

Partnering with African Faith-Based Organizations for a Strong Health Workforce

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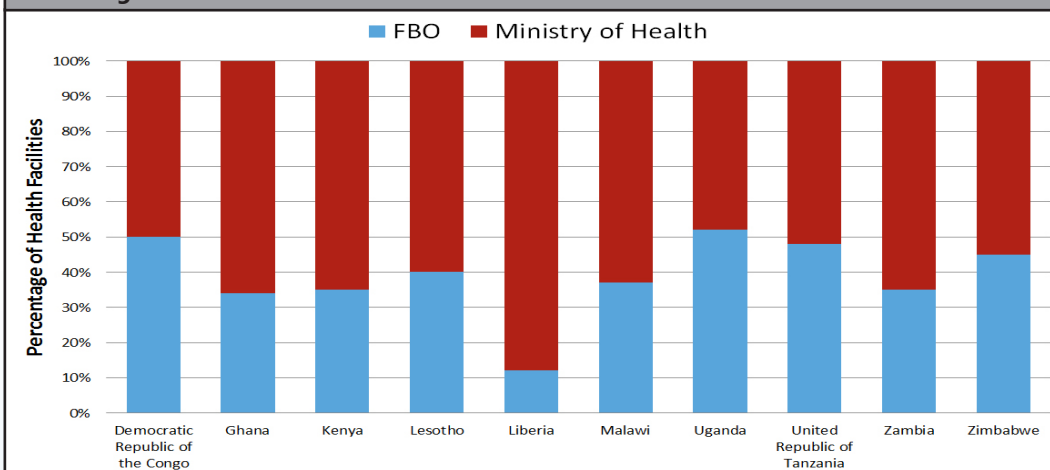
Faith-based organizations (FBOs) play a key role in providing health care in many parts of the world. According to the World Health Organization (2007), FBOs own and operate an estimated 30% to 70% of health facilities in some African countries. A 2011 assessment in ten countries found a similar range of FBO involvement (see Figure 1). FBOs train a significant portion of health workers, especially nurses and midwives (Dwyer 2011). In addition, they often serve remote and rural areas where the public sector has difficulty attracting and retaining health workers, thereby increasing accessibility and equitable distribution of health services for vulnerable populations.

Yet FBOs remain underrecognized for their immense contributions to the health sector. In many contexts, national human resources (HR) information systems fail to count FBO health workers, and FBOs are often not integrated into planning and resource allocations for national health systems, leading to service and system redundancies and gaps.

This technical brief presents examples from the Africa Christian Health Associations Platform and its members' efforts to strengthen human resources for health (HRH) and integrate FBOs into national health systems and the HRH community. The brief highlights achievements in selected areas, provides lessons learned, and offers seven key recommendations for furthering FBOs' efforts.



Figure 1: Contributions of Christian Health Networks in Select African Countries



Source: Dimmock 2011

Faith-based organizations and human resources for health in Africa

Similar to other public- and private-sector health institutions providing health services in Africa, FBOs face numerous HRH challenges. High staff attrition rates, partially attributable to

the migration of health workers, present one major challenge. In 2011, the Churches Health Association of Zambia identified a number of other HRH challenges within FBOs:

- Poor and unattractive conditions of service
- Emergence of competitive local, regional, and international markets for health workers
- Reluctance of qualified medical staff to serve in rural locations
- High absenteeism
- Restrictions on new staff recruitment.

Africa Christian Health Associations Platform

The Africa Christian Health Associations Platform (ACHAP) has strengthened its members' capacities to address HRH challenges with support from CapacityPlus. ACHAP is an advocacy and networking organization made up of 34 Christian/church health associations (CHAs) in 28 sub-Saharan African countries (see Figure 2).

Building on foundational work within ACHAP that occurred under the USAID-funded Capacity Project (2004–2009) in the areas of retention, HR management, and leadership, CapacityPlus has also provided direct support to five ACHAP members: the CHAs of Ghana, Kenya, Liberia, Malawi, and Zambia, which provide between 20% and 40% of health services in their countries.

Through partner IMA World Health, CapacityPlus seconded an HR technical advisor to work closely with ACHAP



Source: IMA World Health

members. CapacityPlus supported the establishment and strengthening of an ACHAP HRH technical working group that has grown to include 13 CHAs from ten countries. The group meets regularly to learn from country experiences. Six workshops on HRH have been held since 2007, with growing interest from members and partners in enhancing these exchanges. These forums have served as capacity-building sessions for HR professionals and leaders in the FBO community.

Integrating faith-based organizations into national health systems and the global human resources for health community

Active engagement with FBOs has strengthened their integration and participation in global, national, and sector-wide HRH activities. For example, after CHAs in Malawi and Zambia negotiated memoranda of understanding with government, this became a model for other CHAs to follow or adapt to their country situations. Through ACHAP's urging and facilitation, a number of CHAs developed and refined their own memoranda of understanding, leading to improved integration with the national health system and greater participation in national HRH planning processes.

Integration has also taken place via FBOs' adoption of the open source iHRIS health workforce information systems software supported by CapacityPlus (www.ihris.org) to provide a more comprehensive national picture of HRH. In addition, FBOs have participated in key meetings such as those of the Global Health Workforce Alliance and the African Platform on Human Resources for Health, and shared HRH information, tools, and publications at ACHAP conferences and other regional forums.

During a 2012 meeting in Kenya, members of ACHAP's HRH technical working group discussed the need for advocacy to increase support for the health workforce in Africa. Members developed advocacy messages to guide FBO leaders, proprietors, partners, and stakeholders in their advocacy efforts. Through support from Novo Nordisk and CapacityPlus, ACHAP (2012) published [Because Health Workers Matter: They Need Our Support](#) and disseminated it at the sixth biennial ACHAP conference in Zambia in 2013.

Achievements

Notable achievements have been made in strengthening and integrating the HRH expertise of FBOs. These include improved HRH leadership of ACHAP itself; knowledge advancement through an eLearning course; effective HR management policies and practices within the CHAs of Kenya and Malawi; strengthened HR management within the Christian Health Association of Ghana; targeted retention mechanisms within the Churches Health Association of Zambia; and strengthened institutional capacity of the Christian Health Association of Liberia and the ACHAP secretariat. These achievements are further described below.

Africa Christian Health Associations Platform

Human resources for health technical working group: The group has held regular meetings and workshops that have built members' capacity in key thematic areas such as

Table 1: Selected Results from Study of Human Resources Management Policy and Practice Intervention at Christian Health Association of Kenya Facilities

| Data source | Key findings (percentages or 1-10 ordinal scales) |
|--|---|
| Interviews: managers | Substantially increased knowledge, skills, authority, and effectiveness, as evidenced by: <ul style="list-style-type: none"> • Promotions and new positions • More staff assigned (from an average of 1.5 to 3.7) • Improved HR management offices (from 3.3 to 7.1) and computers (from 3.2 to 6.3) • Improved recruitment, contracting (from 5.3 to 9.4), compensation (from 5.1 to 8.8), and HR support practices (e.g., performance-based promotions) (from 4.5 to 7.3) • Study and travel abroad (approximately two-thirds) |
| Interviews: health workers | Significant improvements in HR practices, including: <ul style="list-style-type: none"> • HR manual available in workplace (from 33% to 73%) • Safety regulations (from 28% to 67%) • Incentives received (from 27% in the two years preintervention to 64% in the two intervention years preceding the interviews) • Increased fairness in hiring, promotion, and firing (scale from 5.4 to 6.8) |
| Exit interviews: clients | Areas of improvement: <ul style="list-style-type: none"> • Perceived increase in courtesy • Health workers “seem to know what they are doing and consulting” (from 50% to 83%) |
| Client records (2009–2012)* | <ul style="list-style-type: none"> • Steady and high levels of antenatal care visits • Slight increase in use of labor and delivery services |
| Source: Mbindyo et al. *Statistics were compiled from facilities participating in the intervention in an ecological way only (i.e., not specifically tied to the intervention). Thus, we cannot directly attribute any service delivery changes to the intervention. | |

retention of health workers, HR policy implementation, HR information systems, HRH advocacy, and managing HRH in changing contexts, among others. The group has been institutionalized into ACHAP's constitution, with its membership reviewed every two years to encourage participation from additional countries.

During meetings of the group, the Christian Health Association of Ghana learned about experiences with HR information systems from CHAs in Kenya, Tanzania, and Uganda, and is now implementing a system to manage 13,000 health workers at its health facilities, which provide 35% of Ghana's national health services. Data from the new system are being used by health facilities for HR planning and management and are informing staff postings to facilities. This has resulted in better placement and distribution of staff, while creating awareness and providing facility-level evidence on the type and number of cadres needed. More broadly, the HR information system is making health workforce statistics more visible across different levels of the Christian Health Association of Ghana.

Human resources for health leadership: Through support of HRH activities and HR management workshops at the past four ACHAP biennial conferences, the number and scope of

HR positions has increased. Eight CHAs now have full-time senior positions at the secretariat level to support HRH initiatives and provide technical assistance to HR managers and leaders at the facility level.

Human resources management policies and practices in faith-based health facilities

Kenya: The Christian Health Association of Kenya and the Kenya Conference of Catholic Bishops provide an estimated 30% of health care in the country through their more than 800 affiliated facilities. Assessments in 2008 found that these entities suffered from a lack of effective HR management policies and guidelines, and that this had resulted in ad hoc, informal, or even inappropriate HR practices, often leading to lack of motivation, attrition, and litigation. With assistance from the Capacity Project and subsequently from CapacityPlus, the Christian Health Association of Kenya released a [comprehensive HR management generic policy document](#) in 2008. The document outlined organizational HR policies, procedures, and guidelines with the aim of strengthening HR management at affiliated facilities.

A study later assessed the effect of this HR management policy and practice intervention on managers, the health

workforce, and—to the extent possible—service provision at Christian Health Association of Kenya facilities. Interviews were conducted between December 2013 and February 2014 with leaders, managers, and health workers. The study also included observations and data extraction in health facilities as well as client exit interviews. The HR management policy and practice intervention proved successful among managers and health workers, who indicated that the new policies had fundamentally changed the way they managed HRH. Table 1 highlights some of the key findings from the interviews and review of client records.

The study also identified areas that need more attention. For example, although more health workers reported having received training on sexual harassment, the overall proportion was still low (24%, up from 6%), and there was no improvement in perceptions of gender discrimination in the workplace. All in all, however, the study demonstrated a significant change in the HR management practices of the Christian Health Association of Kenya and its facility managers, with large and statistically significant increases in managers' reported capacity and satisfaction (see Figure 3) and corresponding positive changes in the workplace environment and its organization.

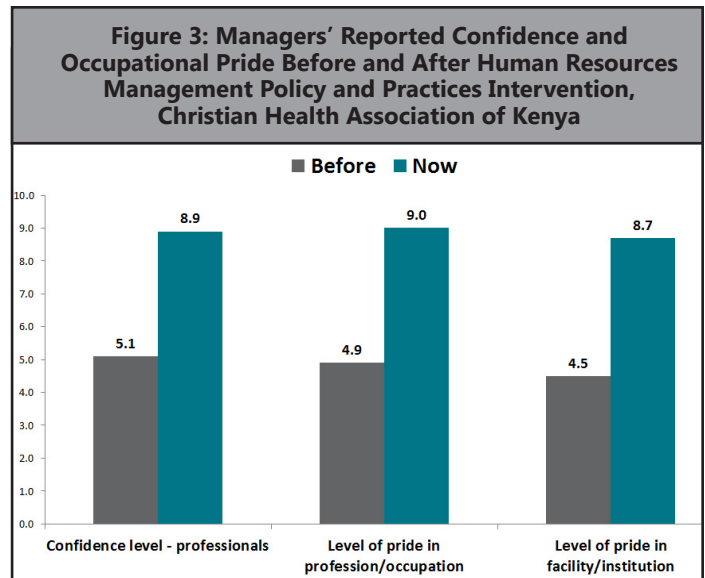
Through ACHAP, other CHAs have sought to adapt the generic HR management policy approach used in Kenya for their own constituencies. To date, the approach has been replicated by CHAs in Ghana, Malawi, and Lesotho.

Malawi: An exchange visit between the CHAs of Malawi and Kenya was supported in 2010, which, coupled with technical assistance, allowed the Christian Health Association of Malawi to adapt the HR management generic policy document for use at its secretariat as well as its approximately 170 member health facilities. It continues to work with its facilities to customize these policies to meet different contextual needs and existing national health sector guidelines and labor laws.

Ghana: In 2012, the Christian Health Association of Ghana piloted an HR management scorecard adapted from CapacityPlus's [Human Resources Management Assessment Approach](#) (Marsden, Caffrey, and McCaffrey 2013). Following dissemination of the scorecard to national coordinators, it was incorporated into a wider health systems assessment mechanism called the Organizational Performance Assessment Tool. The Christian Health Association of Ghana institutionalized the new tool in 2013 and plans to apply it across all 184 member health facilities through a pilot and phased approach. The pilot began in September 2013 with 14 facilities and ends in November 2014 with 30 facilities. Thereafter, the Christian Health Association of Ghana plans to review the findings and identify areas for HR management strengthening. It also plans to scale up the application of the tool across all its member facilities and adopt it as a framework for monitoring and evaluating its members.

Rural retention in faith-based health facilities

Zambia: In 2010, the Churches Health Association of Zambia developed strategies to address retention of health workers in rural facilities, particularly those trained in the association's training institutions. The strategies included strengthening partnership mechanisms with the Ministry of Health to



Source: Mbindyo et al. $N=17-21$ facility managers; $p=0.000$

support retention of students trained in the association's institutions; strengthening HRH workforce development systems; targeting Churches Health Association of Zambia health facilities in implementation of country-level retention strategies; and strengthening integration of the association's HR management systems into the wider health sector and ministry HRH systems.

The ministry and the Churches Health Association of Zambia developed a retention package known as the Health Worker Retention Scheme, which they rolled out to specified districts in hard-to-reach locations. The package consisted of a rural hardship allowance to top up health worker salaries as an incentive to work in rural locations. As additional incentives, the association provided decent and affordable accommodations for health workers and modernized the health facilities. The scheme has had a positive impact on retention, increasing health workers' motivation to stay in the rural locations and continue to offer quality health services.

Institutional capacity-building

Kenya-Africa Christian Health Associations Platform secretariat: Key outcomes of the secondment of an HR technical advisor to the ACHAP secretariat include the development of the ACHAP constitution in 2011 and ACHAP's legal registration in 2012 as an international nongovernmental organization in Kenya. ACHAP's membership almost doubled over the period 2009–2014, growing from 18 to 34 CHAs. In addition to the HRH technical working group, ACHAP supports working groups that address other advocacy issues affecting the FBO sector in Africa, including family planning, HIV/AIDS, and the increasing burden of noncommunicable diseases. Plans are in place to transition the HR technical advisor role into ACHAP's existing structure.

Liberia: With technical assistance, the Christian Health Association of Liberia achieved its priority objectives of selecting a new board chair and full-time executive director. These crucial leadership changes brought increased dedication among staff. In addition, the association developed a plan that defines key elements and actions for

sustainability and improved its visibility and external communications through the development of a website (<http://challiberia.org>). CapacityPlus's support has helped renew the association's energy to reclaim its key pre-civil war role in health service delivery as an effective implementer of health programs and the coordinating agency of its 43 member institutions in 12 of 15 counties.

Conclusions

With nearly ten years of relatively modest support for the FBO sector, significant interventions have produced positive results. This is critically important in a number of countries where FBOs provide more than 30% of health care. FBOs now recognize that in order to continue providing quality care, they need to improve their HRH. Through the somewhat limited technical assistance provided by CapacityPlus in response to requests from ACHAP members, a number of important lessons have been learned.

Government and faith-based organization partnerships

Integrating FBOs into government HRH initiatives can work well when FBOs have established memoranda of understanding with the public sector, or where FBOs are included in Ministry of Health HRH technical working groups or initiatives. ACHAP member experiences indicate that FBO-government partnerships on HRH issues are stronger where there is government support for FBO health worker salaries (such as in Ghana, Malawi, and Zambia). This is because both parties are involved in the planning and management of the health workers assigned to FBO facilities. On the other hand, where such arrangements do not exist, FBOs have sometimes experienced significant migrations of their workers to the public sector due to more attractive terms and conditions for service (GTZ/GIZ 2007). More research can confirm the effectiveness of memoranda of understanding, service-level agreements, and other types of FBO-Ministry of Health arrangements.

Inclusion of health as a priority for faith-based organization leadership

Involvement and advocacy with church leadership and structures can be challenging due to the fact that FBOs also manage non-health-related initiatives and do not always consider health a priority. For example, with the study on HR management policy implementation conducted in Kenya in 2013–2014, competing priorities made it difficult to obtain the participation of the Kenya Conference of Catholic Bishops, even though over 400 Catholic health facilities benefited from the HR management intervention.

Integration of faith-based organization health workers into national databases

It is critical to integrate FBO health worker statistics into national databases. Integration will make it possible to obtain a true picture of health workers in a country. More resources are required to fully support efforts to ensure participation and inclusion of FBOs in national HR information systems.

Documentation of successes

Health workers at faith-based facilities deal with many of the same HRH challenges faced by government health workers, and FBOs generate solutions to many of these challenges that could benefit the public sector. However, many FBOs do not sufficiently document their accomplishments.

Retention of health workers

FBO institutions experience high turnover and retention challenges due to salary issues and lack of training and career development opportunities, among other problems. In many cases, FBOs lack the resources to implement promising retention strategies. On the other hand, FBO health workers are often more willing to work in remote and rural settings than public-sector health workers, especially if they are posted to sites in the same areas as the remote and rural health training institutions in which they are trained.

Intercountry exchanges

Working through ACHAP—an organized regional FBO network—made it easy to foster shared learning and exchange, support scale-up of interventions, and carry out joint advocacy efforts. The HRH technical working group offered a particularly effective forum for intercountry exchanges and learning. CapacityPlus was able to tailor and pilot a variety of studies and products, including a wage study, the HR management assessment approach, application of Global Health Workforce Alliance recommendations, and testing of eLearning courses. This proved mutually beneficial for ACHAP members and CapacityPlus. Working through a field-based staff member seconded to ACHAP also helped establish and sustain relationships between the various CHAs and the ACHAP leadership.

Recommendations

- 1. Explore ways to build the ACHAP HRH technical working group** as an interactive knowledge gateway for all HRH field practitioners extending beyond the FBO networks.
- 2. Work to increase FBOs' application and institutionalization of evidence-based tools** to strengthen the health workforce and improve service delivery.
- 3. Increase monitoring and evaluation of FBO HRH efforts** such as HR policies, HR data collection and utilization, productivity and retention interventions, preservice education, and in-service training.
- 4. Advocate for strengthened Ministry of Health and FBO partnerships** through harmonization of systems such as HR information systems, national HRH plans and retention strategies, and other health worker support systems.
- 5. Increase HRH research and studies among FBOs** to provide the necessary evidence base for FBO advocacy efforts and strengthen documentation and participation of FBO training institutions in regional, national, and global initiatives.

- 6. Increase FBO visibility** through appropriate representation on relevant global-level steering committees, councils, and task forces where policies and resource allocation decisions are made. This will enable FBOs to engage decision-makers on how they can better serve as partners in achieving major HRH and other global health goals.
- 7. Increase documentation and publication of FBO accomplishments** in peer-reviewed journals and other strategic media to further advocate for FBO inclusion in national HRH initiatives and to strengthen partnerships with governments, development partners, and among FBOs.

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Staff members at Agogo Presbyterian Hospital, a Christian Health Association of Ghana-supported facility. Photo by Carol Bales, CapacityPlus/IntraHealth International.

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