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Review of human resources for health units in the ministries of health

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Abbreviations

HMIS	health management information system
HRH	human resources for health
HRIS	human resources information system
MDG	Millennium Development Goal
WHO	World Health Organization

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Foreword

Health governance or leadership capacity at national level and all other levels is considered fundamental in order for health development efforts to succeed. Issues of coordination, stewardship and steering of the health agenda in a systematic and coherent way can only be addressed with good health governance. In a similar manner, the capacity to govern the health workforce agenda in the country for effective service delivery is crucial, especially in the context of shortages of qualified health workers. While many countries are making great strides in providing the required leadership, it is clear from field visits that health workforce interventions remain fragmented not only within the ministry of health, but also with related sectors that influence the availability and performance of the health workforce.

This report on the functioning of HRH units or departments in the ministry of health offers a window into what is generally observed as capacity challenges of the health workforce governance. The intention of this report is to use the results to advocate for strengthening the ministerial HRH function so that ministries of health can improve coordination with other sectors and partners to ensure better service delivery.

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1
Introduction

Human resources for health (HRH) are an integral part of the health system. Functioning health systems are the key to effective service delivery in any country regardless of its level of development, within which it is important to mobilize competent and motivated health workers to become key drivers for primary health care. The HRH element is thus recognized as one of the six building blocks of the health system (*1*). Despite the multiple sectors and stakeholders involved in building, deploying and maintaining a health workforce offering high performance, the HRH unit in the ministry of health is considered to be key to moving forward the HRH agenda.

It is widely accepted that many different stakeholders have a role to play in HRH governance, including the ministries of health, education and finance, public service commissions, local and national governments, professional associations, unions and academic institutions. The unique contribution of each group makes its participation an important factor in HRH planning and implementation. However, the presence of such a wide range of stakeholders requires mechanisms for policy dialogue in order to ensure coordinated action. To this end, the ministry of health is best placed to provide leadership, for which it needs to have an appropriate mandate and the capacity to take up the challenges.

In order to understand the present capacity of HRH departments or units at the national level in the African Region of the World Health Organization (WHO), an intercountry review was undertaken. The review attempted to analyse the current status and functionality of the departments or units responsible for HRH actions in the ministries of health, so as to contribute to strengthening HRH governance capacities in countries. This report provides an overview of the survey findings.

1.1 Context

When *The World Health Report 2006* identified 57 countries globally as having critical shortages of skilled health workers (*2*), the global momentum to reduce the HRH crisis was set in motion. Immediate action was urged to resolve the crisis in countries with the support of partners. Since then, global and regional forums have continued to call for improvements in availability and performance of the workforce, including those focused on attaining Millennium Development Goals (MDGs) 4, 5 and 6. One of the key actions to reduce the HRH crisis and maintain gains has been identified as developing or strengthening the capacities for HRH governance. One of the measurements for this capacity has been the status of implementation of policies and practices on the HRH situation in countries. A desk review in 2009 tracked implementation of policies and practices of the 57 countries facing crisis shortages, 36 of which are in the WHO African Region (*3*). The results revealed some symptoms of governance capacity challenges. It was found that 45 countries had policies and plans, but only 55% of these plans were being implemented and only 53% of them incorporated monitoring and evaluation of implementation. The results implied that the major obstacles in implementation were governance capacities and insufficient investment.

HRH governance capacities encompass the ability of individuals, organizations or systems to perform the functions for HRH development effectively, efficiently and sustainably (*4*). The capacities of all stakeholders and institutions are critical for HRH governance. The capacity for HRH development in the ministry of health plays a central role, as the ministries take the main responsibility and leadership in HRH policies and management and also in the coordination of stakeholders. Therefore, this study looks at the capacities for HRH governance in the ministries of health and, more specifically, at the departments/units of HRH in the ministries of health as an initial step of assessing HRH governance capacities. HRH departments, divisions or units (which may be known by different terminology) within the ministries of health are referred to in this report as "units" in a generic sense.

It is essential to have a well-functioning HRH unit with the requisite number of qualified teams who can perform their tasks effectively within the health system. Management of the health workforce is improved and better health services are developed when the teams are able to fulfil the following roles:

- coordinating and managing the national health workforce agenda;
- strategic policy, planning and implementation for an improved workforce and quality health services, ensuring commitment to action;
- enhancing motivation and effectiveness of health workers at all operational levels through improved management capacity for HRH;
- coordinating and facilitating local partnerships with other sectors such as local government, finance, civil/public service, education, private sector and various professional bodies;
- coordinating collaborative work on HRH inputs/requirements with other sections of the ministry, including priority health programmes, in order to ensure a more integrated approach to planning and implementation of HRH interventions;
- coordinating and facilitating the generation, analysis and dissemination of health workforce intelligence and evidence for effective decision-making at policy, planning and implementation levels;
- coordinating and monitoring the implementation of the HRH plan.

Anecdotal evidence suggests, however, that many of these units do not have sufficient capacity to ensure the availability and management of an effective and sustainable health workforce that can provide appropriate health services for

the people who need them. While a few countries have well-established systems, most HRH units are poorly structured, are not fit for the purpose, and lack the ability to influence policy directions (*5*). Such units tend to operate only at an administrative or operational level rather than at a strategic level as well. Many of them suffer from high staff turnover, which poses a challenge for continuity and capacity-building. A similar study undertaken in the Region of the Americas revealed similar anecdotal observations (*6*).

1.2 Scope

This review aims to detail the status of HRH units in countries in the African Region of WHO. It encompasses all units that handle HRH matters (policy, planning, management, training, payroll, human resource information systems, etc.) at national level, exploring the following areas for each country within the ministry of health :

- how the HRH functions are structured ;
- how the HRH unit is positioned in the ministry's structure;
- staffing capacities ;
- how the HRH unit is equipped to perform at both strategic and operational levels ;
- functions of the HRH unit.

The study methodology was based on a self-administered questionnaire adapted from the study in the Americas (see Annex 2.1) and a qualitative interview (see Annex 2.2). In some cases, face-to-face interviews were conducted using the questionnaire in collaboration with WHO country offices.

Of the 46 WHO Member States in the African Region[1], 26 countries participated in the study: Benin, Burundi, Cameroon, Cape Verde, Central African Republic, Côte d'Ivoire, Eritrea, Gambia, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Malawi, Mali, Mauritania, Namibia, Nigeria, Rwanda, Senegal, Seychelles, Sierra Leone, Togo, Uganda, Zambia, and Zimbabwe. In order to respect confidentiality, the countries are not cited by name in presenting the results.

[1] The African Region consists of 46 WHO Member States: Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

2
HRH functions in the ministries of health

Management of the health workforce is required at both strategic and operational levels of the health system. National government oversees the strategic direction of the health workforce by developing, managing and monitoring policy targets and outcomes, while health facilities and institutions at decentralized or operational levels are responsible for ensuring that the required personnel are available to deliver the services. The core functions of health workforce development in this report have been broadly categorized as : HRH policy development ; HRH planning ; management of personnel ; training and development ; HRH information systems ; research, studies and documentation; and monitoring and evaluation.

It is expected that the ministry of health should assume all the above-mentioned functions in a country. The study revealed that the ministry handles all these functions in 20 of the 26 countries. In other countries, some functions lie outside the ministry of health. This is especially true for training (pre-service) and recruitment. More importantly, it was noted that there was no locus of some functions; for example, a monitoring and evaluation function is not referred to as an HRH responsibility in 90% of the countries. The aspect of research, studies and documentation is similarly absent as a recognized function in the HRH units.

Even in the countries where all the functions are performed by the ministry of health, the functions are fragmented in various departments. In only six countries, all major HRH functions are housed in one unit in the ministry.
In 14 countries all the major HRH functions are allocated in the ministry of health but not all of them are contained in one unit. For example, in four countries two units are handling the functions, while in six other countries three units are responsible, and four units handle the functions in one country.

In countries where several units handle the HRH functions, another interesting aspect is the existence of an apparent duplication of some of the functions. An example of this duplication concerning three countries is shown in Table 1.

2.1 HRH management and administration

A further review was undertaken on personnel management functions. At the national level, the responsibility for management of personnel administrative tasks – recruitment, deployment, discipline/promotion, payroll management, administration of leave and pension issues – was deemed to be shared between the HRH and personnel units in almost all the countries surveyed. For payroll management, five countries indicated that the ministry of finance was involved.

Table1. Distribution of units by HRH function at national level in three countries

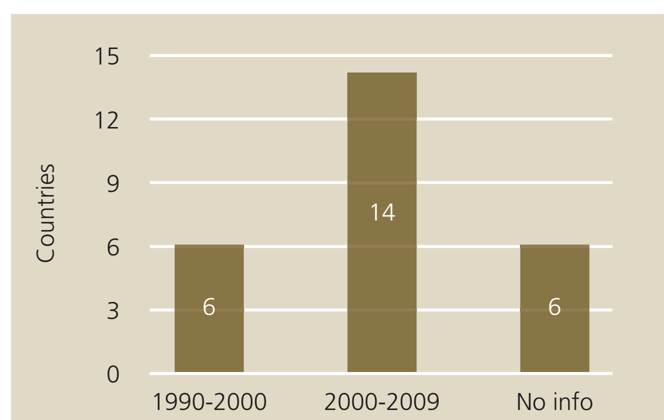
Country	HRH policy	HRH planning	Management of personnel	Training and development	Information systems	Research, studies and documentation	Monitoring and evaluation
A	1. Planning and cooperation, Office of the Minister 2. General directorate of HR and administration	1. Planning and cooperation, Office of the Minister 2. General directorate of HR and administration	General directorate of HR and administration	1. Planning and cooperation, Office of the Minister 2. General directorate of HR and administration 3. National centre for health development 4. General health directorate 5. Other directorates	General directorate of HR and administration	1. Planning and cooperation, Office of the Minister 2. National centre for health development	1. Planning and cooperation, Office of the Minister 2. General directorate of HR and administration 3. National centre for health development 4. General health directorate
B	1. HRH Directorate 2. Policy, planning, monitoring and evaluation division	1. HRH Directorate 2. Policy, planning, monitoring and evaluation division	1. HRH Directorate	1. HRH Directorate	1. HRH Directorate	1. HRH Directorate	1. HRH Directorate 2. Policy, planning, monitoring and evaluation division
C	1. Human resources development unit 2. Nursing unit	Human resources development unit	1. Resource management unit	1. Human resources development unit 2. Nursing unit	Human resources development unit	---	Human resources development unit

The magnitude of the personnel administration function varies in relation to the degree of decentralization. While most countries (*23*) are responsible for HRH management and administration of the staff at the national level of the ministry of health, in 15 countries the personnel administration functions for staff employed at subnational levels are also with the ministry.

In many of the English-speaking countries, traditionally, cadre-specific units for specialties such as pharmacy, medicine and dentistry, laboratory services and nursing located in other departments outside HRH (i.e. health services department) also handle directly the related personnel administrative functions. These functions include cadre-specific placements, appointments (of new graduates), promotions, transfers, general staff discipline and selection of candidates for training, while involvement of the HRH units is limited to processing the paperwork. However, there has been progress in moving towards integrating these functions into the HRH units. In some countries where the movement is more advanced, cadre-specific units now focus on strategic functions such as ensuring technical quality of services rather than on routine HRH administrative functions.

In more than half the countries, HRH units have been established during the last 10 years, and in some others the HRH unit has been in existence for longer (see Figure 1). This trend shows some indication of the movement of country HRH leadership in paying attention to the coordination of the HRH functions.

Figure 1. Distribution of year of foundation of HRH unit (n = 26)

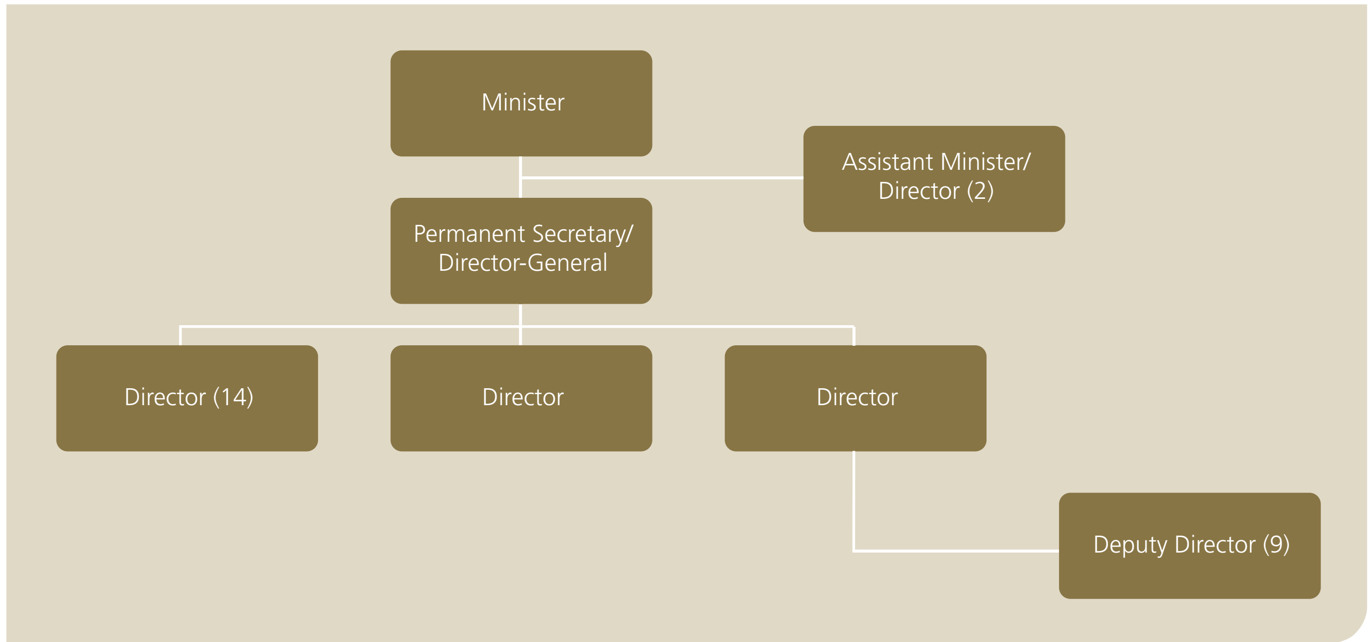


3

HRH units in the ministry of health

While the existence of an HRH unit tasked with appropriate functions is a prerequisite, the position of the unit in the hierarchy of the ministry of health is of equal importance. From observation or anecdotal evidence, it can be seen that some HRH units are mainly given the responsibility of administering personnel matters and located at quite a low level in the hierarchy without much voice in HRH-related decision-making processes. If the unit is positioned at a

Figure 2. Number of HRH units according to their level in the structure of the ministry



higher level in the ministerial organization, it is more likely to be involved in decision-making.

The study indicated that in the majority of the countries, the head of the HRH unit was at the level of director, reporting to the permanent secretary or director-general. In two countries, the directors of the unit report directly to the minister. The heads of unit are at the level of deputy directors in the remaining countries, except for one unit whose position was not indicated (see Figure 2).

This finding is quite positive where the head of the unit is at director level or higher because it indicates several advantages. One is that the unit head is part of the senior management team and therefore takes part in the decision-making process of the ministry; this could mean direct participation or proactively influencing the HRH agenda at senior policy level. Another advantage implies sufficiently high status (being part of management) to make it easier to engage stakeholders in other sectors such as education (including training institutions), finance, public service, and the private sector in strategic matters of HRH development. Furthermore, this level of status could also facilitate better and more useful engagements at intra-ministerial level with other technical programmes.

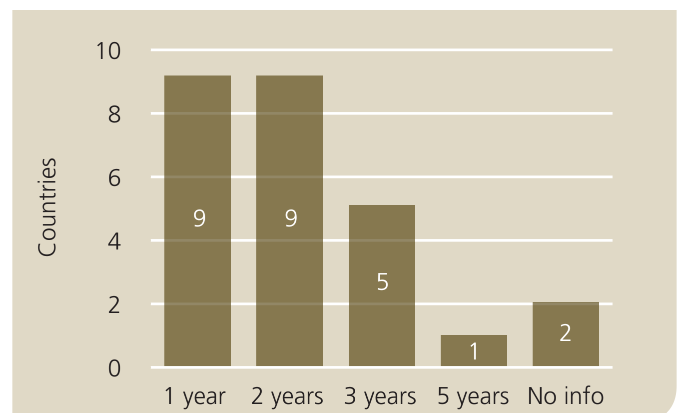
However, contrary to those directly reporting to the permanent secretary or equivalent, an equally significant number of unit heads (9) were below director level. This may imply that they are not necessarily part of the senior management team themselves but through their immediate supervisor. It may mean that they are not directly involved in the direct high-level decision-making processes. Instead, they rely on the supervisor who has responsibilities other than those of HRH; as HRH is not their only focus it is therefore not necessarily prioritized in the expected manner in influencing policy decisions in day-to-day interactions.

4

Mobility, tenure and experience of heads of HRH units

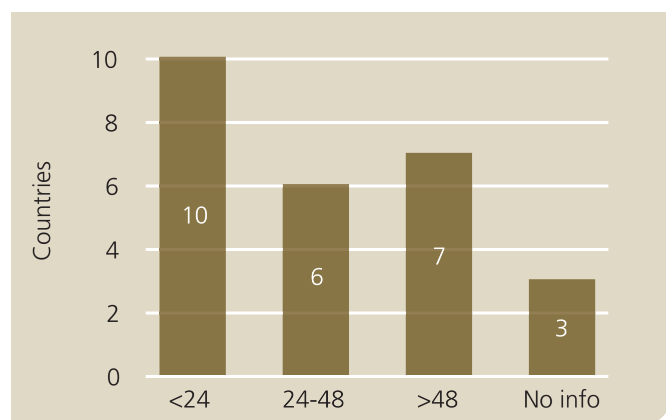
The tenure of heads of any department can affect the functioning of that department, as a high turnover rate has a negative effect on continuity and stability of direction. The results of the study indicate that less than half of the countries had the same unit director in the last five years. The same number of countries had two directors within the same period. Of the remaining countries, five had three directors, while one unit had an average of one director per year in the five-year period (see Figure 3).

Figure 3. Number of directors/heads of HRH units in the last five years (n = 26)



That almost half of the countries had the current head of the HRH unit in place for less than two years is an indication of the frequency of the turnover (see Figure 4). Furthermore, if the unit heads come from outside the department, they would have been going through a learning curve at the beginning of their tenure. Less than 30% of the countries had a head in place for more than four years and 23% had their head for between two and four years. This implies frequent changes in these units that maybe affecting the performance of the units.

Figure 4. Duration of work (in months) in the HRH unit by the current director/head



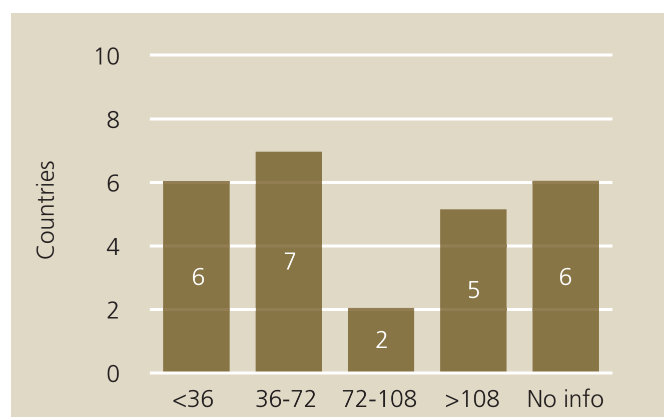
The profile of the heads of HRH units in the countries surveyed is quite mixed, the main difference being that some officials have a health training background while others do not. Those who do not usually have a general human resources background or training in administration.

The turnover rate of heads of HRH in the ministries of health affects the continuity of work, policies and strategies for development and implementation, including the institutional memory of the unit. The pattern of turnover seems to underlie at least two aspects. In reference to the profiles mentioned above, some of the heads may have other health backgrounds – they could be doctors, nurses or other qualified health professionals – and they could be promoted or transferred from elsewhere in the ministry. Furthermore, English-speaking countries traditionally have staff seconded from the public service ministry or equivalent to different ministries to serve as human resource officers. In eight of the English-speaking countries surveyed, the current directors had been in their posts for periods ranging from six months to two years; the average number of directors in place for the last five years is two, the highest being five. Another implication is that they are also liable for movement to other ministries on lateral transfer or promotion. It would be interesting to explore further other reasons for this turnover, which is also expressed in the related question of how long the current head has been in the unit.

The observations of turnover rate and limited experience with HRH functions are consistent with a comment from a senior member of a ministry of health: ''Each time investment has been made into a head of the HRH to a stage where they are able to function competently, they are normally transferred or promoted in other areas of the ministry or even outside the ministry, making it necessary to start the orientation all over again".

The work experience of the heads of HRH units provides an interesting facet of their profiles, especially when linked to the turnover rate and professional activity. This is considering that not all these officials have specific HRH experience. In half of the countries, heads of units had less than six years' work experience and seven others had more than six (see Figure 5).

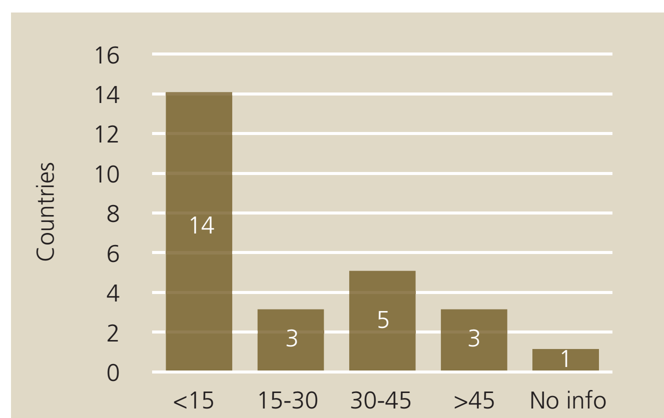
Figure 5. Months of HRH work experience of the head of the unit (n = 26)



5
Staff capacities

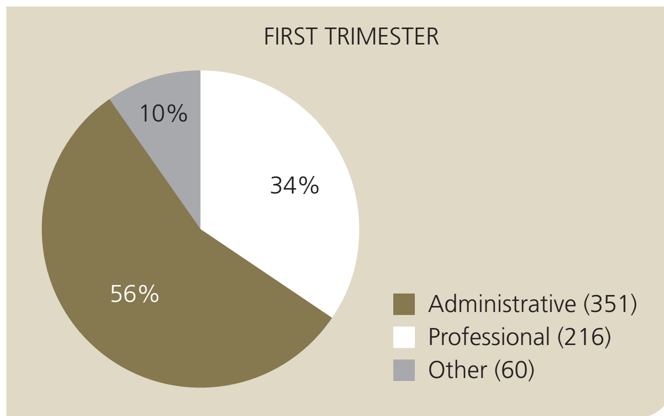
Adequate staff in terms of numbers and capacity are necessary for achieving targets set or work plans that have been developed. More than half of the countries had less than 15 staff in total; three other countries had up to 30 staff and five had up to 45 staff (see Figure 6).

Figure 6. Numbers of staff in HRH units (n = 26)



In general, more staff are available where the unit is responsible for performing all administrative procedures. More than half (56%) were of the administrative category (see Figure 7). If this function is separated by those dealing with issues, the number of staff is generally quite small.

Figure 7. Distribution of staff by category for the 26 countries

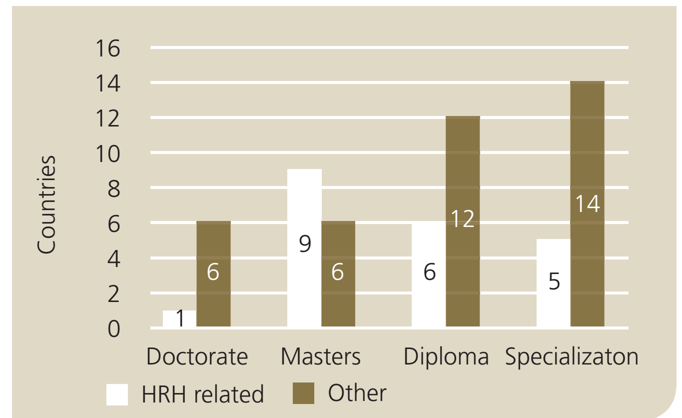


The lower proportion of professional staff might partly indicate that many of these units do not engage in strategic aspects of the HRH functions, including that of intrasectoral and intersectoral coordination of stakeholders and partners, being outside the senior management team and not of high enough status.

Staff members of the HRH units had varied professional backgrounds, and many of them did not have formal training or a background in HRH. The professional staff category for this survey was defined as those that had a technical or professional qualification and/or an HRH background.

For example, in the professional category in all the countries, only one had a Ph.D in HRH-related studies (see Figure 8). Of the 15 who held a masters degree, only six were in HRH; for the diploma holders, 50% were in HRH. For the specialization, less than 30% were in HRH. The fact that the majority did not have HRH qualifications but were in professional categories other than HRH may signify the need for institutional establishment of HRH orientation or training for staff in these units. Such orientation is a means of updating staff in HRH knowledge and skills such as HRH planning and its tools and the use of guidelines, etc.

Figure 8. Educational background of staff in the professional category in HRH units



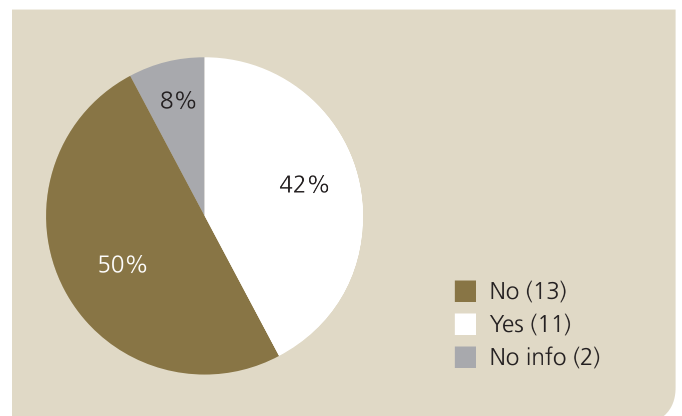
6
Working environment of HRH units

A working environment that is conducive to productivity is essential for the efficient running of HRH units. This environment includes physical facilities to work in and equipment, including technological tools, available for use by the workforce.

6.1 Office space

Only four countries had a staff member with an individual office in the HRH unit, and another four were sharing with another person; 10 countries had three or more people sharing an office. In 50% of the countries the staff perceived that office space was not sufficient, while in 42% they said it was adequate (see Figure 9). Almost all the countries (*23*) have remained on the same premises: only one country reported moving offices in response to a specific question.

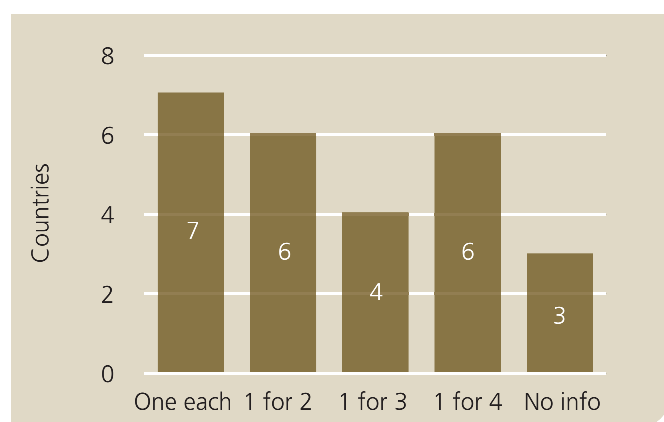
Figure 9. Perception of HRH unit staff on adequacy of physical space



6.2 Access to technology

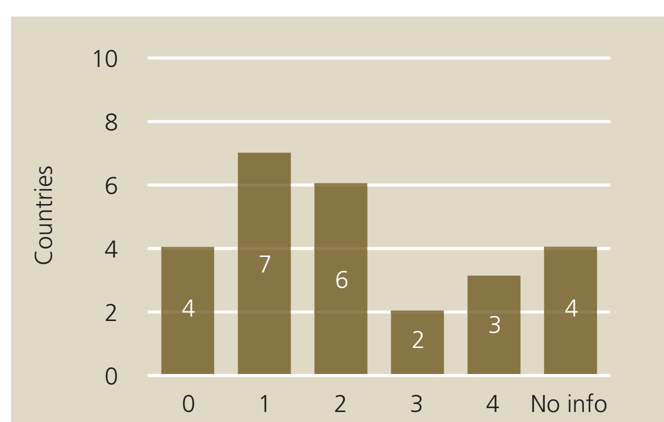
Access to technology such as computers is necessary for the performance of any work. Taking both desktop and laptop computers into account, seven countries provided a computer for each staff member; in six countries computers were shared between two people on average. Four countries had one computer for three staff, while six countries ranged between four and seven people sharing a computer (see Figure 10 and Annex 1).

Figure 10. Access to desktop and laptop computers



For the laptop computers, four countries had no laptop in their unit, seven countries had only one; six countries had two; two countries had three; and three countries had four (see Figure 11).

Figure 11. Laptop computers in the HRH unit



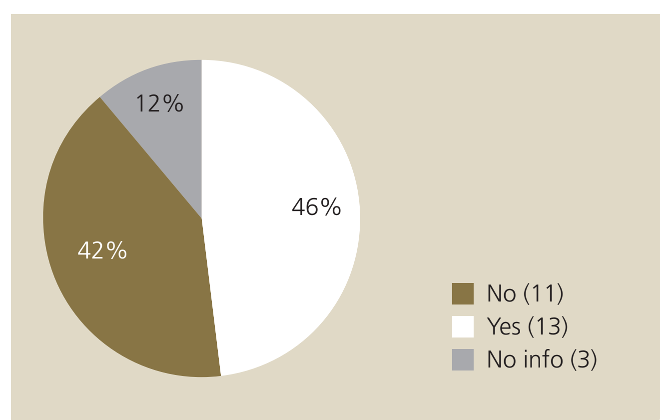
In the 16 countries that were sharing computers between 2–7 people per computer, access to computers may not be as commonplace as assumed. This may also make limitations on the availability and maintenance of computerized data and information on the workforce in the ministry and where it exists; there is implied limited access even for people within the HRH units.

6.3 Internet connectivity

22 countries (84%) reported having an Internet connection, and only three (12%) reported that they did not. This result is much higher than when a similar question was asked in a regional survey in 2005, at which time fewer than half the 33 countries surveyed reported an Internet connection (*7*).

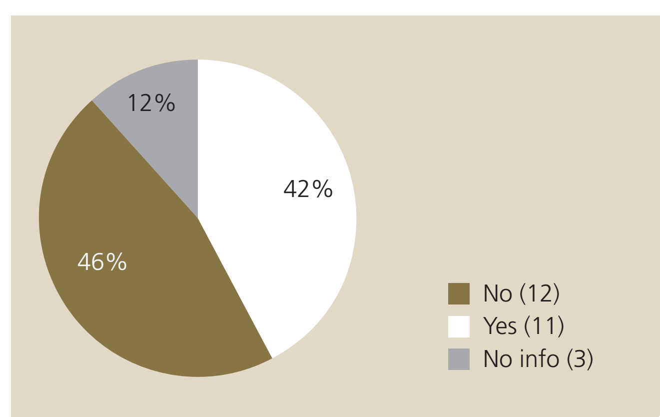
When it came to individual access, however, less than half of the countries were able to provide everybody in the unit with connection to the Internet (see Figure 12).

Figure 12. Existence of Internet connection for all HRH unit staff



Similar results were found on the reliability of Internet access: less than half the countries had reliable as well as consistent connection to the Internet, while the remainder did not (see Figure 13).

Figure 13. Existence of reliable and consistent Internet connection



This situation of access and reliability of the Internet implies some limitations in the access and use of HRH data and information; for many HRH units, much of their work may still be paper-based. Unreliable and inconsistent Internet connectivity has an effect on how much information can be downloaded and used for work purposes. It is almost certain that this lack of reliability is also related to lack of speed in terms of band width, etc.

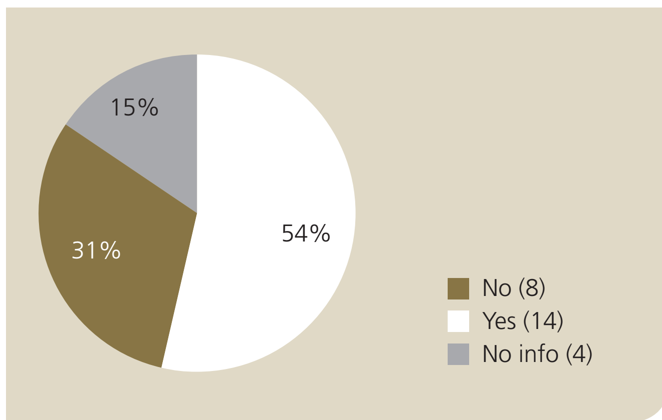
In addition, given that computer availability and access is still

fairly limited, it must be challenging to access important electronic documents and materials that are increasingly being published and posted on web sites.

6.4 Telephone network

Over half of the countries had sufficient telephone facilities (see Figure 14). However, an equally high proportion (31%) of the countries had insufficient telephone access for their operations, given that telephone communication is one of the oldest and most basic communication media available for use in business.

Figure 14. Sufficient telephone facilities for the unit's operations



These findings on communication media give an impression that there is considerable scope for strengthening these aspects of HRH units.

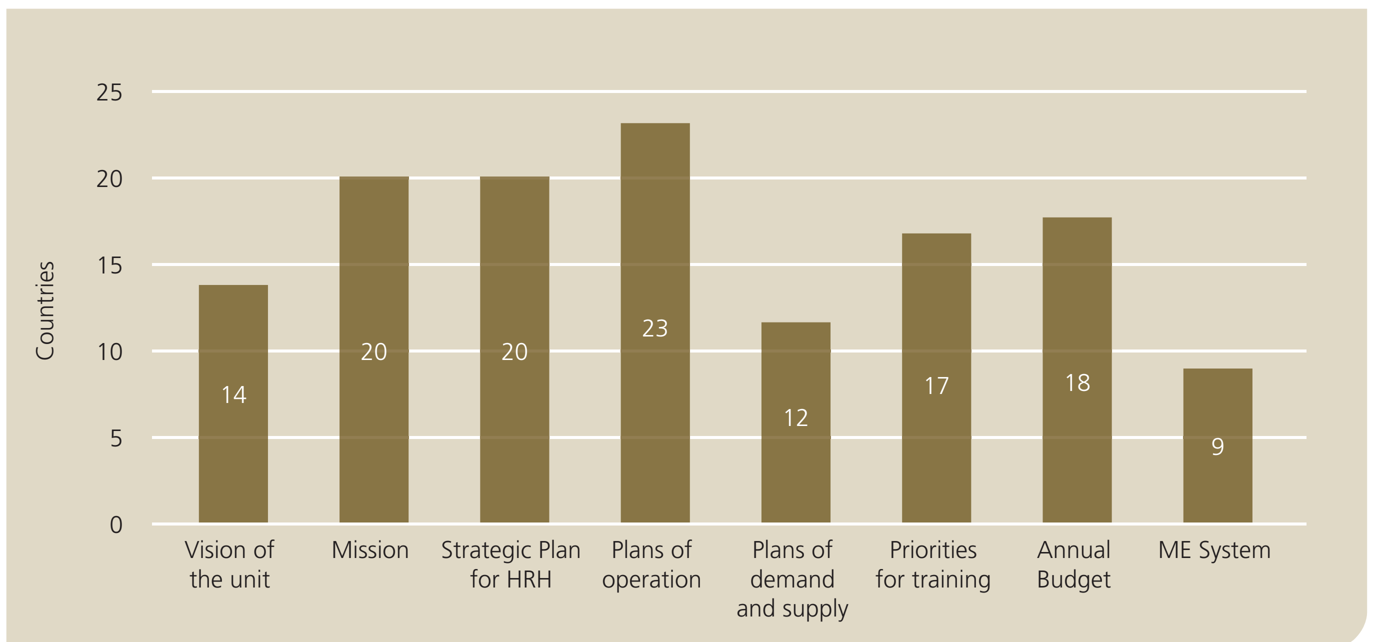
7 Financial resources

Available figures for some countries showed that most of the budget was for the payroll, where up to 95% of allocations for staff recruitment and/or payment were disbursed. The funds were released for that particular budget cycle and the funding that was allocated but was not fully utilized – for reasons of weak capacity such as failure to recruit the staff. This was more prevalent at subnational level compared with central level for those countries with decentralized HRH systems.

8 Availability of HRH planning and strategic tools

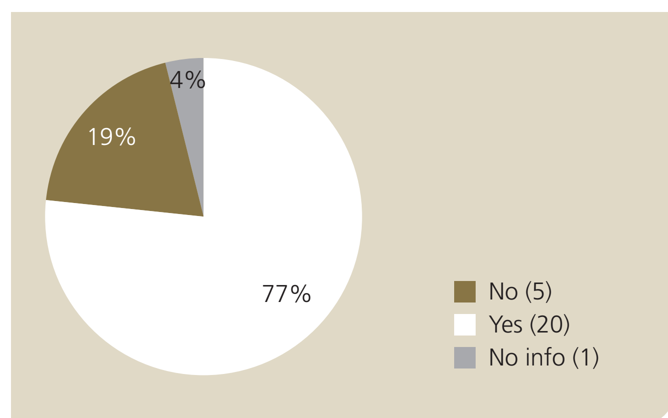
The majority of the countries (*20*) had in place their mission statement, strategic plan and plans of operation. A good number of them, over half, had formulated their vision. The lowest result was on the issue of a monitoring and evaluation system and strategy, which was in place in only nine countries (see Figure 15).

Figure 15. Existence of some planning and strategic tools



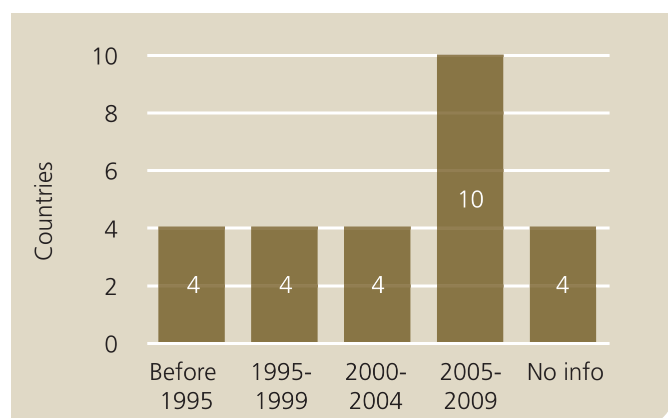
Over three quarters of the countries had produced a document that defined their organization and functions. However, 19% acknowledged that no such document existed.

Figure 16. Existence of documents defining organization and functions



The documents cited ranged from the overall national health strategies, such as organizational structure documents of the ministry or national health policy documents, to specific documents on HRH. This result shows that most of the countries have at least a document referring to their mandate and responsibilities, but does not necessarily mean that countries with such documents were necessarily functioning according to the written mandates, goals and targets. Inexistence of such a document in 19% of countries could imply a number of scenarios, one possibility being that these units could have the challenges of working without reference to the overall vision, goals and targets. This could provide further challenges in measuring progress.

Figure 17. Dates of the document defining the unit by countries

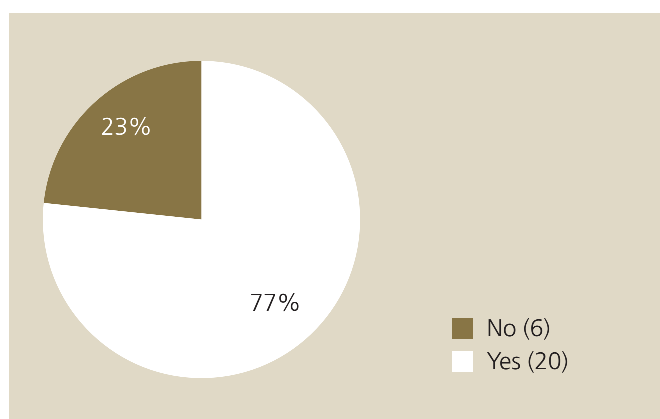


The dates of the cited documents provide an interesting array. The dates ranged from 2005 to 2009 for 10 countries, which coincides with the creation of most units (see Figure 17). Two of the countries that cited documents in the period 1990-1994 may require updating their document considering considering the changes that have occurred over the last two decades. The range of document dates reveals a pattern that appears consistent with the period of global, regional and country advocacy and momentum to produce national instruments for policy, planning and implementation of the health workforce.

8.1 National policy

Most of the countries (77%) had a national HRH policy in place and the remaining 23% did not (see Figure 18). These figures are consistent with the findings of the tracking survey (*8*).

Figure 18. Existence of national policy for HRH

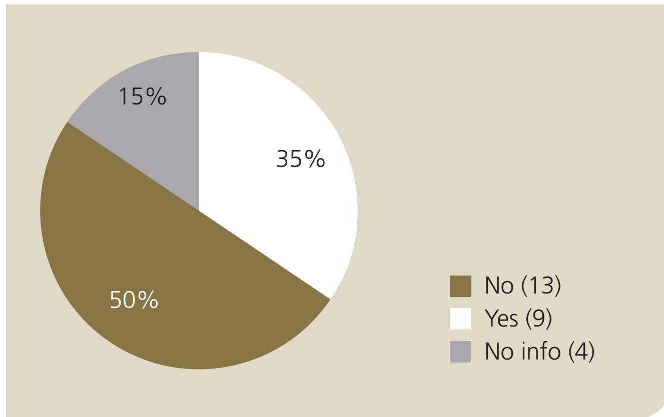


From the findings it is becoming clear that countries are increasingly making efforts in documenting the HRH developments for the use of stakeholders and partners in support of national HRH planning and implementation. Countries now recognize that articulation of the policy direction of different aspects of HRH issues is critical as a basis for HRH planning, with less emphasis on where this articulation could be placed. This is done using global and regional tools and guidelines on development of HRH policies and strategies as well as national health policy development guidelines (*9*). Thus, the HRH policy instrument in some countries is contained within the national health policy, while in others it may be detailed in a separate document or included as part of the national strategy document. However, the challenges remain of disseminating the existing strategic documents for use in decision-making or implementation, where their application is still very limited.

8.2 Agreements with international and bilateral agencies

Related to the existence of strategic documents guiding the work of the units, interaction with different international partners is viewed as quite important. Less than half of the countries (35%) confirmed the existence of such agreements within their units; half of the countries did not have any agreements with partners and agencies (see Figure 19).

Figure 19. Agreements with international and bilateral agencies



These findings can be interpreted in several ways. One could be that these units may not be directly involved in the negotiation of agreements. The survey would probably have been clearer if the existence of actual agreements had been compared with those known to the units.

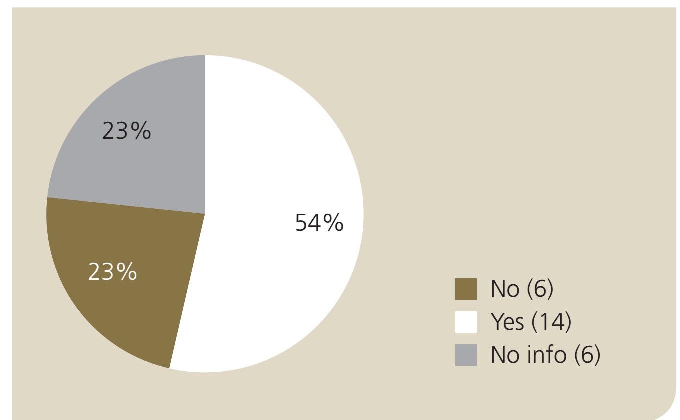
8.3 Coordination with other departments and sectors

Coordination with other units and other sectors in order to ensure their involvement is evidently a critical function of an HRH unit. It also shows the complex nature of HRH governance in countries, calling for better forms of coordination mechanisms to reduce duplication and fragmentation of evidence, planning and implementation.

While there has been considerable improvement in coordinating mechanisms, with the establishment of HRH observatories, national working groups and technical working groups in recent years, the majority of countries in the survey indicated that meetings were the standard operating procedure for coordinating HRH functions. Only two were specific about the existence of a committee as the mechanism. Four had no formal method of action in place. As one country indicated "In reality, all these functions are carried out jointly by the two directorates; this implies a permanent consultation and coordination of all activities". Another country cited poor coordination as a weakness among related departments, resulting in duplication of activities such as HRH management, training and planning. Confusion was striking in one country, where 57% of line managers responding were unaware of the work of the HRH unit in the ministry when asked to state what they knew about it.

Given the reality of different departments being involved in the different aspects of HRH functions, questions were therefore asked to confirm the unit's involvement with particular aspects. Concerning contact with health professional associations, trade unions and insurance, more than half of the countries were involved in coordination and/or consensus-building efforts between the government and the health professional associations, while 23% were not (see Figure 20). For other providers of services such as mutuality funds, social insurance or private insurance, nine countries were involved and 12 were not. The fact that almost half of them responded in the negative could mean that these functions were being performed by other units in the ministry, mostly without their involvement.

Figure 20. Government coordination with health professional associations and trade unions



The vast majority of the countries (81%) organized or were involved in dialogue to coordinate and collaborate with other sectors or stakeholders on HRH issues; only 4% indicated they were not. However, using other evidence such as the feedback from a planning workshop involving 15 countries in West Africa in August 2010 (9), most countries expressed challenges in coordinating such participation. It would have been interesting to check on what kind of issues this coordination dealt with, in order to verify the nature of the involvement. Based on a few participants who gave further details, some mentioned issues of salary and conditions of service negotiations with unions, for example.

Figure 21. Organizing or participating in dialogue with other sectors or stakeholders

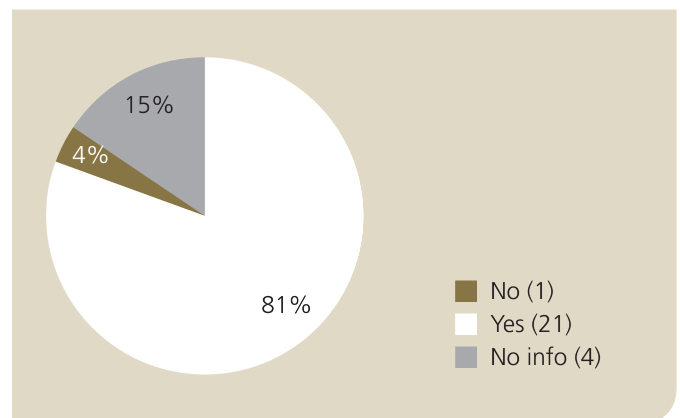
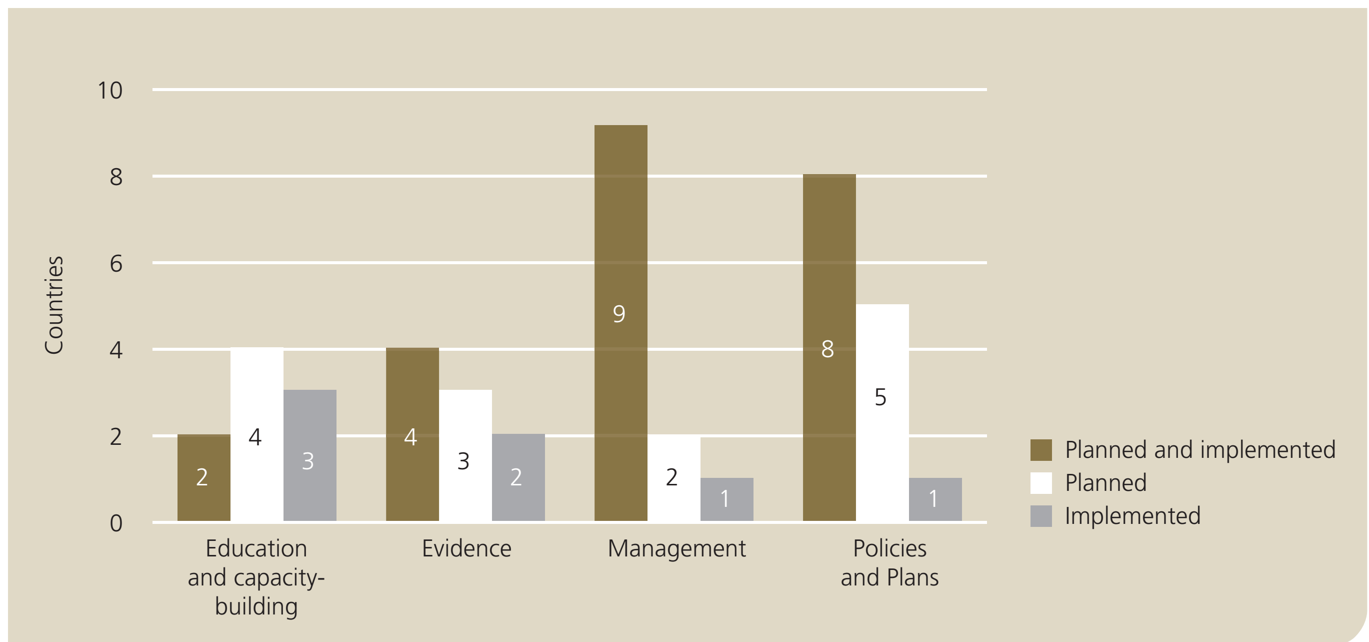


Figure 22. Summary of HRH issues that were handled in the previous year



8.4 Annual priority-setting agenda

Countries listed up to five items of issues discussed (planned) on HRH in the previous year and priorities that were actually dealt with or implemented in the same year (see Figure 22).

Out of 14 countries, eight activities that were both planned and implemented related to HRH policies and strategies, and only one was implemented without being planned. Five countries raised issues regarding the policies and strategies but did not implement any activities that year. In the area of health education and capacity-building for the nine countries concerned, two countries both planned and implemented the activities, three implemented some activities though they did not plan for them, and four countries did plan but did not implement in this area. Of the 12 countries that handled issues regarding HRH management, nine of them both planned and actually implemented, two planned without implementing, and one implemented without having identified it as a priority area for the year. Seven countries were concerned with activities in the area of HRH evidence: four both planned and implemented their activities, while three planned but did not implement, and two implemented without having planned for them

From the priority issues that were actually handled or discussed, countries provided further information on what was considered or received priority attention. The subjects most cited were HRH policies and plans, including issues of budget (15 countries); HRH management, including recruitment, deployment and restructuring processes (14 countries); HRH evidence, including a national inventory of the health workforce, establishment of a human resources information system (HRIS) database and national observatories (12 countries); motivation and retention, i.e. management including staff development and career progression (9 countries); and education and training, including institutional capacity-building (9 countries).

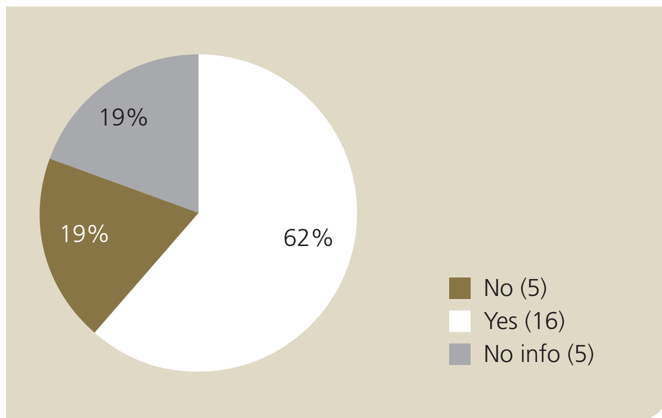
These responses show how busy these units are given their capacity, especially in terms of their effectiveness ; they also provide a window on whether what were planned or raised as issues for focus for the year were actually implemented. It is not uncommon to find these unit members extremely busy during the year, juggling the many priorities aside from participating in meetings and workshops (both internal and external). Further study on how successfully completed these topics are, would offer a window on the aspect of the strategic or operational nature of the areas covered.

On a positive side, though there was no baseline before the survey, there is an observation that is consistent with the result on the date of the key documents discussed earlier in the report, which shows that most HRH policies and plans were developed from 2000 onwards. Ministries of health seem to be recently giving health worker issues more focused attention. There is also a close link between the issues discussed during the year and the ones prioritized as HRH activities for action, even if there are some gaps.

8.5 Evidence generation and use

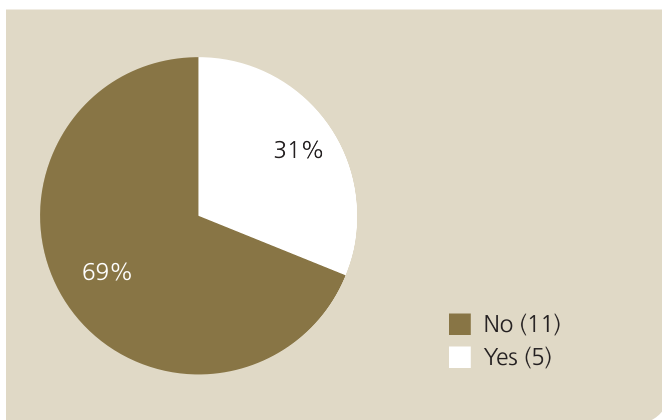
Lack of sufficient health workforce data and information has always been a concern in the African Region. Over half of the countries had an HRIS in place for the ministry, 19% did not (see Figure 23).

Figure 23. Existence of human resources information system (HRIS)



This finding confirms the understanding that all ministries have some form of information on the health workforce. Even in the weakest of situations, the payroll provides the basic form of information – as everyone has to be paid – and ensures completeness to the best possible extent at least for public sector.

Figure 24. HRIS as part of the health management information system (HMIS)



Only five of the 16 countries were linked to the health management information system and the remaining 11 countries said the system was not linked (see Figure 24). This could mean that these systems are currently stand-alone systems that do not relate to each other. It could also imply that there may be some duplication in existence of the databases in the various departments that each handle different aspects of the HRH function, e.g. cadre-specific data sitting in the different programmes. If not linked, the overall picture is not clear. With the current movement towards strengthening HRIS in countries with the help of a number of partners, it is hoped that this situation will greatly improve.

The current challenging context of the generation, storage, analysis and use of HRH data and information in countries is well known; in many countries health workforce data and information are rather scanty, scattered and uncoordinated. This problem also relates to the aspect of monitoring and evaluation when functions of the HRH unit were discussed in the earlier part of the report. When countries were asked about this function, the few countries that confirmed monitoring and evaluation was being done placed it within the planning department: it did not take place systematically, meaning that monitoring and evaluation of HRH implementation is a weak area that requires a lot of investment to strengthen it. The increasing interest by countries in improving the generation and use of evidence via the mechanism of national HRH observatories and HRIS strengthening is already providing the long overdue opportunity for better baseline and monitoring of HRH progress.

9

HRH units at subnational level

In the decentralized system where the districts are autonomous with local government structures in place, the functions of human resources are vested within the district. Some districts have some full-time human resources or personnel officers, while other districts have administrative officers managing the HRH functions as well as performing other tasks such as accounting.

For some countries where the subregional level includes regional or provincial aspects, the autonomy was a bit more limited. For instance, the subnational level can only recommend promotion or final disciplinary action to the national level that may include involving ministries outside the ministry of health such as public service. Yet, even with this limited autonomy capacity challenges are similar – limited staffing and nonconducive work environment.

There seems to be a tendency of the central levels to implement HRH initiatives that are part of the subnational functions. The suggestion is for the national level to remain with policy formulation, support supervision and quality control rather than going into implementation.

Communication disparities exist between the national and district levels in terms of telephone landlines, and sometimes the use of mobile or cellular telephones is used to close this gap. Internet connection at subnational level is more of a challenge because of the limited or inexistent electricity supply or Internet connectivity. Office capacity is generally inadequate as the HRH workers often share with others.

Decentralization of human resources is a challenge where under-resourced districts or regions with weak capacity are mandated to manage the health workforce, notwithstanding the challenges experienced at the national level.

10
Concluding remarks

Information regarding the overall status of HRH units has been generally lacking, especially in countries where the health workforce is in greatest need. This study looked at the capacities for HRH governance in the ministries of health and, more specifically, in the units of HRH in the ministries of health as an initial step to assessing HRH governance capacities. The study has provided some light on this issue and contributed to knowledge about it.

Overall, the capacity of HRH units is generally promising. There are some areas that countries seem to do well; these include the overall recognition that HRH is important and requires attention, especially in the last 10 years.

The study showed that efforts in acknowledging and addressing HRH challenges have increased in the last decade, which also witnessed the establishment of HRH units in more than half of the countries studied. It is plausible that this coincides with global and regional developments concerning the rise in momentum of the HRH agenda, including the regional consultation in Addis Ababa, Ethiopia, in 2002 (*10*), the report of the Joint Learning Initiative in 2005 (*11*), the high-level forums on health MDGs and the Oslo HRH consultation in February 2005. The momentum gained culminated in *The World Health Report 2006* (*2*) and World Health Day 2006, both dedicated to the subject of health workers. Notable follow-up events, including the high-level continental HRH meeting of Permanent Secretaries/Directors-General of ministries of health, education, finance and public service in Gaborone, Botswana, in March 2007 (*12*), the global HRH forum in Kampala, Uganda, in March 2008 (*13*) and the 2nd global HRH forum in Bangkok, Thailand in January 2011 have given prominence to the issues of HRH in the African Region and globally. However, there is still a lot of room for improvement.

Many countries still have more than one unit handling HRH functions, which reflects a fragmented approach to managing the health workforce. Even where the HRH unit is officially responsible for all HRH functions, some apparent duplications were noted where other units were also involved in similar activities; on the other hand, key functions such as monitoring and evaluation were virtually absent in the HRH units and are presumably being performed by other units such as planning.

Associated to the issue of functions is the difference between what is expected/perceived as the role of the HRH units, what is mandated (written down) and what is actually done in day-to-day activities. This is why one of the key competences required in HRH units is the ability to coordinate and negotiate with other departments, partners and stakeholders. A related aspect that has direct correlation with the ability to effectively interact with these stakeholders is the level of status accorded to the units. Weakness of coordination among the related units is also structural, as is non-formalization of the functions between and among the units. Some countries are still struggling to synchronize the functions of personnel administration and the strategic HRH functions of the ministry affecting the functionality of these units in terms of roles played by the units and their staffing capacity/profiles.

The improvements in half the countries having director status show promise, with the challenge of advocating for the remaining ones that are yet to be elevated to this level. Equally, the staffing profiles require updating with a view to determining core competences required to perform the HRH functions that the ministry of health needs, while at the same time resolving the negative aspects of high turnover rate as necessary.

There is inadequate human resource planning and management capacity at subnational level regardless of the form of decentralization that is being implemented. Many of the systems at this level is still largely guided by the national resources processes and procedures that are not only limited to ministries of health but apply to others as well. Aspects of increasing the capacity of the subnational level must include retention aspects for health workers, especially in remote and rural areas.

The establishment of HRH units with increased capacity of staffing, status and work environment is a step in the direction towards improving HRH governance in ministries of health. If the implementation rate of the national human resource policies and strategies has to improve, these HRH units can be an entry point for strategic investment for advocacy and engagement with the relevant stakeholders within and outside the ministry of health to ensure success. Therefore, the strengthening of leadership and governance of HRH at both national and subnational levels through empowering HRH units is imperative if the availability and performance of the health workforce to deliver health services is to be improved.

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Annex 1. Summary of findings

HRH unit staff, office space and computers in 26 African countries

Country	No. of staff				No. of offices occupied by the unit	Computers
	Total	Professional	Administrative	Others		PC pentium IV or equivalent
1	44	4	40	0	15	12
2	10	1	5	4	5	4
3	72	16	56	0	26	34
4	24	3	11	10	6	No Info
5	12	0	12	0	3	2
6	35	10	22	3	12	5
7	39	5	25	9	10	13
8	60	20	40	0	4	10
9	5	5	0	0	2	2
10	10	7	2	1	1	4
11	6	3	2	1	3	1
12	115	30	80	5	30	50
13	38	25	13	0	Half a floor	22
14	5	2	3	0	2	4
15	6	4	1	1	5	3
16	14	3	2	9	8	5
17	10	7	3	0	8	10
18	7	1	6	0	No Info	No Info
19	2	1	0	1	2	2
20	43	29	14	0	No Info	15
21	6	1	5	0	10	6
22	22	3	2	17	5	No Info
23	14	3	10	1	4	3
24	4	4	0	0	No Info	No Info
25	33	22	11	0	13	9
26	26	17	8	1	13	0

Annex 2. Study questionnaires

2.1 Self-administered questionnaire to be completed by the manager of the HRH unit in the ministry of health[1]

General information

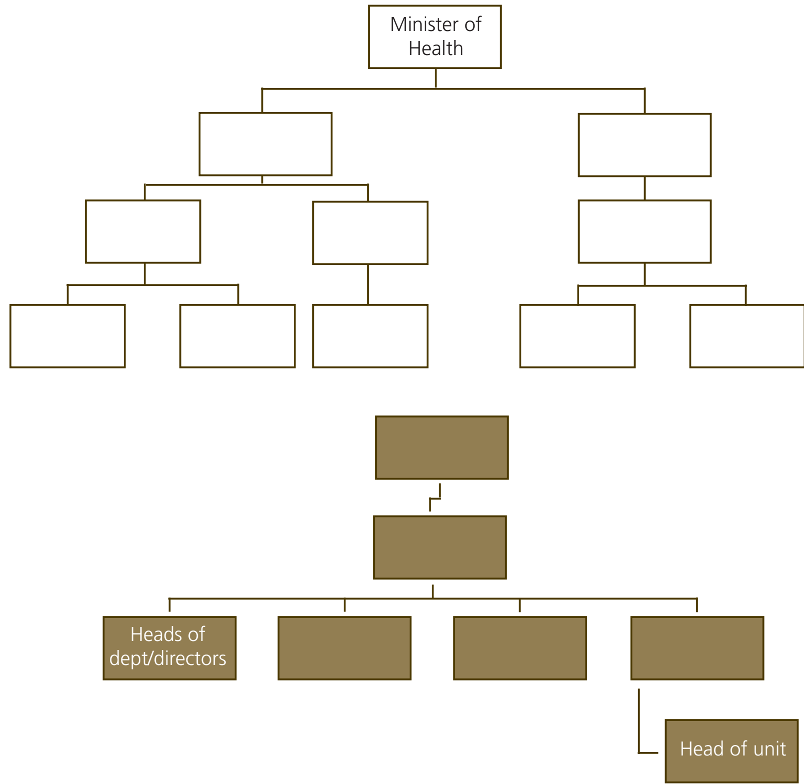
Question	Answer
1. Name of the HRH unit:	
2. Country:	
3. Date:	
4. Name of questionnaire respondent:	
5. Position of questionnaire respondent: **HRH functions at national level** • HRH policy • HRH planning • Management of personnel • Training and development • HRH information system • Research, studies, documentation • Monitoring and evaluation	
6. Are all the functions listed above situated in the same unit/department/ division?	
7. If yes, what is its title ?	
8. What is the title of its overall head?	
9. To whom does the head of this unit report (title)?	
10. If no, in which units are each of the functions placed?	
11. What mechanism is in place to coordinate the different units?	

Structure

Question	Answer
12. How many HRH units or structures does the ministry have in order to serve health sector needs?	
13. In which year was this unit inaugurated?	

[1] The key respondent completing this questionnaire should be the direct head/director (hereafter referred to as the head) of the HRH unit/department/ division (hereafter referred to as the unit) in the ministry of health.

14. Please identify the position of the HRH unit(s) in the organizational structure of the Ministry of Health



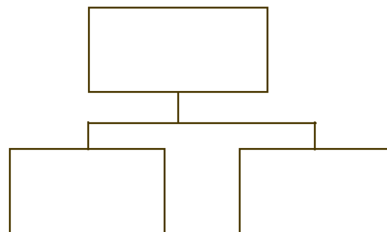
15. Does the unit(s) have an organizational chart? *(Mark with X)*

☐ Yes

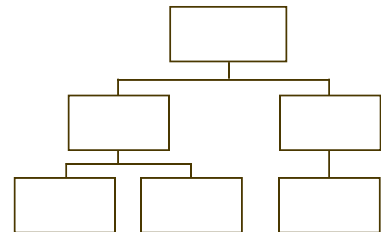
☐ No

16. Which of the following organizational charts better reflects the existing decision-making levels? *(Mark with X the option that realistically reflects the unit – the uppermost box indicates head of the unit)*

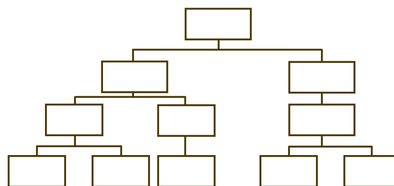
a. One level



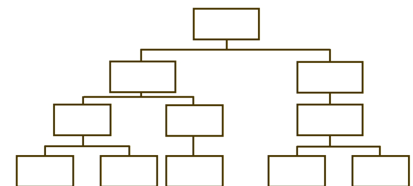
b. Two levels



c. Three levels



d. Others *(Please specify):*



17. Which areas does the unit deal with? *(Please specify)*

a. ....

b. ....

c. ....

d. ....

Other: ....

18. Does the unit have a document that defines its organization and functions?	☐ Yes ☐ No
19. What is the name of the document?	
20. When was the document issued? *(Year)*	
21. Has it been updated?	☐ Yes ☐ No
22. When was the last time it was updated? *(Year)*	

Staffing

23. How many staff work in the unit?		24. How many of them have contracts, and of what type?[2]			
		a. For indefinite time and social benefits *(Name two)*	b. For limited time (fixed term contracts, by non-personnel services)	c. Secondments from other ministries	d. Comments
Type of staff	Number of staff				
a. Professionals					
b. Administrative					
c. Others *(Please specify)*					
d. Total workers in the unit					

25. Among unit personnel, how many are professional and how many are administrative staff?	26. How many have postgraduate training *(Please specify HRH-related and others):*								27. Total
	a. Doctorate		b. Masters		c. Diploma		d. Specializations/ graduates		
	HRH-related	Other	HRH-related	Other	HRH-related	Other	HRH-related	Other	
a. Professional									
b. Administrative									
c. Total									

Head of the unit

28. How many heads of unit have occupied the post in the last five years?	
29. How many months has the current head been working in the unit?	
30. How many months of work experience does the head of unit have in HRH? (e.g. if worked one year and three months, enter 15 months)	

[2] Full-time, permanent and pensionable.

Staff training

31. How many training courses have HRH organized or proposed for your unit in the last two years?	
32. What proportion of unit staff received at least one training course in technical subjects related to HRH in the last 12 months?	

Infrastructure and equipment

33. How many offices does the unit occupy?		
34a. Has the unit always functioned in its current site?	☐ Yes ☐ No	
34b. What reasons led to the change of site?		
35a. Is the physical space for the unit sufficient for the personnel to fulfil their tasks?	☐ Yes ☐ No	
35b. For what reasons?		
36. How many meetings were held with the participation of more than five stakeholders in the last two years?		
37. How many meeting rooms does the unit have?		
38. How many functioning computers are available at your institution and which type? *(Multiple response)*	**Type of equipment**	**Number of items**
	a. PC Pentium IV or equivalent (desktops)	______
	b. Laptops	______
	c. Servers	______
	d. Others *(Please specify)*: ______	______
39. Does the unit have an Internet connection?	☐ Yes ☐ No	
40a. Do all unit staff have an Internet connection?	☐ Yes ☐ No	
41. Is telephone access sufficient for the unit operations?	☐ Yes ☐ No	
42. Which multimedia tools are available in the unit? (LCD projector, photocopier, etc.)		

Financial resources

43. What was/is the unit budget for the years 2007, 2008 and 2009?						
	2007		2008		2009	
	Budget	Expenditure	Budget	Expenditure	Budget	Expenditure
Total budget						

44. Does the unit have any agreements with international and bilateral agencies?	☐ Yes ☐ No
45. What are these agreements based on?	a. …… b. …… c. …… d. …… e: ……
46. With which institutions have these agreements been signed?	a. …… b. …… c. …… d. …… e: ……

Management

Functions and scope of management

47. Which of the following functions are within unit remit? *(Mark with X)*	a. Policy-making ☐ b. Preparation of standards, regulations or directives ☐ c. Regulation of education and training for HRH staff. ☐ d. Management of ministry of health staff in: • recruitment ☐ • deployment ☐ • discipline, promotion, etc. ☐ • payroll management ☐ • administration of leave and pension issues of unit personnel ☐
48. Who is responsible for the following functions in relation to the management of HRH at national and district levels? *(Mark with X)*	• recruitment ☐ • deployment ☐ • discipline, promotion, etc. ☐ • payroll management ☐ • administration of leave and pension issues of unit personnel ☐
49. What scope does the unit have in terms of function and responsibility for the management and administration of HRH? *(Mark with X)*	a. institutional (involved at the level of HRH in the ministry of health) ☐ b. sectoral (involved at the level of all health sectors) ☐ c. extrasectoral (involved in other ministries or sectors) ☐

Coordination and consensus-building

50. Does the unit organize or participate in any dialogue to coordinate and collaborate on HRH issues with other sectors and stakeholders?	☐ Yes ☐ No
51. If yes, in what way does it participate?	a. .... b. ....
52. Does the unit participate in coordination and or consensus-building between the State/government and the health professional associations and trade unions on the subject of HRH?	☐ Yes ☐ No
53. Is the unit involved in dialogue with other providers of services (mutuality funds, social insurance, private insurance etc.)?	☐ Yes ☐ No

Planning and strategic tools

54. Does the unit have some of the following management tools? *(Please collect a copy of the available tools)*	a. Vision of the unit	Yes ☐	No ☐
	b. Mission of the unit	Yes ☐	No ☐
	c. Strategic plan for HRH	Yes ☐	No ☐
	d. Plan of operation or annual programmes	Yes ☐	No ☐
	e. Plans of demand and supply for HRH in the country	Yes ☐	No ☐
	e. Priorities for training	Yes ☐	No ☐
	g. Annual budget	Yes ☐	No ☐
	h. Monitoring and evaluation system	Yes ☐	No ☐

On the priority subject of HRH and the unit agenda:

55. What issues were discussed on HRH during the last year?	a. .... b. .... c. .... d. .... e: ....
56. Which subjects or topics were prioritized for the work of the unit during the last year?	a. .... b. .... c. .... d. .... e: ....
57. Is there a national policy for HRH?	☐ Yes ☐ No

58. Are there any incentives for staff in the HRH unit?	a. Generally: .... b. Specifically *(Please mark the appropriate column with an X, rating incentive systems 1–5, limited to extensive):*

Incentive systems	Limited				Extensive
	1	2	3	4	5
i. Existence of incentives in order to promote continuing education					
ii. Existence of incentives in order to promote specialization					
iii. Existence of incentives in order to reward performance					
iv. Others *(Please specify)*					
v. To what degree has the unit promoted incentive schemes?					
vi. Existence of disciplinary procedures to deal with poor performance					

59. Is there an information system for HRH?	☐ Yes ☐ No
60. If it exists, is the system integrated?	☐ Yes ☐ No
61. Is it linked to the health management information system?	☐ Yes ☐ No

2.2. Guide for qualitative interview with the manager (or designated staff member) of the HRH unit in the ministry of health

1. General information

1. Name of the HRH unit: . . . .
2. Country: . . . .
3. Date: . . . .
4. Name of the interviewee: . . . .
5. Position of the interviewee: . . . .

2. Organizational history

6. Can you tell us when and how the HRH unit was created? What triggered the creation of the unit (e.g. a new regulation)?
7. Can you tell us the critical or central events and achievements in the history of the unit in the last 10 years? What have been the milestones or key moments in the development of the unit? (Examples could include approval of planning standards, positions and wages, etc.)
8. Can you tell us what changes have occurred in the institutional set-up or organization of the HRH unit? How long has the unit been situated in its present location and when was an organizational structure established (e.g. change in status of the organizational structure, generation of new subdivisions, integration of structures)?
9. Can you tell us at what stage there have been improvements or a decline in the unit's position/reputation over the last 10 years? What were the reasons for that?

3. Structure and organization

10. Could you tell us how many HRH units there are in the country; in which institutional locations are they found; at what level of the organization structures are they located; and what are the functions performed by each?
11. Which functions of HRH have been decentralized to local levels? Which functions are covered at the following level: state, regional, province and/or municipality?
12. Can you provide the organizational diagram for the HRH unit with areas of responsibility?
13. Is this organizational structure supported by regulation through a manual (or similar documents) in terms of functions and staff?
14. What problems can you identify in the organization or structure of the unit? What changes would you suggest?

4. Staffing of the unit

15. Could you give us your perception on the staffing of the unit? Are thepersonnel sufficient? Is there a need for more personnel in some areas? In which areas?
16. What is your perception of the staff capacity in the unit? What do you consider are the principal strengths and weaknesses of staff? Which specialties do you believe are needed in the unit?
17. Could you indicate whether the unit provides or promotes training for your personnel? Is there a training plan based on a needs analysis for your team?

5. Management of human resources of the unit

5.1 Functions and scope of the management of the unit

18. What are the specific functions of the HRH unit? Is there a subunit for every function (e.g. policy, standards, training and education, management of personnel, administration)?
19. What is the scope of responsibility for the unit (institutional, sectoral, extrasectoral)?
20. Does the unit generally intervene in workforce negotiations (e.g. in sectoral and institutional conflicts)?

5.2 Coordination and consensus building on HRH issues

21. Coordination or consensus-building with other relevant ministries and civil servants in relation to HRH development: Is there such coordination? What activities have been conducted in a coordinated manner? What have been your achievements? Is there a mechanism or policy in place for coordination? How much time has passed since the creation of such a mechanism/policy? How would you quantify the operation of this mechanism/policy (good, fair, poor)? (Examples of coordinating or consensus building entities include: national health councils, departments of education, regulatory bodies, associations, etc.)
22. Coordination or consensus building between State and professional associations and trade unions for health workers: Do mechanisms exist? What activities have been undertaken in a coordinated manner? What have been your achievements?

5.3. Strategic planning

23. Is there an up-to-date strategic plan for HRH? How are the priorities set for education and training? Is there a projection of supply and demand for the health workforce?
24. Which policy papers, annual plans of operation, standards, directives and central regulations has the unit formulated or supported during the last three years?

5.4. Operations

25. What percentage of programmed activities has been fulfilled in the last two years by the unit?
26. Has the unit utilized all the assigned annual budget? If not, why not?

5.5. Monitoring and evaluation

27. Could you indicate whether there is a system of monitoring and evaluation of unit activities? Who is in charge of the monitoring and evaluation? Have there been frequent reports of monitoring and evaluation in the last two years?
28. What is your opinion on the performance of the HRH unit? How would you qualify the operation of the subunits? What are the achievements or results obtained through the unit during the last three years, with regard to HRH in your country?
29. Is there frequent evaluation of the performance of HRH unit personnel? If yes, what is the frequency?
30. What are the difficulties you face in performing your functions? What are the principal difficulties that the subunits experience inimplementing their plans? What changes would you propose for the improvement of the operation of the unit?

5.6. Incentives and motivation of unit personnel

31. Could you give your perception of the working environment in the unit? Which characteristics would describe this best?
32. Are there mechanisms or policies in place for incentives for unit employees? What do they consist of? How often are they distributed?

Health workforce governance or leadership capacity at national level and all other levels is considered fundamental in order to steer the health workforce agenda in the country for effective service delivery.

This survey report on the functioning of HRH units or departments in the ministry of health offers a window into what is generally observed as capacity challenges of the health workforce governance. The intention of this report is to use the results to advocate for strengthening the ministerial HRH function so that ministries of health can improve coordination with other sectors and partners to ensure better service delivery.

This publication is available on the Internet at :
http://www.who.int/hrh/resources/observer