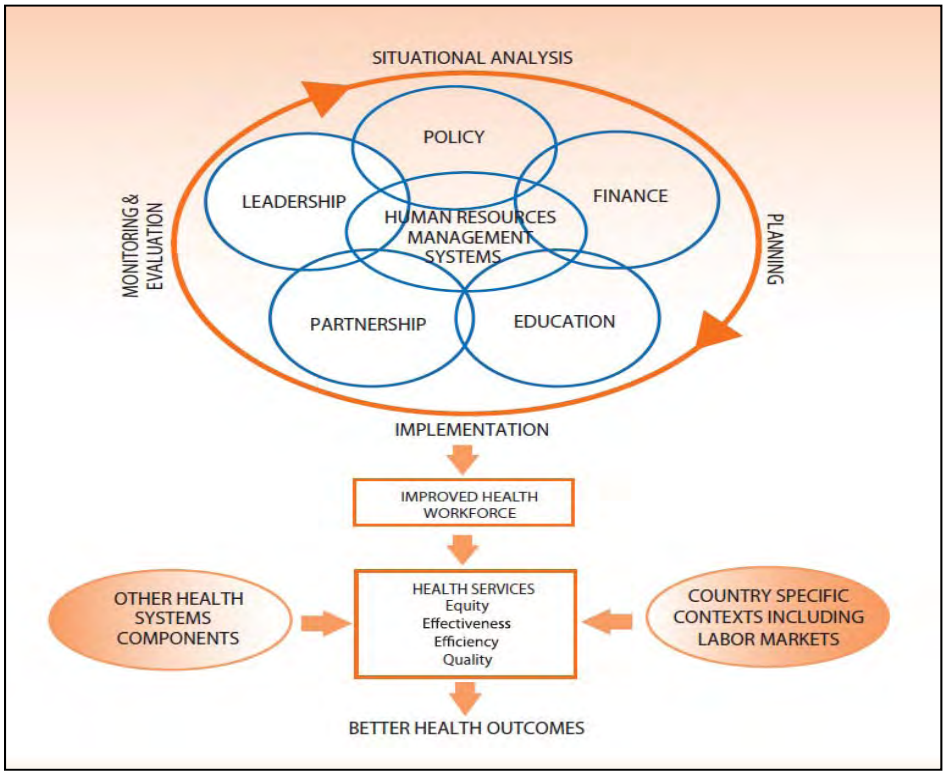
Every day, approximately 369,000 children are born (UNICEF 2012). If a child is born in sub-Saharan Africa, there is about a 50% chance that the child's mother gave birth without the presence of a skilled health worker (UNFPA n.d.). If the child lives in Southern Asia, he or she may become the one in 15 children in the region who dies each year before his or her fifth birthday, mostly from preventable and treatable conditions (UNICEF 2011). If health systems globally remain as weak as they are today, the child may grow up to be one of the unacceptably high number of people who has no one to turn to for health care needs, ranging from infectious disease prevention and treatment to family planning and HIV/AIDS services to support for management of chronic conditions and noncommunicable diseases. Nearly one billion people in the world currently have no access to health care (Global Health Workforce Alliance 2011b). To improve the chances that their citizens have access to quality health care to meet their needs, countries should have functioning, effective, and equitable health systems.

Health workers are at the nexus of health systems and are the cornerstone of quality health care; yet 57 countries are currently facing health workforce crises, meaning they are experiencing extreme shortages of doctors, nurses, and midwives given their population sizes and needs—less than 2.3 doctors, nurses, and midwives per 1,000 population (World Health Organization 2006). Access to quality care is constrained by a multitude of health workforce issues extending beyond a sheer lack of doctors, nurses, and midwives. Inequitable geographic distribution of health workers, mismatches between the population's needs and the composition of the health workforce, insufficient skills tied to inadequate education and training capacity, low retention and productivity, and weak human resources management (HRM) are all well-documented problems affecting the health workforce and health systems.

Given the multitude of factors to consider, it can be difficult to determine where to start and which approaches to take in developing the health workforce. In December 2005, the World Health Organization (WHO) and USAID convened a multisectoral meeting that resulted in the development of the HRH Action Framework (HAF) (see Figure 1) (Global Health Workforce Alliance, World Health Organization, United States Agency for International Development, and Capacity*Plus* 2011). The HAF has been used by stakeholders to plan and implement human resources for health (HRH) interventions and strategies.

The Kampala Declaration and Agenda for Global Action, adopted at the First Global Forum on Human Resources for Health in 2008, articulated global consensus on priority strategies for addressing health workforce crises (World Health Organization and Global Health Workforce Alliance 2008). Leading up to the Second Global Forum on Human Resources for Health in Bangkok in January 2011, the Global Health Workforce Alliance (GHWA) summarized advances made since the Kampala Declaration. It was found that significant progress had been made in commitments and leadership, particularly in the development of national HRH plans; however, insufficient progress was noted in the costing, funding, and implementation of national HRH policies and strategies (Global Health Workforce Alliance 2011b).

**Figure 1: HRH Action Framework**




Though it is apparent that insufficient progress has been made globally in implementing HRH interventions, including national HRH policies and strategies, the reasons for this lack of progress are not well documented or understood. Within the global health field, less is known about how to successfully implement and scale up health workforce interventions than is known about other types of global health interventions with a longer history of implementation and documentation, including targeted service delivery interventions such as tuberculosis treatment or immunization programs. Given the relative newness of the field, the literature regarding factors that facilitate and hinder the implementation of HRH interventions is very limited.

Inadequate leadership, and the exclusion of important leaders and stakeholders at national and local levels in both public and private spheres, have been identified as barriers to the implementation of HRH interventions (O'Neil 2008; Deilman, Gerretsen, and Jan van der Wilt 2009). Involving key local authorities, stakeholders, and community members has been found to facilitate both problem identification and the design of solutions adapted to the local context (Dieleman, Gerretsen, and Jan van der Wilt 2009). Another barrier to scaling up HRH programs is the financial investment required to fill gaps in the workforce. Vujicic (2005) and Williams and Hays (2005) used mathematical models to explore this issue under several scenarios. They concluded that the long-term success of these investments is dependent upon the behavior of both the donor (e.g., the duration and volatility of aid) and the recipient (e.g., prioritizing fiscal sustainability and that aid is used effectively) (Vujicic 2005; Williams and Hay 2005).

The priority approaches and regulations put forth by donors have also been documented as factors that impact the implementation of HRH interventions. For example, although donors and other global actors often point to weaknesses in the health system as a barrier to improving health outcomes, the interventions they fund are primarily aimed at specific diseases and not at the general health system (Marchal, Cavalli, and Kegels 2009). In Zambia, it was reported that a general lack of coordination between the many implementers and donors led to increased workloads for those health workers responsible for fulfilling the various reporting requirements (Hanefeld and Musheke 2009). Additionally, removing some donors' restrictions on aid can result in improved implementation. For example, donors in Malawi, having reviewed their HRH programming, concluded that staffing shortages were substantial barriers to improving health outcomes. Salary top-ups, which generally cannot be paid for with donor funds, were seen as necessary to ease workloads until longer-term initiatives, such as strategies to increase the country's capacity to train health workers, had time to take effect (Palmer 2006).

Access to data has been an important element in facilitating the expansion of health initiatives. The development of health management information systems (HMIS) to monitor the workforce and track program outcomes is a key strategy used by many countries to lay the groundwork for HRH interventions. As with many HRH interventions, an HMIS is a long-term investment that takes several years to develop, deploy, and use (Chaulagai et al 2005). Chaulagai and colleagues (2005) identified several factors that increased the likelihood that data generated from an HMIS in Malawi would be used, including accountability, developing strong leadership around HMIS, providing leadership and management training that includes modules on data use and decision-making, and developing an effective strategy for disseminating information. In contrast, punitive environments and failure to create a plan that accounts for resource constraints were factors that threatened the success of the intervention. Similarly, the USAID-funded Capacity Project's human resources information systems (HRIS) strengthening work in Rwanda, Swaziland, and Uganda highlighted the importance of allocating adequate resources to increasing computer literacy and building capacity in data entry and analysis, further professionalizing human resources functions, and focusing on retention and professional development among technical workers (de Vries, Blair, and Morgan 2009).

Shortages and poor retention of health workers have also been noted as barriers to implementing HRH interventions. For example, participants in a qualitative study in Zambia noted that health workers are in high demand and that donor health initiatives poach the best workers, stripping the health system of the very resources needed to implement and sustain the interventions. It is also not uncommon for health workers to leave the public sector or be moved by the Ministry of Health to different positions once they have been trained (Hanefeld and Musheke 2009). Interventions that do not include strategies for retaining health workers run the risk of failing to place trained health workers where they are most needed (Freedman et al 2007). Recruiting nonphysician health workers from rural and poor areas has been documented as a strategy for addressing issues of deployment and retention of health workers in hard-to-serve regions. Additionally, nonphysician health workers can be trained relatively quickly and at a lower cost than physicians (Mullan and Frehywot 2007).

Training plays a central role in many HRH interventions. Through a systematic review of the literature, McCarthy, O'Brien, and Rodriguez (2006) identified several challenges to the successful implementation of training for the HIV health workforce, including a lack of evidence on the effectiveness of the various training modalities. Many countries experiencing health worker shortages are also crippled by weak training capacity, the lack of a comprehensive national training plan, and inadequate financial resources to budget for training. Additional challenges include not having completed an assessment of the country's training needs or not having developed a plan for large-scale training. In another review of the literature on the implementation of human resources management interventions, Dieleman, Gerretsen, and Jan van der Wilt (2009) found that, overall, training is more effective if it includes some sort of supervision. This supervision can take many forms, including being integrated into the training and in field work, or as follow up discussions about field experiences.

It is critical that practitioners addressing HRH issues compile and share evidence of what is and is not working in terms of implementation approaches. The literature discussed above highlights barriers and facilitating factors to implementing HRH interventions; however, there are limitations and gaps. First, the evidence is mainly found in project reports and evaluations in the form of general lessons learned, rather than more formal evaluations. In the research studies identified, reporting on challenges and success factors to implementing HRH interventions tends to be a secondary objective and thus given less attention. Additionally, most projects and studies that discuss these factors tend to focus on a single aspect of HRH (e.g., human resources management or health management information systems), limiting the generalizability of the findings.

In response to these limitations and in recognition of the need for a more systematic approach to understanding the challenges and success factors in implementing HRH interventions, Capacity*Plus* undertook a qualitative research study with over 30 staff from multiple USAID-funded HRH projects in Kenya, Uganda, and Tanzania.

## Background and Objective

Since 2004, Capacity*Plus* lead partner IntraHealth International has been a leader in partnering with national governments to strengthen HRH programs. Significant country-level technical assistance began with the five-year, USAID-funded Capacity Project, a global initiative to improve health service implementation by strengthening HRH in developing countries. Toward the end of the Capacity Project, the USAID missions in Kenya, Tanzania, and Uganda, in coordination with country governments, chose to continue the investment in HRH being made through the Capacity Project by developing direct agreements with IntraHealth and its partners. This established three five-year, USAID-funded programs: Capacity Kenya, the Tanzania Human Resource Capacity Project (THRP), and the Uganda Capacity Program (UCP).

The principal objective of this qualitative research study was to determine the factors that defined the enabling environment for HRH project implementation led by IntraHealth in Kenya, Tanzania, and Uganda in order to better inform the implementation of country-level HRH interventions by governments, donors, and NGOs in similar settings. These three countries were

selected because IntraHealth has been working in partnership with their national governments for five years or longer implementing HRH programs, providing an adequate time frame over which to draw lessons learned. Given that HRH objectives and activities varied greatly across the three countries, the research intentionally focused on key challenges and facilitating factors that were identified across HRH intervention categories and projects, rather than focusing on specific interventions in the individual countries. However, examples of specific HRH interventions are spotlighted in this report to highlight patterns and themes in the findings, and additional details about the individual projects' objectives and activities in the three countries can be found in the appendix.

# METHODS

## Sample

For this study, in-depth interviews were conducted with 32 field- and US-based project staff members who previously worked or are currently working on USAID-funded HRH projects led by IntraHealth in Kenya, Tanzania, and Uganda. Individuals were selected for interviews based on their experience with the following HRH intervention areas:

- Partnerships and advocacy
- Stakeholder leadership groups and HRH champions
- HRH policies
- HRH finance
- HRH management systems
- HRH information systems
- Preservice education
- In-service training
- Continuing professional development
- Health worker retention
- Health worker productivity
- M&E
- Gender
- Knowledge management.

Seven participants were based in Kenya, five in Tanzania, six in Uganda, and 14 in the United States. The vast majority of field-based staff were host country nationals. Inclusion of staff from both field- and US-based offices in the sample was important to gain a broader and more diverse range of perspectives. Field-based staff are more aware of the day-to-day challenges as well as the contextual factors that influence success in implementing HRH programs. However, we also felt that including US-based participants added value. On average, the US-based

participants in the sample had been working for a longer period of time on HRH program implementation for the projects highlighted in this study and thus brought more years of experience and expertise in HRH than many of the field-based staff. Additionally, many of the US-based participants had worked across the three countries, allowing them to compare and contrast experiences and provide a more macro-level perspective.

## Data Collection

Prior to conducting the interviews, project reports were reviewed and program managers interviewed to collect and catalogue the major HRH initiatives implemented across the Capacity Project, the bilateral country programs (Kenya, Tanzania, and Uganda), and Capacity*Plus*. Building on existing frameworks, including the Capacity*Plus* results framework and the HAF, and in collaboration with IntraHealth staff, a matrix of the key HRH intervention areas (listed above) was developed as a classification scheme. Each interview was focused on one or more of the identified HRH intervention areas, depending upon the expertise and experience of the participant(s). Between three and seven participants were interviewed per intervention area, with at least one participant from Kenya, Tanzania, and Uganda representing each intervention area.

Some participants were interviewed about a single HRH area of intervention, whereas others were interviewed on several topics. Some participants were interviewed more than once and some participants chose to be interviewed together. In some cases, US-based respondents were key informants for activities in more than one country.

An interview guide was developed that included the following set of four questions asked systematically across each HRH area of intervention:

1. What project results were anticipated in this area in your project?
2. What progress has been made to date?
3. What factors have contributed to success?
4. What factors hindered progress?

The questions were designed to elicit examples of factors that have contributed to or hindered successful implementation. Probes and follow-up questions varied by interview and were used to obtain additional information about the specific activities and intervention areas being discussed.

Interviews were conducted in person, via Skype, or over the telephone by two interviewers over a five-month period from May to September 2011. An attempt was made to audio-record all interviews, and interviewers also took detailed notes. Due to technical difficulties, some of the recordings failed, which disproportionately affected interviews with Tanzania-based staff. Interviews that were successfully audio-recorded were transcribed verbatim into a Microsoft Word document. Detailed notes from the interviews were reviewed to construct comprehensive summaries for the audio recordings that were lost. As a result of the lost audio recordings, fewer

direct quotes from Tanzania-based participants are included relative to quotes from those based in the other countries.

## Data Analysis

The summaries and transcripts from the interviews were uploaded into NVivo 9 software for analysis (QSR NVivo 9 2010). A team of three researchers developed a coding scheme and coded the data based on the interview guide and emerging patterns. The main successes and challenges to HRH implementation were identified and further explored across countries and within specific areas of intervention. Although researchers identified numerous factors that facilitate or hinder implementation, the Results section presents selected findings that emerged as the most prevalent and critical themes. Some of the specific factors discussed are closely related to more than one theme (e.g., "champions" is related to both the advocacy and partnerships themes); however, the discussion of each factor is housed under a single theme for ease of reading.

In addition to presenting the findings in the results section, the report includes spotlights written to showcase specific activities so that readers can better understand how these factors interact in the implementation of different types of HRH interventions. Information from workplans, reports, and studies is included in the spotlights to provide context for the activities; thus, some of the information in the spotlights extends beyond the data gathered from the interviews.

A subset of the participants reviewed the final report to verify that the interpretation of the study findings is valid and accurately reflects program activities and experiences.

# RESULTS

Overall, remarkable similarities in the types of implementation challenges and strategies for success across the three countries were identified. Within and across HRH interventions, three key themes emerged as critical for success when implementing health workforce strengthening activities:

- Advocacy
- Partnerships
- Technical expertise.

## Advocacy

The importance of advocacy as a prerequisite for successful HRH implementation emerged as a major theme in this study. The lack of high quality data and evidence needed for advocacy was cited as one of the key constraints in every country and across all HRH intervention categories. Development and implementation of HRH plans have been more successful when advocacy efforts are included that address the long time frame required to impact service delivery and that align the priority agendas of existing health sector decision-makers.

### Perception

Advocacy for health workforce investments does not evoke the same visceral response and sense of urgency among key actors as does advocacy for specific health services and outcomes, such as in the HIV/AIDS or maternal and child health sectors. As a result, health workforce issues remain below the radar of key stakeholders and leaders, who deal with a large number of competing demands for their attention.

In reference to retention and human resources information systems (HRIS) interventions in Uganda, M&E interventions in Tanzania, and partnership establishment in Kenya, participants all echoed the challenge of raising health workforce issues to the level of attention needed to make substantial implementation progress, including mobilization of financing.

Participants also noted that the time frame between an HRH investment and improved health outcomes is typically quite long, especially in the case of health worker preservice education. Engaging stakeholders in interventions that are unlikely to produce significant changes in health service use or health outcomes in the short-term is a significant challenge. This is especially true for leaders who must show progress and results to their stakeholders, including donors, within a finite time period. Speaking of his experiences in Uganda, a study participant summarized this challenge as follows:

> *Human resources investments are long-term, and direct relationships with health outcomes are usually difficult to show in the short-term. So many development partners are more focused on diseases and service improvements and so on…[and] find it hard to invest in human resources…They say 'what if you invest in them [and] then they are not absorbed in the service? Or you invest in them [and] then they leave the country or move to other work places?' You know! All sorts of 'what ifs'… That is a major drawback in supporting the health workforce.*

This reluctance to embrace health workforce interventions can also slow down implementation once an intervention has begun. For example, respondents describing implementation of HRIS in these three countries mentioned how important, yet difficult, it could be to attract senior participation and leadership around HRIS. Senior officials can be quick to dismiss or delegate their participation in such activities, which may be seen as somewhat perfunctory, time-consuming, and low-level, and therefore not worthy of their attention. Yet without someone at the top leading the effort, which includes obtaining agreement on information needs and standardization of data across regions, partners, and sectors, an otherwise well-intentioned HRIS intervention could result in limited and/or poor quality data. Even if data are collected and available, the data might not be used for decision-making or advocacy purposes.

Often decision-makers also have the perception that HRH already gets its fair share of government resources. A participant in Kenya discussed how difficult it is to advocate for more resources from the government budget for the health workforce when nearly 70% of the recurring spending in the overall health sector budget is already allocated to human resources. However, almost all of this spending goes directly toward salaries, leaving no budget for induction (orientation) programs, human resources management programs, improving health

workforce technologies, or interventions designed to address retention or productivity. Yet the HR budget still looks bloated relative to those of other units.

While advocacy remains challenging, the analysis also revealed that for those who have worked in HRH for many years, HRH advocacy has come a long way, especially at the global level, since they first started in the field. Speaking from his vantage point in Uganda, one participant said:

> *I think the other success factor is the global trend with a lot of focus on HRH. Awareness on the whole, globally, is enormous. So HR has become something everybody would want to be concerned about in the first place.*

### Evidence

Underlying the above examples is the reality that data on health workforce dynamics and evidence describing the impact of HRH interventions on health outcomes are limited, which makes effective advocacy a challenge. While participants were quick to describe the importance of their work in HRH, they were forthcoming about the barriers they face in making evidence-based arguments to ensure buy-in for health workforce interventions.

Specifically, the empirical evidence directly demonstrating the impact of health workforce interventions on health outcomes is lacking, which makes it difficult to develop tangible advocacy arguments (e.g., that investing in a particular HRH intervention will ultimately improve a specific health outcome). As one participant talking about work in retention said, "What governments want you to say is, if you invest this much money, this will be your return on investment. I think that's very hard to say in retention."

Another argument for better evidence-based advocacy derives from the comment that HRH decision-makers view investing in human resources to be riskier than other health sector investments that lead to concrete, immediate results. Even with improved production, performance, and distribution of health workers, many other non-HRH factors and interventions must be in place for service use and health outcomes to improve (e.g., demand for services, ability to pay for services, functioning logistics systems for supplies and drugs).

The importance of finding and using data that *are* available to generate compelling advocacy messages is a key corollary of participants' observations. For example, Ugandan respondents discussed using costing data derived at the district level to request additional funds for HRH interventions. By specifically aggregating costs and procuring funding at the district rather than national level, the Uganda program has begun to see modest increases in government allocations for HRH overall.

**Spotlighting Evidence:**
**Using Costed Plans to Advocate for Human Resources for Health Financing in Uganda**

IntraHealth and its partners have been supporting the Uganda government to advocate for increased funding for HRH for a number of years beginning with activities under the USAID-funded global Capacity Project and then continuing with the bilateral UCP.

HRH advocacy is not only about convincing decision-makers of the importance of investing in the health workforce; it's also about being able to articulate exactly how much a given HRH intervention will cost and what the expected return is on that investment. Historically, district officials did not always present a clear breakdown of projected costs or needs when requesting money to recruit more staff or to implement other HRH interventions. UCP aimed to improve funding for HRH in part by supporting districts to develop these skills and generate the data needed to produce costed HRH recruitment and action plans.

A participant explained that making the case for HRH explicitly—by showing the gap, what is needed to fill the gap, and then what that will cost—makes it much easier for the government and other partners to find the resources to fill those gaps. On the other hand, vagueness and uncertainty about the amount of financial resources needed make it highly unlikely that decision-makers will provide funding.

For the 2011-2012 fiscal year, the UCP team set out to support 112 districts to develop costed staff recruitment plans for a five-year period, which were then presented at a human resources technical working group meeting and submitted to the Ministry of Finance, Planning, and Economic Development for funding. UCP further worked in partnership with advocacy groups to advocate at the parliamentary level for additional recruitment resources. The plan provided comprehensive information for all stakeholders to use to advocate for recruitment of health workers.

UCP also set out to help the Ministries of Health, Public Service and Finance to support the 112 districts to develop annual HRH action plans, which clearly delineate priorities and costs; 105 districts developed plans, and project staff credited these plans with some modest improvements in government allocations for HRH, including successful new recruitment efforts. Requesting funding on a district basis, rather than on a national basis, has helped. "[Decision-makers] found it much easier to comprehend and to want to invest in [a proposed intervention] because it didn't look like it was terribly expensive," said a participant working in Uganda.

A costed HRH action plan, however, still does not guarantee funding. The main hindrance continues to be an overall lack of financial resources (or conflicting priorities about where the resources go) to implement planned HRH activities (e.g., recruitment of new health workers, construction of staff housing, training to improve staff members' skills). For example, one district interviewed 51 health workers for vacant positions, but their appointments were halted due to wage budget shortfalls, while another district failed to implement its previous HRH action plan due to lack of funds.

The lack of funding can be a challenge, not only because desired interventions cannot be implemented and tested, but also because the lack of funding can discourage district officials who worked hard to develop the plans. Expectations need to be carefully managed throughout the planning process.

However, persistent advocacy efforts with strong supporting data make a difference. When faced with a sector-wide public recruitment ban for Uganda's 2012-2013 fiscal year, Uganda's Ministry of Health and UCP called together a meeting of HRH stakeholders. Using data from UCP-supported HRH audits as well as costing data, the stakeholder group wrote a memo describing the HRH crisis, the potential impact of the ban, and evidence-based and feasible interventions that would help to

stabilize the country's health workforce. In September 2012, after reviewing the memo, Uganda's parliament found a way to allocate 49.5 billion Ugandan shillings to HRH for the fiscal year. Most of this money will go toward recruiting more than 6,000 new health workers and some will go toward raising the salaries of doctors, which is expected to help with retention efforts in rural areas. Next year, the ministry hopes to be able to raise the salaries of other cadres of health workers, as well.

Participants voiced a desire to use evidence generated from HRH interventions already implemented in other settings to make their own advocacy messages more compelling, as well as the need to build data and evidence-producing activities into HRH projects. If key decision-makers are not convinced a problem exists—e.g., that gender discrimination is negatively affecting the health workforce or that the health risks that health workers face on the job need to be addressed—then data are needed to make the empirical case. Such data collection, analysis, and use activities should be integral components of any HRH project or program, whether it is through routine monitoring and evaluation (M&E) or other evaluation and research activities. In Kenya the importance of conducting a national risk assessment as part of the project's work climate improvement initiative was emphasized, as evidenced by the comment that, "without data on the seriousness of the health risks that workers are exposed to… you can't really get policy-makers to do anything on it."

Experience in the three countries with HRIS implementation demonstrates the importance of an HRH intervention that provides the data needed to develop strong advocacy messages, as well as to plan and manage the health workforce. With an eye toward the sustainability of this invaluable data source on health workforce dynamics, participants working in all three countries argued that a key success factor for implementing and scaling up HRIS is the utilization of free, open source software (the iHRIS suite developed by the Capacity Project and supported by Capacity*Plus*), which means that governments and other stakeholders do not have to guarantee financial resources for ongoing licenses and future upgrades.

> *If [HRIS] wasn't open source, if it wasn't free, then we wouldn't be able to have as broad an impact. All our training material was created with creative commons licenses because [the University of Dar es Salaam has] taken our training materials and adapted them for their local context.*

### Spotlighting Evidence: Strengthening Human Resources Information Systems in Tanzania

THRP is providing technical assistance in the implementation of iHRIS Manage, a module that facilitates human resources management, in the public and faith-based sectors in mainland Tanzania and Zanzibar.

The fact that the iHRIS software is open source has been a success factor in its implementation in Tanzania, allowing the system to be customized to specific contexts without incurring steep licensing and user fees. It also allows the software to be implemented and used without the direct support of the project or other external technical assistance. One design challenge currently being addressed by iHRIS developers is the need for Internet connectivity to use iHRIS, which is problematic in places like Tanzania, where electrical outages are common. Power surges, which are also common in Tanzania, can damage equipment essential for running iHRIS. Ensuring interoperability is another challenge,

especially when working across sectors. For example, the public health sector and faith-based organization (FBO) health sector use different geographical catchment areas for grouping health facilities. To aggregate data across sectors, interoperability must be taken into account when building the system. With the help of champions, bringing people together early and often to discuss interoperability issues was determined to be key to overcoming this challenge.

Training and supporting local developers can help ensure long-term sustainability and use of iHRIS. THRP has forged a relationship with the Health Informatics Program within the Computer Science Division at the University of Dar es Salaam and is working to build its capacity to maintain, strengthen, and support open source software like iHRIS. This partnership has been a key success factor supporting the implementation of iHRIS in Tanzania. With THRP support, the university held an iHRIS administration exam during the Tanzania Software Freedom Day Conference in September 2012, and 13 individuals passed the exam earning certificates in iHRIS administration. In collaboration with THRP, the university also developed and is currently administering an internship program for 10 government information, communications and technology staff to train them to provide onsite support for iHRIS users.

The University of Dar es Salaam recognized a business opportunity to develop its capacity as an implementer of iHRIS for Tanzania and the larger sub-Saharan Africa region. In fact, the university received an award from the World Health Organization to assist the Ministry of Health and Sanitation in Sierra Leone with customizing and deploying iHRIS. This work is currently under way. Additional opportunities for the University of Dar es Salaam to provide iHRIS technical assistance are also opening up in Malawi. At the individual level, a Tanzanian developer recently applied for and was granted a code bounty—a short-term development project with a small monetary award—offered by Capacity*Plus* for creating iHRIS documentation to guide the decentralization of iHRIS implementation in Ghana. This developer is also providing technical assistance for iHRIS activities in Botswana. THRP's partnerships with local entities such as the University of Dar es Salaam and the Christian Social Services Commission have also led to a better understanding of the country's needs for HR data, as well as an unplanned but highly successful partnership with two Islamic FBOs.

iHRIS has been recognized for solving several challenges with storing and finding health worker information effectively and efficiently. Use of iHRIS data for decision-making has, however, been limited to date and remains a challenge in part due to a lack of understanding of how the data can be used, though this is beginning to change. Senior leaders, including the minister of health, are beginning to specifically request HR data. In Zanzibar, an individual seconded to the Ministry of Health and Social Welfare (MOHSW) from a partner organization has played a role in coaching government staff on data use and emphasizing the importance of data quality. Identifying and training the staff, whose main roles include upkeep of the HRIS and use of iHRIS data, are important for producing data to guide and drive HRH policies and programs—for example, the Zanzibar Health Sector Training Plan and the recently drafted HRH strategy.

Another challenge that THRP continues to face is the coordination of information systems across the three ministries involved in HRH: The Prime Minister's Office of Regional Administration and Local Government (PMO-RALG), MOHSW, and the President's Office of Public Service Management (POPSM). PMO-RALG decided to implement the Local Government HRIS (LGHRIS), whereas the MOHSW worked with another partner to implement a different HRIS based on iHRIS. POPSM uses

yet another system called the Human Capital Management Information System. There is a need for a coordinated HRIS, and the lack of interoperability between the three existing systems is resulting in inefficiencies and duplication of effort. Although technically feasible, coordination will require partnership, collaboration, and political will among the three ministries and their associated stakeholders.

For more information on the iHRIS Suite, please visit: http://www.capacityplus.org/ihris

### Data use

Despite the recognized need for empirical HRH evidence, the lack of M&E skills among those responsible for implementing HRH interventions was described as a barrier to ensuring data collection and use for advocacy efforts as well to inform program implementation. Some stated that a lack of coordination between different collaborators affects the ability to adequately generate and use data for advocacy purposes. Others explained that a lack of prior experience implementing HRH interventions makes it difficult for program implementers to understand what inputs and outputs the interventions will entail, leading to challenges in adequately planning and managing the M&E of the interventions.

HRH program implementers also face the challenge of describing short-term progress of long-term interventions. To address this challenge, one participant working in Kenya described the importance and use of qualitative methods to measure short-term progress. This sentiment was echoed by another participant also working in M&E. However, it was noted that collecting qualitative data and getting stakeholders to tell their stories requires a large investment of both stakeholders' and staff members' time.

Once data are collected for M&E or research activities, there is an added challenge of identifying experts able to analyze and use the data for advocacy and decision-making, including policy development. One study participant from the US described how the lack of data use has hindered HRH policy development in all three countries highlighted in this report:

> *The other thing, I think, across all three programs [that] has been a real hindrance is we have a limited number of policy people helping to improve the use of data. Even at [Capacity*Plus*] you have mainly [IT] developers, you don't have policy people… I think it's great in Tanzania that we're working with the University of Dar es Salaam, but we now need to have a parallel where we're working with a school of public health that has a policy division to have them use the data for answering key policy questions.*

### Champions

Identifying the right messengers to advocate for HRH interventions is as important as identifying the right audience. The involvement of dedicated champions to advocate and provide support for HRH interventions was articulated as a key facilitating factor across all countries and all types of HRH activities.

Participants described the importance of identifying HRH champions in diverse settings and organizations, including within the central ministries, various levels of government, partner organizations, the faith-based sector, at facilities, and within a project team. For example, one

participant noted that health workforce gender interventions in Tanzania were moving forward because the implementation team in Tanzania had staff members who, immediately after participating in a gender and HRH workshop, understood gender issues well and became committed to incorporating gender activities into HRH strategies, as appropriate.

In Uganda, the successful championing of a knowledge management intervention by both the project's chief of party and a Ministry of Health staff member was credited as critical to smoothing the way for successful implementation:

> *Having really strong champions. I think we could have done everything right, but still not have gotten through, but they were the most critical piece. Having people that wanted [the intervention] and spending the time to talk with them…to make sure [this intervention] was something they really wanted.*

Another participant speaking about his experiences in Kenya discussed how champions cannot necessarily be created or developed, but rather, they are individuals who should intentionally be identified and leveraged. Finding someone with the right level of influence and enthusiasm, who grasps HRH issues quickly, can help mitigate potential implementation obstacles.

Ideally, champions and other important stakeholders are identified early in the implementation process. In Kenya, it was argued that performing an environmental scan and aligning stakeholders from the beginning were successful strategies for conducting advocacy. Champions helped to facilitate the project's ongoing implementation efforts by securing stakeholder support. This assertion is evidenced in the following quote related to success factors for securing financing for HRH:

> *I think being a proactive project, taking the agenda where it actually is and seeking out those who we identify as relevant. And normally we scan the environment to see who are the key dealers for some of these issues. We have identified the key dealers based on my previous engagement…I think that is a factor that has been very strategic for us. [Identifying and engaging the right people] accelerated the permeation of [the] financing environment with the issues we have on HR.*

Respondents also talked about the importance of identifying multiple champions and not overly relying on single individuals to maintain the momentum for implementation. Describing her experience with M&E in Uganda, one US-based participant claimed:

> *When there's a champion, someone who moves it along—a DHO [District Health Officer], or hospital supervisor, or health facility manager—yes, there's always an issue of financial and health resources, but if that advocate is there, they will find a way to make it happen…but this is another example where this person could get transferred and the incoming person does not have that passion.*

## Partnerships

Partnership is another strong theme that emerged from the data analysis. Study participants talked about an intense, non-negotiable need for developing and leveraging partnerships to implement health workforce interventions. While a significant level of partnering occurs when implementing targeted health service delivery projects, health workforce interventions arguably

require an even broader and deeper range of engagement. Instrumental to moving implementation forward, partnerships must be actively managed and can also lead to challenges, including tensions among partners and among representatives of the various health cadres.

### Identification

Implementing health workforce interventions requires collaboration across multiple government agencies, as well as with the private sector. Potential partners can include: ministries of education (related to health worker training); ministries of finance; ministries of public service (related to workforce policies and wage bills); ministries of health; ministries of women's affairs (related to addressing gender inequalities); ministries focused on specific geographic areas or populations, such as the Ministry of State for Development of Northern Kenya and Other Arid Lands; professional health associations and councils, universities and health training schools; and others, depending on the type of intervention. FBOs, which provide a substantial proportion of health services in many countries, are equally important stakeholders. Private-sector health facilities, providers, and training institutions also need to be engaged.

The first step in developing partnerships is identifying whom to invite to the table; however, given the vast number of potential collaborators, this is not always easy to do. Working in partnerships with government, respondents observed challenges in identifying and engaging the right partners at the right level. One participant, discussing partnerships in Tanzania, noted that in retrospect, not realizing who the most appropriate stakeholders were at the beginning of the effort to implement HRIS stalled the intervention. Once the project began working with the Prime Minister's Office of Regional Administration and Local Government (PMO-RALG), local government officials quickly saw the benefits of the system and implementation moved forward. (See the Spotlight on page 11 for more details.)

> *We really should have been with PMO-RALG from the beginning, especially considering how decentralized the government structure [is] in Tanzania…as opposed [to] other countries [that] have a more centralized government. That was probably a challenge, not recognizing who the key stakeholders really were. Really, the national Ministry of Health was only interested in the larger budgeting issues—what are the total numbers—[a] much smaller data set than they were concerned with [at] the district level. They didn't necessarily see the need for a full system.*

Conducting a formal environmental scan to identify strategic partnerships and engaging partners early in the process were two suggestions provided for forming and maintaining successful partnerships. One participant summarized how early engagement with stakeholders provides implementers with an opportunity to improve the design of interventions based on their input, which also cultivates longer term buy-in. Early inputs from partners at the Kenya Medical Training College were cited as instrumental in the design of an improved scholarship scheme to encourage students who live in underserved northern Kenya to become health workers.

> *The success factors again have been involving stakeholders right from the beginning of conceptualization of the entire scholarship program. They brought in some very insightful points*

*into developing this scholarship program and they are really looking into having a more sustainable program that is going to last long after the project is closed...*

### Spotlighting Partner Identification: Implementing a Knowledge Management Portal in Uganda

Knowledge management (KM) connects people with the best available evidence to inform a decision. Ensuring the availability and use of information requires conscious effort and a systematic approach. In the HRH field, which has a nascent evidence base, KM can provide critical tools for improving the sharing and use of data and evidence for making decisions.

The Capacity Project partnered with the Uganda Ministry of Health (MOH) in 2008 to address the HRH KM needs of the Ministry staff, health sector employees, and professional councils. The desire for HR information was strong within the Ministry and among stakeholders; however, the volume of different tools that provided access to various types of information sources, from journal articles to Ministry documents to HR data to HRH-related tools and reports, made it a challenge to determine where to find the desired information. The project therefore collaborated with the Ministry to create a KM portal integrating several existing HRH global tools and resources (e.g., HRH Action Framework website, HRH Global Resource Center, and HRIS software) with a digital library for MOH documents and links to relevant journals in a unified and simple interface. After the project ended, the Ministry hired a dedicated staff member to manage the portal. The portal remains active (as of January 2013), and Ministry employees access it regularly to retrieve Ministry and partner HRH documents and to get information on related events. The Ministry's library is in charge of keeping it up to date and is currently adding new features to the portal including the ability to browse resources by theme and to view document abstracts.

Having a diverse set of champions was instrumental in overcoming implementation challenges. One challenge arose from the unanticipated sensitivities about which stakeholders to involve in the development of the system. The activity manager successfully navigated the politics by being forthcoming about not knowing everyone who needed to be included and soliciting the advice of experienced and well-connected champions. Bringing stakeholders together in a collaborative process during the assessment, development, and review stages was key to building a product that would both satisfy the Ministry's interests and be useful for problem-solving and decision-making. In addition, spending dedicated time training various levels of users of the portal (from end users to the librarians to systems administrators) helped to overcome the reluctance users may experience when faced with learning a new system.

Other critical success factors included an initial information needs assessment and collaborative and iterative development. Focusing the assessment on the information-related problems stakeholders were actually experiencing (e.g., What questions are hard to answer? What information are you searching for daily?), rather than on eliciting specifications (e.g., What do you want the portal to do?), established the foundation for a system that would meet real information needs. For example, one stakeholder initially requested that a calendar module be added to the portal. While this would have been a simple feature to accommodate, the activity manager probed deeper to ask why and discovered that the stakeholder really wanted to be able to tell which books checked out from the Ministry library were overdue. A calendar module was not the most effective way to meet this

information need. In addition, a wiki, a website that is open to all key stakeholders to add, edit, and read, was particularly useful for ensuring stakeholders all had access and could contribute to the same set of requirements and information. After implementation, the wiki, which inadvertently also documented the entire implementation process, proved to be a valuable archive for future reference.

### Representation

Even when stakeholders' institutional affiliations have been identified, it can be challenging to ensure that stakeholders at all levels are effectively represented. For example, participants noted that while FBOs and private-sector health facilities vary by country in how they are organized, in some cases these organizations are much more loosely structured than the government. As a result, it can be difficult for HRH implementers to determine exactly which individuals to invite to the table to represent the larger group.

The challenge of engaging with FBOs in Kenya was described as follows:

> *…faith-based organizations are not necessarily as well and efficiently structured as government in terms of order of business. So you find sometimes you are engaging at different levels and there may be challenges [where] you meet someone today and you think now your things are on course and the next time you require a meeting, they send somebody else who is sounding very green in terms of knowing what you're talking about. You have to start all over again explaining where you are.*

The private sector presents similar challenges in Kenya.

> *I think figuring out how to get private-sector representation is very tricky. [Identifying FBOs is] easier because it's identifiable. Private sector, at least I think, in Kenya, is much more difficult. They are totally not organized. We tend to rely on [one private-sector organization], kind of the voice in the private sector, and they might be the biggest fish in the pond as it were, but there are so many different private health care providers that as private sectors grow and grow, [determining] how to represent them is very difficult.*

**Spotlighting Partner Representation:**
**Engaging the Faith-Based Sector in Kenya**

A significant portion of health services in sub-Saharan Africa are provided by the faith-based sector, which often serves communities in some of the most remote, rural, and forgotten areas of the world. In accord with national HRH strategies and approaches, Capacity Kenya has worked closely with the Christian Health Association of Kenya (CHAK) and Kenya Episcopal Conference (KEC) to help strengthen HRM and retention of health workers at FBO facilities. These coordinating agencies have prioritized HRH and HRM as critical pillars of health service delivery and have established a dedicated HRM department with HR officers. They have also developed an HRM peer learning cycle among HR leaders from FBOs through which they share ideas, address emerging issues, and profile health workforce issues.

Following an HRM assessment at 127 FBO health facilities, Capacity Kenya supported the introduction of an adaptable HRM policy manual that covers disciplinary procedures, pay, and other aspects of HRM for implementation in FBO facilities. Additionally, a salary survey was conducted to understand compensation terms and conditions and possible factors contributing to poor retention.

Recommendations were developed based on key findings and disseminated in two stakeholder forums. As a result, FBO facilities developed proposals on how to harmonize their pay structures, which were adopted by CHAK and KEC. The salary survey findings and guidelines have been applied to harmonize pay structures within certain departments and in some cases for the entire staff of some of the largest FBO referral health facilities. Having data to share with FBOs was well-received and helped provide a better understanding of factors related to high turnover.

Participants working in Kenya noted the importance of engaging the faith-based sector when designing and implementing HRH interventions, but also described some of the key differences and challenges faced when engaging this sector as compared to the public sector:

- Historically, representatives from FBOs have not always been invited to engage in national-level HRH discussions despite being major players in service provision. Forming stakeholder leadership groups with FBO representation is one strategy that has been successful in improving collaboration with FBOs and discourse between the public and private sectors, more generally, in Kenya.
- The structure of FBOs within a country varies greatly and can significantly impact their level of engagement with the public sector. For example, representatives from FBOs that are well-established with a centralized ownership structure are more easily identified than FBOs that are smaller and more decentralized.
- Health workers employed by faith-based facilities are often paid less than their counterparts at public facilities in Kenya, which can result in a migration of staff away from faith-based facilities. Not only does this create gaps in health care, but it can also cause tension between the two sectors.
- The management and operation of FBOs are guided by principles of faith. This can create challenges when the principles of a FBO conflict with the principles of other partners. A participant gave the example that FBOs might only recruit staff members who are compliant with their faith while other partners explicitly prohibit using religious affiliation as a condition for employment.
- FBOs are often located in remote and hard-to-reach places serving some of the most vulnerable populations. They are important partners in improving health coverage by frequently serving in communities that lack government facilities. Their remote locations can cause some challenges when convening meetings or conducting trainings. Partners and programs need to consider issues such as duration away from post, as well as travel expenses, when planning trainings with FBO staff in remote facilities.
- FBO leaders do not always have a health or HRH background. Technical knowledge and skills may therefore be more limited than when working with public-sector stakeholders.

There are significant and fundamental differences experienced by the faith-based and public-sectors with respect to their engagement and representation in HRH program implementation. These differences should not dissuade HRH leaders from collaborating with FBOs, but they highlight the need to tailor approaches and strategies for developing and maintaining partnerships with the FBO sector.

While there are clearly positive effects of creating and sustaining HRH partnerships for successful implementation, these same partnerships can lead to problematic dynamics, an issue not necessarily unique to the HRH field. Three study participants, one from each country, noted that a lack of harmonized pay among project staff, government officials, FBOs, and the private sector can be a challenge, contributing to high turnover as well as fostering stakeholder mistrust or conflict. One sector sees the other sector(s) offering better pay for the same work or poaching talent. Staff at FBOs may leave for government jobs that offer longer-term security. Government officials may leave to take a job with an NGO or the private sector for higher pay. The extent to which these differences in pay can impede the establishment of effective partnerships is reflected in this respondent's assessment for Uganda:

> *Human resources has a lot of implications…and they're difficult to tackle without considering change of policies…. So because of that we necessarily have to work through government structures and they are the owners of policies and so on…. That has been a challenge in terms of what is done and what we do. Because we have to work with them…and the fact that they feel like…we project staff are better paid than them—they sort of feel like they are doing our work. Those…little things, so to speak, have been there in the background.*

Addressing health workforce issues also involves engaging with various cadres of health workers. Any professional tension between the cadres can be a challenge, as one comment from the Kenya respondents suggests:

> *At the subnational level, one challenge we've had is the intercadre competition, where the doctors and nurses [are] permanently competing for visibility. [Doctors and nurses] are the most articulate, the most powerful cadres. They [have] associations; they [have] councils…to really push their agendas…. A doctor has very little respect for a nurse and a nurse believes [that a nurse] is the backbone of health care… So there is a bit of that competition that sometimes inhibits teamwork, and when [you try] to engage these people in joint forum, joint planning, there is a bit of negative competition that drags interventions…. [Other cadres] are always suspicious of what doctors and nurses are up to. That's the clinical officers, the pharmaceutical technologists, all those other cadres in the health system. They always feel marginalized or belittled…and as a result, interventions that require them to engage substantively occasionally get arrested by those competitive forces.*

The participant also provided an example of how collaborative efforts to develop a national committee to work on an occupational safety and health workplace initiative slowed down due to intercadre tension. The leadership within the ministry driving the formation of the committee was made up of doctors, yet some of the other stakeholders at the subnational level felt that within health facilities, doctors are sometimes part of the problem. They were therefore reluctant to trust a committee chaired by a medical doctor. This mistrust slowed down the development of the committee and, consequently, implementation of the initiative.

### Coordination

Once partners are on board, effectively coordinating partnership engagement is critical to successful HRH program implementation. Participants noted that standard coordination challenges such as scheduling stakeholder meetings, competing priorities among stakeholders, ensuring that high-level officials participate, inefficient meetings, and stakeholder turnover all hinder program implementation. This can be exacerbated by the large number of groups

involved. Developing relationships, building on existing relationships, and energizing stakeholders with strong leverage within their host organizations (public and private sector) were all mentioned as ways to solidify partnerships that ensure effective buy-in. Participants also stressed the importance of communicating frequently and of partners simply getting to know one another in sustaining an environment of trust.

Stakeholders may come into a partnership with very different expectations. Formal partnership agreements, such as a memorandum of understanding, can be an effective coordination mechanism by clarifying roles and responsibilities, as characterized by the following description of an experience with the Kenya Medical Training College (KMTC):

> *We have a standing partnership agreement with KMTC [that] gives KMTC its side of responsibility to the activities that Capacity Kenya is engaged in. Also, [it] gives us room to mobilize KMTC and begin activating our activities in the institution.*

**Spotlighting Partner Coordination:**
**Building Stronger Preservice Education Institutions in Kenya**

To support the Government of Kenya's goal of strengthening preservice education for HRH, Capacity Kenya has partnered with the Kenya Medical Training College (KMTC) to implement a variety of interventions. Partnership development and stakeholder engagement have been critical to successful implementation of these preservice education interventions.

One intervention was the establishment of a Center of Excellence in family planning and reproductive health (FP/RH) on KMTC's Kitui campus. This work has involved strengthening the FP/RH curriculum; building faculty capacity in FP/RH knowledge and teaching methods; and equipping and updating the school's resource center, skills lab, and computer lab.

Successful coordination of partnerships at various levels of the school has been essential to gaining acceptance of and support for implementing the center of excellence as well as other activities. For example, initially Capacity Kenya began to work directly with the Kitui campus on the center of excellence, which created "some tension…because…the central office didn't feel as involved as they wanted to be," reported a participant. Improving engagement of the central office was valuable to creating buy-in for other priority activities as well, such as a faculty mapping exercise. Capacity Kenya's written partnership agreement with KMTC, which explicitly outlines each party's role and responsibilities, facilitated implementation progress.

Faculty champions have also been a success factor. Supportive faculty members actively participate in activities such as trainings on translating FP/RH content into eModules, performance improvement, and supervision. A participant cited the importance of faculty (and administration) champions who prioritize and drive activities. However, turnover poses a challenge to sustaining that support in the long term.

Partnerships with external stakeholders, who leverage technical and financial resources to further the reach of new initiatives, have been equally important to this successful partnership. For example, KMTC and Capacity Kenya worked with the University of North Carolina's School of Nursing to procure equipment for and train faculty in the use of an updated skills lab. While overall a strength, the multitude of external partners working at KMTC also led to competing priorities for KMTC staff

and to overlapping activities. Different stakeholders operate on different workplan and budgeting cycles, which makes aligning activities and priorities a big challenge. The need for coordination during planning and implementation should not be overlooked.

Stakeholder leadership groups (SLGs) also featured prominently as a partnership coordination strategy that facilitates implementation. Ideally, national HRH SLGs consist of representatives from all key entities involved in planning, producing, managing, and supporting a country's health workforce. These groups can be very effective at advocating for priority HRH issues within the ministry. They can also provide feedback and input into activities, given their expertise and knowledge of the context and field. Engaging with stakeholders as part of a formal SLG can systematize collaboration, ensure ongoing communication, and foster opportunities for leveraging of resources. Capacity*Plus* has developed stakeholder leadership guidelines (Gormley and McCaffery 2011*)* to share best practices in developing and sustaining these groups.

**Spotlighting Partner Coordination:**
**Human Resources for Health Stakeholder Leadership Groups**

HRH SLGs are designed to bring together key representatives from multiple entities to work together to strengthen and support the health workforce more efficiently and effectively. HRH SLGs have played important roles in addressing key HRH issues in Kenya, Tanzania, and Uganda and were discussed broadly by several participants in the study.

Documenting the successes and challenges of working with SLGs is important to building understanding of how best to manage these groups. In 2010, Capacity*Plus* conducted a study of the HRH SLGs in Uganda and Kenya to document lessons learned and recommendations for future roll-out of SLG capacity-building initiatives. More recently, Capacity*Plus* also developed Guidelines for Forming and Sustaining Human Resources for Health Stakeholder Leadership Groups, which outlines key steps in identifying who to involve in stakeholder leadership groups, how to engage them, and how to manage the groups to maximize country ownership and sustainability. These guidelines were based on field experiences and case studies implemented in Kenya, Tanzania, and Uganda. Participants in the present study echoed many of the success factors, challenges, and recommendations identified in the 2010 Capacity*Plus* study and the SLG guidelines, examples of which are highlighted below.

Identifying the right stakeholders is an essential first step in creating an HRH SLG. A study participant in Kenya noted that those charged with forming stakeholder leadership groups must have high-level connections and influence to bring together key representatives from government agencies, FBOs, educational institutions, and professional councils and to keep them engaged in the SLG's work.

Defining the SLG's structure and functions is also vital to forming effective SLGs. One participant observed that the SLGs in Kenya can be rather large and may therefore slow down implementation if consensus is needed from the entire group. Consequently, it is the smaller working groups or subcommittees within the SLG that actually get the work done. Additionally, both the SLG guidelines and the 2010 study also note that formalizing relationships between the government and other partners helps to equip the SLG with the decision-making authority necessary to make recommendations and take action.

Regular, effective communication is also critical to ensure that an SLG runs smoothly. Without it, some stakeholders may not have access to the information they need to make decisions, or they may feel excluded from the process. A participant with experience in all three countries noted that many SLG members are also senior level and have busy schedules that do not always allow for meetings or requests on short notice. Some delegate to junior-level staff or do not engage in activities that they consider too detailed, all of which can slow down implementation. The SLG guidelines recommend strategies such as appointing a secretariat, creating information-sharing platforms, disseminating meeting notes, maintaining a calendar, and planning meetings well in advance.

By convening key representatives and actively engaging them in the HRH issues and challenges facing a given country, SLGs encourage local stakeholders to take ownership of interventions and results, whether or not they are positive. For example, Capacity Kenya worked with an SLG to implement a performance needs assessment of preservice education institutions. Although the findings did not show progress in all areas, a participant felt that the fact that the process had gone through the SLG, rather than a project or other external consultant, contributed to broader acceptance of the recommendations.

When implemented effectively, SLGs not only support HRH strategy implementation, but they serve as advocates for HRH resources and catalysts for HRH capacity-building and information-sharing. For example, the Health Workforce Advisory Board (HWAB), an SLG in Uganda, played an instrumental role in establishing and developing a human resources information system (HRIS). Involving the HWAB resulted in an HRIS that is designed to generate data that satisfies the information needs of multiple stakeholders for use in decision-making.

In Kenya, the HRH Inter-agency Coordinating Committee (HRH ICC), an SLG that Capacity Kenya helped establish and continues to support, saw concrete results from their initiatives to profile health workforce challenges and expand advocacy efforts with the following specific outcomes:

- Completion of a national overarching strategic plan on HRH
- Increased development partner focus and investment in HRH
- Increased budgetary allocations to HRH, which led to hiring additional health workers
- Improved terms and conditions of health workers
- Greater collaboration in curricula, strengthening faculty, and expanding investments to improve quality and output by convening health training institutions.

For more information on the SLG guidelines please visit:
http://www.capacityplus.org/files/resources/Guidelines_HRH_SLG.pdf

Stakeholder groups can also provide excellent opportunities for learning from other diverse constituents' experiences. For example, discussing the development of continuing professional development guidelines for the Clinical Officers Council, a study participant in Kenya stated how a small technical working group with representation from the council, the Ministry of Health, and training institutions came together to work on developing draft guidelines. The initial draft was informed by similar guidelines developed in Uganda. The technical working group then

took the draft to a larger group of stakeholders, including the Nursing Council of Kenya, for further input that was then incorporated into the final guidelines.

The value of integrating health workforce interventions into stakeholders' existing agendas and plans was another coordination strategy that was mentioned in several interviews. Demonstrating to stakeholders how health workforce investments contribute to the achievement of results under their existing agendas, rather than competing with them, facilitates buy-in for HRH program implementation. For example, a participant discussing HRIS in Tanzania described the benefit of integrating HRH activities into the agendas of a local university and the faith-based sector:

> *[We] didn't provide as much direct support to them because they had their own agendas we were fitting [into], and they were able to incorporate the two Islamic organizations even if that wasn't in the original workplan. Giving the local organizations an opportunity to pursue interests as they saw appropriate I think was important.*

As a result of strong partnerships and collaboration, participants suggested that many donors and implementing partners who were not previously working on explicit HRH activities later agreed to integrate HRH elements into their work. In Uganda, for example, the World Bank, Baylor College of Medicine, the World Health Organization, and the Northern Uganda Malaria, AIDS, and TB Project have all funded or otherwise supported implementation of HRIS in districts where they are working.

### Government

Development of partnerships across government entities, in particular, must be deftly handled to ensure implementation success. An observation frequently articulated was the challenge presented in HRH by the need to involve and coordinate across multiple ministries. Obtaining consensus and approval from multiple stakeholders can delay program implementation of HRH interventions and requires "careful management." Expectations and communication may vary between the national and subnational levels in the ministries, so it is important that government representatives be engaged, not only from each ministry, but also across various levels. In Tanzania, for example, a US-based participant described a surprising lack of communication between different levels of the health sector. The nursing council had a database with approximately 22,000 nurse records from all over the country, but a local government official located in the same building was unaware of the database and reported some frustration with not having a way to access the data on the number of nurses available.

**Spotlighting Government Partnerships:**
**Supporting Task-Shifting in Uganda**

To improve the efficiency of health service delivery and align the policy environment with actual practice, UCP supported the Uganda Ministry of Health (MOH) to: 1) understand the task-shifting approaches that are already happening informally; 2) decide which practices should be kept and developed; and 3) design a regulatory and policy framework around these practices.

The first step was to conduct a study to determine where task shifting was already happening on an informal basis. Although completed, the study took longer than anticipated. One main challenge was disagreement among stakeholders on what task shifting entailed and whether it was a positive or negative practice. Some wanted to call it "task sharing"; others, "delegation." Ultimately, to defuse tension and to ensure a shared understanding of the work, a new term was coined —*rational utilization of the health workforce*—which according to one informant, "underpinned [the] philosophy [of the intervention]."

UCP then worked with the MOH to develop tools for analyzing task shifting and to produce a policy position paper to share with one of the senior decision-makers in the ministry. The official requested an option appraisal paper that was presented with the study results to a multistakeholder group that included members of the government's Human Resources Technical Working Group. Feedback from this forum led to the request for a strategic implementation paper based on the findings.

Three different scenarios were developed and submitted to the MOH for review:

1. Continue with "status quo task shifting"—the shifting of tasks that happens organically in practice without regulation or falling within a policy framework.

2. Regulate selective task shifting and implement training and supervision support to improve service coverage with available staff. Establish a policy and regulatory framework.

3. Reengineer the health workforce, which would entail job reprofiling, review of cadre mix and review of and aligning preservice education. Include this as an integral part of the long-term HRH strengthening strategy.

Subsequently a draft task shifting strategy based on the second scenario was developed; however, the strategy document has not yet been finalized due to delays in obtaining consensus from the MOH and other stakeholders. A participant noted that one of the major challenges has been that the MOH has not always been able to sustain focus on this work; it needs a champion within the Ministry driving the process. The participant felt that with more focus on the intervention, fewer reports would ultimately have been needed to move the work forward and agreement would be easier to achieve.

Future activities include a competency analysis and implementation of the strategy. This will entail defining tasks to be shared, analyzing competencies of existing health workers, and determining which tasks to shift and to which cadres.

Strong relationships and frequent contact with government officials can help speed up activities, provide access to key players and decision-makers, and build engagement and support. When providing technical assistance in the context of HRH program strengthening, having senior technical staff with prior government experience is an asset. Seconding staff to the ministry was also described as a successful strategy to forge close government ties and stay on top of and contribute to key policy issues.

Some of the coordination needed to form and maintain partnerships with governments entails anticipating and adjusting to change. For example, transitions in government leadership due to elections and the resulting revisions of constitutions, laws, and policies, as well as associated

budgets, may negatively or positively affect HRH program implementation. The outcome depends on whether the new leadership, policies, or budgets allocate more or fewer resources to HRH than did their predecessors. Typically, any major change in government or policy tends to at least temporarily cause implementation delays during the transition period. For instance, in the case of Kenya, it was suggested:

> *The health sector reform has been a very slow process in this country…. The point is that at the central level there is a lot of reluctance to reform because reform takes away authority and some other things. Our observation has been that this is one area which has posed a challenge, and it requires a very careful management and handling of those people even as we get some of these policy issues to get underway.*

Political processes may often be viewed as cumbersome. However, participants in Kenya noted how political reform and the adoption of a new constitution, while initially slowing down activities due to uncertainties and logistical changes, such as the development of two separate ministries of health, have since created a strong demand for HRH implementation and government investment.

## Technical Expertise

Technical skills and knowledge also emerged as critical conditions for successful implementation of HRH interventions. As with all interventions, successful implementation requires staff with specific technical skills and knowledge. However, in relatively new fields such as HRH, recruiting, developing, and retaining local staff and partners at all levels with the requisite technical expertise were described by participants as being particularly challenging. Because they are in short supply, specialized skills in HRH are also highly marketable. Thus, strategies are needed not only for building HRH capacity among individuals and within partner organizations, but also for subsequently retaining individuals with HRH expertise.

### Recruitment

Implementation of well-defined procedures for recruitment of staff with requisite HRH skills and knowledge is an important facilitating factor for successful implementation of activities. As noted by a participant from Tanzania, working with a team of competent technical staff allows for deeper understanding of challenges and greater ability to brainstorm solutions together. Specific skills and knowledge in non-HRH specific technical areas, such as advocacy and IT, are necessary for successful implementation as well. For example, several individuals shared that the general lack of understanding about HRH and its importance requires staff to spend more time and energy to advocate for increased funding, changes in policy, and improved implementation of HRH policies and programs. HRH technical experts must not only be well-versed in HRH interventions, they must also be comfortable undertaking advocacy efforts.

While it can be difficult to identify partners or individuals with core HRH technical competencies, several participants mentioned that it is especially difficult to recruit experts with skills and knowledge in a few key subareas of HRH, including gender. USAID initiatives have placed increased emphasis on integration of gender initiatives in development programming, as outlined in the Gender Equality and Female Empowerment Policy launched on March 1, 2012

(USAID 2012). However, a US-based respondent observed that most HRH projects do not have field-based gender advisors with the necessary skills and knowledge to lead such an approach, nor is such expertise typically available among local stakeholders. In addition, most partners and government counterparts do not have a strong understanding of gender issues within HRH, such as affirmative action in education or employment and sexual harassment. In Tanzania, where there *is* an effective gender point person, participants described her value and influence in finding entry points for integrating gender interventions into program activities.

Beyond technical expertise, participants also emphasized the value of incorporating staff and identifying local partners with the ability to build and maintain strong relationships and teams, both internally and externally. Strong team leaders who successfully facilitate how a team communicates and works together can enhance how effectively individual skills within a team are being utilized for successful program implementation. For example, a US-based expert in the field of HRIS described how taking a teamwork approach in their activities has helped them tap into the diverse set of skills among stakeholders.

Not surprisingly, participants also uniformly argued that the inability to consistently and quickly identify and/or recruit staff with the requisite expertise and experience was a persistent challenge that slowed down program implementation. The following quote highlights this specific challenge in Kenya:

> *…On the project side we don't have the staff with the skills to push a particular activity. This is a tough area, a new area, technically speaking. So getting staff with the kind of exposure, skills, and confidence you want is a bit of a challenge.*

There simply are very few experts in the core technical areas of HRH, including health workforce policy and planning and human resources management, in these countries. Given this limitation, participants explained that there is a need to build the capacity of implementing staff internally, as well as of partners and government stakeholders, in order to develop a broader pool of technically sound HRH experts.

### Spotlighting Recruitment of Technical Expertise: Implementing and Evaluating an Emergency Hiring Plan in Kenya

Strategies such as an emergency hiring plan (EHP) are needed in countries where there are available health workers but inefficient systems to adequately and equitably recruit and deploy them. The EHP in Kenya was implemented in 2006 by the Capacity Project in collaboration with the Government of Kenya to rapidly expand the health workforce, with a focus on providing HIV/AIDS services in underserved areas. Through the EHP, the management of hiring and employing health workers was outsourced to a private-sector organization.

Key features of the plan's hiring approach included transparency and fairness. For example, job postings were publicly advertised, and short-listed and successful candidates were publicly announced. In a 2009 evaluation of the EHP conducted by the Capacity Project, most new hires reported receiving written job descriptions, as well as salary and benefits information in their contracts. Transparency was also promoted after hiring was completed, as new hires received a

standard public service induction that informed them of their rights. Improving fairness was another objective of the EHP, which used a set of standard interview questions and merit-based criteria to assess and select candidates. The 2009 evaluation found that 99% of new hires reported that they felt they were treated fairly during the interview process. Respondents also appreciated the EHP's approach of informing candidates why they were successful or not successful.

As a result of the EHP, the recruitment process in Kenya was reduced from over one year to three and a half months and 100% of the priority posts were filled. These 830 new health workers were rapidly hired, trained, and deployed in 193 facilities in 63 districts. This recruitment approach was critical to improving service availability. For example, a subdistrict hospital in the remote Turkana district was able to stay open because of the new hires.

Yet designing, implementing, and evaluating the EHP was not without challenges. Negotiating the details of the hiring approach was time-consuming and many stakeholders were reluctant to change the existing hiring processes. However, strong working relationships and staff seconded to select ministries were important factors in the success of the EHP.

Conducting a rigorous evaluation of the EHP relatively early in its implementation was beneficial in assessing the approach's impact and providing evidence and support for developing additional HRH strategies. Having dedicated staff in Kenya who fully supported the evaluation of the EHP was crucial in collecting high-quality data. However, due to local staff capacity and other competing priorities, the completion of the data analysis was more of a challenge. Technical support and leadership from staff at headquarters were important factors in successful completion of the analysis, as was partnering with other organizations that provided additional evaluation skills such as expertise in qualitative methods.

Through persistence and patience, the EHP was mutually developed with and fully embraced by the Government of Kenya. The government is placing more emphasis on addressing longer-term HRH challenges, and as a result, a Rapid Hiring Workforce Mobilization Plan and a comprehensive recruitment plan were developed. The EHP eventually evolved into the Rapid Hiring Plan (RHP), which is more focused on long-term needs. Since then, Capacity Kenya has continued to hire additional contract health workers for the health ministries under the RHP, in which an additional 1,000 new workers have been hired. Lessons learned from the EHP have been applied to create greater efficiency in the hiring and management of contract health workers under a unique partnership with the health ministries.

For more information on the EHP strategy, please visit:
http://www.capacityproject.org/images/stories/files/legacyseries_1.pdf

For more information on the facility evaluation referenced above, please visit:
http://www.capacityproject.org/images/stories/files/evaluation_rapid_workforce_expansion_strategy.pdf

In addition to recruiting excellent project staff, identifying competent and effective partners and stakeholders, and integrating them successfully into program development and implementation are critical. In instances where staff do not have the necessary skills to implement an activity,

some of those interviewed suggested that the use of partners and consultants with strong technical skills was an effective strategy for overcoming this challenge.

### Spotlighting Recruitment of Technical Expertise: Creating a Parasocial Worker Cadre in Tanzania

The Government of Tanzania classifies five percent of the child population as most vulnerable children (MVC), meaning these children live in extreme poverty, live in a household headed by children, or live without adequate adult care. THRP is partnering with local governments and the Institute of Social Welfare to implement an innovative task-shifting program to reach and provide psychosocial support for these children.

Social welfare officers are an important cadre that helps to identify vulnerable children and link them to the health and social services they need. However, fewer than half of the 133 districts in Tanzania have these workers. Training professional social workers is a time- and resource-intensive investment. Beyond the challenge of training more professionals, the government will have difficulties attracting college-educated social welfare officers with the necessary qualifications to fill positions at the ward level. THRP is helping the government to further develop and implement a program to extend social services to vulnerable children through a new cadre of parasocial workers (PSWs). PSWs work on a volunteer basis to identify vulnerable children in their own communities, connect them to services, and support community members to generate ideas and implement solutions to better meet these children's needs.

In partnership with the government, THRP has trained PSWs and introduced district advocacy teams in 21 districts. The teams are comprised of seven multidisciplinary members of the district government and provide a mechanism for advocating on behalf of vulnerable children to district planners and local decision-makers. The teams are designed to foster local ownership of the work and sustain advocacy activities beyond the project's funding period.

Anecdotal evidence indicates that the program is making a difference in many communities, including in Njombe Town, where PSWs have successfully influenced villages to set up community funds and bank accounts to manage resources for vulnerable children. The district advocacy teams are a key success factor to implementing the program to date, as they not only advocate for vulnerable children, but also for resources for PSWs. For example, the team in Njombe Town worked with NGOs in the local area to procure bicycles for the PSWs.

Anecdotal evidence also suggests that issues related to transportation, remuneration, and sustainability present some of the main implementation challenges for the program. To help address some of these perceived problems, the government intends to develop a career path for PSWs so that they can be trained at the certificate level and become formally employed. However, a major barrier is the lack of evidence on the impact the program is having on MVCs and their families. THRP, in partnership with the Institute of Social Work, is currently undertaking a program review to better understand the most pressing challenges facing the PSW program and how to respond.

### Capacity-building

Occasionally, hiring external consultants is used as a short-term strategy to address limited availability of technical experts locally. For example, one US-based participant described the valuable and necessary addition of a competent contractor with strong data collection and M&E skills to successfully complete an assessment conducted in Kenya. However, participants also articulated the importance of building the technical capacity of staff, local partners, and ministries. This is especially true when working to improve systems such as HRIS that require continued local input to sustain functionality and effectiveness. Another US-based participant stated that when developing a knowledge management portal in collaboration with the Uganda Ministry of Health, emphasis was placed on training local staff and government officials in order to eventually phase out the need for technical support from the project.

> *It was a multipronged thing…we trained the people who were going to be using it for the librarians. We trained the systems folks that were going to be managing the server and software, so that they could do without having to ask us…. And we trained the major stakeholders…some of the ministry staff and some of the district folks. We did a training for them, and walked around and showed them how to use it to get the information they needed out.*

Supporting the development of expertise in areas such as budgeting and forecasting is also essential. A US-based participant discussing work in Kenya reflected on how often those charged with advocating for resources for health workforce interventions, including those charged with human resources responsibilities in ministries of health, do not have the budgeting or financial projection skills to undertake effective advocacy. Historically, those managing human resources were seen as dealing only with payroll and personnel assignments. While the ministry may have a health economist on staff, those working in HR were not typically included at higher levels of financial planning.

In addition to being able to effectively plan for and request funding, the ability to effectively expend funds that have been allocated is also essential to getting future requests granted:

> *One of the challenges has been that the [Ministry of Health officials], particularly in the [human resources] areas, are not accustomed to trying to finagle these things in the budgets. They say, if we ask for it the [ministry] won't give us the money. This could be something to do with the cost of recruitment or induction…Then if you talk to the Ministry of Finance [MOF], they say, well [the Ministry of Health] never ask[s] us for any money so that's why we don't give them any…There are examples as well of them requesting funds for various things but not actually being able to spend the money, which leads to the MOF ignoring requests.*

Another respondent described a challenge to capacity-building being that government staff is sometimes "recycled around." Those placed in the Ministry of Health may not come with health sector experience, never mind the necessary HRH experience and skills. A capacity-building activity to increase the skills and knowledge of ministry officials may be designed and implemented; however, the officials trained may again be transferred to other divisions, resulting in the need for additional capacity-building and training for their replacements.

Capacity-building in a technical area may also need to be paired with coaching on how to approach advocacy around sensitive issues. One participant noted that female staff often

become excellent champions and strong advocates for gender and HRH activities since they "really get these issues of pregnancy discrimination and discrimination in the workforce because they have lived it and so they are very motivated to share it." However, these concepts may also be considered too politically and/or culturally sensitive to address or even discuss. For example, in Kenya, a performance needs assessment (PNA) was conducted and issues of gender equality were identified. However, one US-based participant believed that some of the staff was hesitant to present the PNA data on gender because of the uncertainty of how stakeholders would react.

### Spotlighting Capacity-Building: Gender and Human Resources for Health in Kenya

Gender discrimination and inequalities can have a significant effect on the skills, motivation, satisfaction, and retention of health workers. Capacity Kenya has supported national efforts to identify barriers to gender equality in HRH and provide stakeholders with the information needed to address them. In 2011, the results of an extensive performance needs assessment (PNA) of preservice education institutions were released. The assessment explored issues related to occupational segregation, sexual harassment, and discrimination with respect to pregnancy and family responsibilities. In addition, a gender analysis of HRIS data was undertaken to assess evidence of occupational segregation and gender differentials in career advancement and to inform policy-making.

The findings from these activities, such as female students facing challenging learning environments due to sexual harassment by male faculty, are being used to advocate for interventions to promote gender equality. For example, high-level stakeholders from the Kenya Medical Training College are currently engaged in developing a new code of conduct that integrates nondiscrimination, equal opportunity, and gender equality. Using HRIS data on the gender composition of the Ministry of Health's senior leadership, the Ministry of Health incorporated proposals in its plans for redeployment to the counties, which now include expanding opportunities for mid-level female health workers. In addition, the HRH and Devolution Task Force recently used data on the overall distribution of male and female health workers to identify change management strategies for staffing hard-to-reach areas.

Perhaps due to the sensitive nature of these activities, champions of this work found that it was initially difficult to garner the buy-in of both project staff and local partners. Many individuals had misconceptions about gender integration and affirmative action and were uncomfortable talking about these issues. Even when technical experts understood the issues, the prevailing cultural norms and lack of in-depth understanding among stakeholders discouraged implementers from advocating for solutions. In addition, turnover of experts who had been involved in these activities necessitated additional rounds of training and challenged the sustainability of such activities.

One of the factors that enabled the government of Kenya to continue to address gender issues in HRH was the development and incorporation of an action plan for gender integration into Capacity Kenya's HRH support to the MOH. Although a budget was not specifically assigned to the gender integration action plan, ensuring that the action plan was both incorporated and costed was identified as a key condition for future implementation. Training of and advocacy directed toward both project and government staff also helped to clarify misconceptions about gender equality

concepts and to engage the commitment of leadership to support these activities. Due to the sensitive nature of gender equality topics, creating both attitudinal and resource support for gender and HRH interventions is an essential step to enabling their successful implementation.

Training staff in gender issues and analysis of gender and HRH data has helped build the capacity in Tanzania to advocate for gender and HRH issues. After participating in a capacity-building workshop on gender and HRH, teams developed gender action plans, and many of these activities have moved forward, including: adding equal opportunity and gender equality information in the MOHSW orientation package for new employees of local government authorities in the health sector; developing a gender and HRH module for inclusion in a HRM curriculum for district managers, and creating guidelines for gender mainstreaming in HRM.

### Retention

Given the fundamental importance of HRH expertise for HRH program implementation, it is important to note that quite a few participants stated how difficult it is to retain technical staff who have specialized skills in HRH, both within partner organizations and within government entities. One respondent from Kenya asserted that trained staff members start "selling like hotcakes because they are the only ones who seem to have that kind of exposure." Additionally, low salaries in the public health sector, as compared to the private sector, make finding and retaining local staff with the right skills challenging, particularly in IT. The three countries' activities to implement the iHRIS software have involved training staff and government employees to customize, adapt, and use the system. As described below, it is difficult to retain project staff and partners after they have been trained in IT, because they can typically find higher paid employment in the private sector:

> *Identifying local people to do the work, this is still a challenge, no matter what country it is. Jumping over to Zanzibar, they have particular [problems] because their IT ministry people would get paid something like $500 a month if they employed anybody to do HRIS. They can just hop over to Dar es Salaam on a boat in the morning and come back in the evening and make…more money, so there is no economic incentive for them to remain in the ministry. It's only people who are there because they want to specifically be in Zanzibar, whether it's family or just where they grew up…*

Turnover and tension among HRH stakeholders were also cited as two of the key challenges to successful program implementation. Repeatedly, participants credited a high volume of stakeholder turnover as a factor that could dramatically slow implementation. Frequent reassignments in the health sector left HRH program managers discouraged by the fact that they would make progress with one stakeholder and then need to start from scratch with someone new who didn't have the same understanding of, or commitment to, HRH. A participant from Kenya described how the expectation of frequent turnover left stakeholders reluctant to engage in long-term thinking, which is crucial to implementing health workforce interventions. The same individual also shared some strategies for addressing stakeholder turnover:

> *The turnover issues—what we've done is [build] another layer of alternative leadership (or is it a successive generation?). Those are very high sounding words, but in simple terms what we've done is broaden the engagements. So we engage the leaders, try as much as possible to build skills and understanding on [the] major interventions we want to do [with] as many members of staff as*

*possible. The managers, unit heads, I saw that even [with the CEO, there] is still another level we can engage with and that can induct the new incoming person on some of the priorities the organization is moving with. So it's both ways: you want to engage and keep the high level, the top leadership, and CEO very much engaged, but at the same time you want to be sure that he is not turning this into a personal agenda that when he leaves there is no one else who knows it. And you can move with it.*

In addition to challenges retaining project staff and external HRH technical experts, retaining trained health workers was noted as another significant challenge to implementation and scale-up of HRH interventions. A participant in Uganda discussing the barriers to implementing facility-level performance improvement interventions observed that frequent turnover of health workers in facilities resulted in "a constant need for training and a lack of implementing performance improvement activities." In order to help address this issue, Capacity*Plus* developed a tool for conducting a rapid discrete choice experiment, which aims to help governments prioritize and cost retention strategies. At the request of the government, this tool was used in Uganda and the MOH is using the results to build consensus on feasible financing options for attracting, retaining, and motivating health workers to address the country's health workforce crisis.

## CONCLUSIONS

Over the past decade, global and national health leaders have increasingly recognized the importance of investing in HRH in order to scale up service delivery and meet the Millennium Development Goals. This prioritization has resulted in increased attention to and funding for HRH. Despite these advances, insufficient progress has been made in implementing HRH interventions to improve access to qualified health workers. Therefore, this qualitative study was conducted in three countries to provide evidence and lessons learned on the factors that facilitate and hinder implementation of HRH interventions. The sample for this study was limited to implementers of IntraHealth-led projects; however, the findings can be used to inform a wider audience. The following conclusions summarize recommended strategies for health workforce planners, managers, educators, and other stakeholders to prioritize in creating a robust enabling environment conducive to sustainable HRH program scale-up.

Many of the success factors and barriers to implementing HRH interventions presented in this report are consistent with those of previous reports and studies and further contribute to our depth of knowledge in these areas. Some of the key factors that have both emerged from this study and have been documented as barriers and/or facilitating factors in other studies include the long-term nature of HRH interventions (O'Neil 2008; Chalulagai et al 2005), data availability and use (Rabkin, El-Sadr, and De Cock 2009; Chalulagai et al. 2005), multiple stakeholder engagement (O'Neil 2008; de Vries, Blair, and Morgan 2009), and retention of skilled workers (Hanefeld and Musheke 2009). The findings from this study also bring attention to additional factors that have not been emphasized in previous studies, such as the importance of advocacy for HRH interventions and specific technical expertise among HRH program implementers.

In reviewing the summaries and recommendations put forth in this section, it is important to keep in mind the strengths and limitations of this study's analytic framework and methods. A qualitative research method was selected to allow identification of challenges, as well as to explore and describe how certain factors contribute to successful implementation of HRH interventions. Use of in-depth interviews for data collection allowed us to gain a deeper understanding of how and why certain factors are important in HRH program implementation than would have been possible with quantitative data collection methods. Despite the logical selection of a qualitative approach, there are limitations that must be considered when evaluating the strengths of the findings.

The validity of the study data may be affected by recall and social desirability bias. During the interviews, participants were asked to recall past events, some which took place several years ago. Participants' ability to accurately recall these events may be disproportionately affected by their experience and/or the outcome of the event. Moreover, interviews were conducted with project staff members, some of whom may have felt uncomfortable speaking candidly about certain issues or challenges especially regarding ongoing activities. Their responses may have been influenced by what they believed their colleagues and/or the interviewer would want to hear.

Another consideration is the extent to which the study findings are generalizable. The respondent sample was limited to field- and US-based staff providing technical assistance to IntraHealth-led projects in Kenya, Tanzania, and Uganda; thus the analysis provides lessons learned from the perspective of implementers from a limited number of projects and with an external optic. This sample may in some ways provide a more objective lens but is less likely to reflect some country-specific variables that could help to further describe important considerations. Obtaining the perspective of more players involved in HRH implementation, including government officials, health workers, FBOs, and other implementing partners is an important next step that would further validate and supplement this study's findings. Despite these limitations and the acknowledgement that the conclusions are limited to description of lessons learned, not explanation of cause and effect, the overarching themes and findings should be transferable to other HRH programs in similar settings.

It is also important to keep in mind that for the three countries included in this study, the HRH program implementers worked with populations with similar health characteristics, and who, to a large extent, faced similar health systems constraints. However, unique considerations and events, such as political reform in Kenya, can significantly affect the implementation of both HRH activities and strategies to overcome these constraints. Likewise, the appropriateness of the following recommendations may vary depending on the sociopolitical context, available resources, and level of development of HRH in a given setting. Nevertheless, it is hoped that the recommendations listed below will assist country program planners, decision-makers, and other implementation stakeholders to further the reach and impact of their HRH efforts.

## Recommendations: Advocacy

The importance of advocacy, including generation and use of health workforce data and

evidence, was one of the strongest themes emerging from this analysis. Many participants noted that without effective advocacy, the HRH agenda simply will not advance. HRH implementers should factor in the time and resources necessary to identify champions and conduct advocacy activities, including associated data collection and use activities, to ensure leadership and support among key stakeholders.

- **Allocate time and resources to influence the perception of the impact of HRH investments.** Interest and strong support are essential ingredients for securing investments, yet the current perception and support of HRH issues is less favorable than for other health issues. Emphasis should be placed on developing messages that explain the long-term nature of HRH interventions and how investments in areas such as preservice education and HRH policy can result in changes in health systems and health outcomes over time.

- **Identify, generate, and use data and evidence to strengthen advocacy messages.** Using data to develop advocacy messages makes a stronger case for investing in and supporting HRH interventions. If data are lacking but anecdotal evidence is strong, assessments or studies should be conducted to generate evidence. Using open source software such as iHRIS can help minimize costs of managing and monitoring routine health workforce data. Skills of staff and partners should be developed to strengthen their ability to monitor, evaluate, analyze, and use data for advocacy.

- **Identify and support HRH advocacy champions early in the project and on an ongoing basis.** Identifying the right audience and the right messengers is necessary for initial and continued success of HRH programs. Champions of HRH activities should be identified and supported at multiple levels—e.g., within the Ministry of Health, in partner organizations (e.g., FBO and private sector), and at district and facility levels.

## Recommendations: Partnerships

Identifying, cultivating, and including partners in the design and implementation of HRH interventions is instrumental to implementation success. Potential partners include a broad spectrum of ministries at multiple levels, private-sector organizations, and councils representing the numerous cadres of health workers. The vast and diverse set of partners that can and should be engaged requires careful coordination. In reflecting on approaches that are key to partnership development, participants spoke as often about strategies such as environmental analyses and memoranda of understanding as they did about the "soft skill" of building trust by getting to know partners well.

- **Conduct an initial environmental analysis to identify potential stakeholders and their priority implementation agendas**. HRH encompasses stakeholders from multiple ministries and sectors, so identifying the array of potential partners is a crucial first step. Engaging stakeholders early and often and demonstrating to them how their input contributes to the program is important. Stakeholders at multiple levels within a partner organization should be included; avoid only engaging the top leaders. Seek to determine stakeholders' key priorities and how the HRH portfolio complements their existing agendas.

- **Ensure comprehensive representation and address potential conflict between different stakeholder groups**. Key sectors, levels, and cadres should be represented in the design and implementation of HRH interventions. Make sure representatives from multiple ministries, FBOs, and the private sector, as well as all health cadres (not just doctors and nurses, who are generally better represented) have an opportunity to participate. Be aware of tensions among partners and facilitate as much as possible a team approach, as opposed to fostering competition.

- **Develop systematic and efficient coordination mechanisms**. Given the significant and diverse range of partners that should be represented in HRH interventions, proper and efficient coordination is essential. Strategies for successful coordination of multiple partners include frequent communication, formation of stakeholder leadership groups that can inform and shape the intervention and implementation strategy, and when feasible, development of formal partnership agreements that outline the roles and responsibilities of each partner.

- **Build strong relationships across government stakeholders**. A diverse set of health ministry and other government officials can provide leadership for and facilitate coordination of HRH program implementation. Technical assistance and donor partners should cultivate strong ties by seconding staff to the ministry to strengthen advocacy and support for HRH. Key government processes such as elections and budgetary cycles should be incorporated into HRH implementation plans. Flexibility should be built into implementation strategies and approaches to facilitate appropriate responses when a government leader, budget, or policy changes.

## Recommendations: Expertise

It is evident from this analysis that HRH technical skills and knowledge are essential for successful and sustainable implementation of HRH interventions; however, there are considerable challenges in developing, recruiting, and retaining staff with these specialized skills. Without strategies in place to accomplish all three of these capacity-building components, HRH interventions will experience delays and setbacks. As it is important to invest in and support health workers throughout the life cycle of their careers, it is also important to support and protect HRH staff, partners, and stakeholders throughout theirs.

- **Recruit staff with skills and knowledge in HRH and related areas such as advocacy, IT, and gender**. Additionally, communication and teamwork skills, which cultivate internal and external relationships, are arguably as valuable to an HRH project or program as technical expertise and should not be overlooked. When staff lacks specific expertise, hiring skilled consultants can complement and strengthen the existing capacity over the short-term.

- **To improve sustainability, incorporate capacity-building activities for stakeholders into implementation plans for HRH interventions**. Making investments in developing staff and stakeholder HRH capacity and expertise is important for strengthening interventions, especially HRIS, data use, budgeting, and forecasting interventions. Addressing gender

discrimination and inequality is also needed to advance the HRH agenda. Programs should train staff and stakeholders to be knowledgeable advocates for gender issues.

- **Develop a strategy to improve retention of staff, such as providing a competitive incentive package to employees**. Some turnover within government and among partner stakeholders is inevitable and should be anticipated. However, retaining staff with specialized skills in HRH improves the progress and continuity of program activities. HRH plans should ensure that multiple levels of staff are engaged and understand and feel accountable to the plan's goals. Strategies, such as stakeholder agreements, can help prevent an effort from fading when key leaders transfer out of the HRH sector.

As referenced previously in this report, the HAF was designed in 2005 "…to assist governments and health managers to develop and implement strategies to achieve an effective and sustainable health workforce" (Global Health Workforce Alliance, World Health Organization, United States Agency for International Development, Capacity*Plus* 2012). The framework identifies six key action fields that need to be addressed and strengthened when developing comprehensive health workforce programs. These fields are: human resources management, leadership, partnership, finance, education, and policy. In addition, the framework identifies four components of the HRH action cycle: situational analysis, planning, implementation, and M&E.

This study identified three key themes (and subtopics within those themes) that cut across the HAF's action fields and action cycle components. This should come as no surprise, since the study participants reflected on both *factors* that serve as barriers to and *processes* that facilitate successful implementation of HRH interventions. As an example, this study identified weak partnerships (a HAF action field) as a major challenge and undertaking an environmental scan or situational analysis (a HAF action cycle component) as a key step in the process for identifying potential partners at various levels. While all of the HAF action fields are required to create the necessary and sufficient conditions for defining a comprehensive HRH program, this study's findings suggest that greater attention and resources should be devoted early on to a subset of program elements (advocacy, partnerships, and technical expertise) to maximize the reach of and synergies between HRH investments. If so, the strong enabling environment created is likely to improve the medium- and long-term results produced by HRH investments.

HRH may be an essential building block of health systems, but it is a complex field in and of itself. In an era when most countries and donors must balance numerous funding priorities with limited resources, making the case for HRH calls for a heightened effort from stakeholders in multiple sectors and cadres to advocate for and lead comprehensive HRH programs. As the profile of HRH continues to grow, it will be important to continue to share implementation lessons—such as those reported in this qualitative study—as well as to monitor, document, and disseminate program results and challenges. Strengthening the evidence base will help HRH stakeholders to craft and deliver effective messages for potential funders, partners, and beneficiaries, thereby facilitating implementation, and more importantly, improving the impact of scaled-up HRH interventions on health outcomes.

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# APPENDIX: COUNTRY BACKGROUNDS

## Kenya

With an average of 1.3 health workers (doctors, nurses, midwives) per 1,000 population[1], Kenya does not have the number of health workers required to address the basic health needs of its population and certainly not enough health workers to address the growing burden of disease caused by malaria, HIV, and tuberculosis. The shortage is particularly acute in rural areas, where, according to Kenya's National AIDS Strategic Plan, 70% of the 1.4 million people living with HIV in Kenya reside[2]. Kenya's health workforce is further strained by challenges in attracting and retaining public health workers, performance management issues, diminishing productivity in the health workforce, and outmigration of health workers to other countries. In an effort to address these challenges, IntraHealth has collaborated with the Kenyan government and partners to strengthen systems to recruit, train, deploy, and retain skilled health workers where they are most needed.

From 2004 to 2009, IntraHealth worked with partners, the Kenya Ministry of Health, and health sector leaders through the global Capacity Project to increase the ability of the public health sector to rapidly mobilize additional qualified health workers and to strengthen long-term human resources for health (HRH) for health planning and management. The project implemented a range of targeted interventions, including: 1) the design, implementation, and evaluation of an emergency hiring plan that created a model for fair, transparent, and rapid health worker recruitment procedures; 2) HIV clinical skills training of more than 800 health workers, including community and registered nurses, laboratory technologists, pharmacy technologists, and clinical officers; 3) implementation of a work climate improvement initiative at ten health facilities; 4) development and finalization of a three-year strategic plan to improve hiring and allocation of health workers; and 5) development of a national policy for training health workers.

Since 2009, this work has continued under Capacity Kenya. The project's goal is to strengthen HRH systems across public, private, and faith-based sectors to ensure improved delivery of primary health care and improved health outcomes for the Kenyan people. The project is collaborating with the health sector and its partners and stakeholders to improve HRH planning processes; address health worker capacity development by focusing on skills and competencies; improve health worker safety, productivity, and retention; and support senior technical staff at key government ministries and/or departments.

To reach its goals, Capacity Kenya has organized its activities according to the following intermediate results:

1. Strengthened and institutionalized HRH strategies, plans, policies, and practices at the national and provincial levels

[1] World Health Organization. Global Atlas of the Health Workforce. Accessed August 10, 2012.
[2] National AIDS Control Council. Kenya National AIDS Strategic Plan 2009/10 – 2012/13. Accessed August 10, 2012: http://hivaidsclearinghouse.unesco.org/search/resources/5752_KenyaPlan2009.pdf

2. Improved opportunities for addressing the knowledge and skills needed by workers at all levels, including the community, for the provision of quality services
3. Workforce performance systems in place to improve productivity and retention for the delivery of services, particularly at the community level.

Unique to Kenya among the three countries included in this study is the current climate of sweeping political reform. In August 2010, Kenya enacted a new constitution, ushering in an era of fundamental transformation that included health sector reform. The new constitution's bill of rights includes the right to health services and led to considerable changes in the governance of health services.

## Uganda

Uganda has only 1.4 health workers (doctors, nurses, midwives) for every 1,000 people[3]. About 33% of all established health positions are vacant; 45% of local government positions are vacant[4]. As in many developing countries, Uganda's rural regions, where 88% of the population lives, are most heavily affected by the shortage. While only 12% of the population lives in urban areas, 71% of the doctors and 41% of the nurses and midwives serve urban areas[5]. Low productivity intensifies the effects of the shortage, and a recent study suggests that health workers are absent from their posts as much as 35% of the time[6].

From 2004-2009, IntraHealth's work in Uganda through the global Capacity Project focused on developing HRH leadership and establishing a foundation of data-rich systems and practices to improve access to HRH information, drive decision-making, and improve human resources processes, such as health sector payroll and credential verification. The project collaborated with the Uganda Ministry of Health and other national health organizations on key activities, including: transitioning from paper-based systems at the Ministry of Health (MOH) and four professional councils to electronic management of health worker data; implementing a knowledge management portal at the MOH to provide a single point of access to key health workforce data and documents; and developing policies and guidelines to address safe working environments, continuing medical education, and management support for health workers.

In 2009, the Uganda Capacity Program was launched with the goal of reducing mortality and morbidity by strengthening health workforce systems and practices for the delivery of HIV/AIDS and other health services. The program is working with the central ministries, districts, and professional councils to enhance Uganda's capacity for HRH policy and planning; strengthen systems for an improved quality, performance-based health workforce; and improve health workforce management practices. The project includes a focus on decentralizing health workforce planning, development, and support.

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[3] World Health Organization. Global Atlas of the Health Workforce. Accessed August 10, 2012.
[4] Ministry of Health, Uganda. 2011. Human Resources for Health Bi-Annual Report: April-September 2011.
[5] Interagency Health Team, US Mission Uganda. 2011. Global Health Initiative: Uganda.
[6] Matsiko, Charles Wycliffe. Absenteeism in Uganda: Quantifying the nature and extent of absenteeism rates at the district level (unpublished). Kampala, Uganda: IntraHealth International.

The project organizes its activities around the following intermediate results:

1. Enhanced capacity for HRH policy and planning
2. Strengthened systems for an improved quality, performance-based health workforce
3. Improved health workforce management practices.

## Tanzania

Tanzania, including the semiautonomous region of Zanzibar, has less than 0.3 health workers (doctors, nurses, midwives) per 1,000 people[7]. Tanzania's ability to provide basic services to its population, including the 1.4 million adults living with HIV and the 1.3 million children orphaned by the disease, is severely hampered by a lack of qualified heath workers[8]. In collaboration with local partners and the Ministries of Health and Social Welfare in Tanzania and Zanzibar, IntraHealth works to recruit, train, deploy, and retain more health and social workers to provide care for all Tanzanians, especially those affected by HIV.

Under the Capacity Project, IntraHealth worked with the Tanzania Ministry of Health and Social Welfare (MOHSW) to implement an emergency plan to assess, predict, and manage Tanzania's health workforce; accelerate recruitment and retention of health workers to expand services in underserved areas; and increase the productivity of the health workforce. The project worked with stakeholders to implement a national HRH strategic plan. Other interventions in Zanzibar focused on developing an electronic human resources information system (HRIS), improving quality of care, and developing strategies to increase health worker productivity and retention.

The Tanzania Human Resource Capacity Project (THRP) was launched in 2009 to build on this work. Unique to the projects included in this qualitative study, THRP implements interventions primarily through a local partner coalition with a mandate to build the capacity of these local organizations. The project and its partners support local government authorities and their counterparts to document and scale up HRH approaches and to design interventions and tools to assist in better management of the health and social welfare workforce. Key activities include the implementation of an HRIS and the training of a new cadre of community workers (parasocial workers) who connect HIV-orphaned children to the health and social services they need.

The project has specifically set out to achieve the following objectives:

1. Assist the MOHSW (and the Prime Minister's Office of Regional Administration and Local Government) to orchestrate the implementation of the HRH strategy and the HR components of the Health Sector Strategic Plan III.
2. Strengthen the capacity of the national and local government authorities to predict, plan for, and recruit the health and social welfare workforce.

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3. Improve the deployment, utilization, management, and retention of the health and social welfare workforce.
4. Increase productivity of the health and social welfare workforce.

CapacityPlus is the USAID-funded global project uniquely focused on the health workforce needed to achieve the Millennium Development Goals. Placing health workers at the center of every effort, CapacityPlus helps countries achieve significant progress in addressing the health worker crisis while also having global impact through alliances with multilateral organizations.

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