A HEALTH POLICY AND SYSTEMS RESEARCH READER ON HUMAN RESOURCES FOR HEALTH

Edited by Asha George, Kerry Scott, Veloshnee Govender
Key for classifying research inference

- Descriptive
- Exploratory
- Explanatory
- Emancipatory
- Influence
- Predictive
7.1 Defining the chapter

Policy-making is a critical component of human resources for health (HRH) governance, concerning the development and implementation of rules and regulations that shape the health workforce (Dieleman et al., 2011; Fryatt et al., 2017). Significant normative and technical work supports the content of HRH policy, such as rural retention of health workers (World Health Organization (WHO), 2010a), task-shifting (WHO, 2007) and international recruitment (WHO, 2010b). Policy-making pertaining to HRH remains highly uneven, however, with many policies often unadopted or inadequately implemented (Fieno et al., 2016). From a research standpoint, scarce attention is given to the process of policy-making, including the role and interests of stakeholders (Buse et al., 2005). Politics and power often lie behind these phenomena, and, therefore, examining policy-making through these lenses is critical for a more holistic and realistic understanding of health workforce policy-making in low- and middle-income countries (Buse et al., 2005; Dieleman et al., 2011; Mitchell and Bossert, 2013).

This chapter highlights exemplary research on HRH policy-making and politics in low- and middle-income countries, with a particular focus on policy development and its underlying power dynamics (Table 7.1). Research that informs the technical basis of HRH policy or that evaluates HRH policies is found throughout the reader. For example, Shen et al. (2017) in Chapter 4 review the impact of performance-based financing on health worker motivation in Zambia; and Kwamie et al. (2014) in Chapter 6 assess the implementation of a decentralized management and leadership initiative in Ghana.
Table 7.1 Key definitions for governance, policy, politics and power

| Governance | “... governance entails transferring some decision-making responsibility from individuals to a governing entity, with implementation by one or more institutions, and with accountability mechanisms to monitor and assure progress on decisions made” (Fryatt et al., 2017, pp. 1–2) “Governance is about the rules that distribute roles and responsibilities among societal actors and that shape the interactions among them” (Brinkerhoff and Bossert, 2008, p. 3) |
| Policy | “Broad statement of goals, objectives and means that create the framework for activity. Often take the form of explicit written documents, but may also be implicit or unwritten” (Buse et al., 2005, p. 4) |
| Politics | “The art or science concerned with guiding or influencing governmental policy” (Merriam-Webster) “Who gets what, when, how” (Lasswell, 1936) |
| Power | “The ability or capacity to do something or act in a particular way” (Oxford Dictionaries) “The capacity or ability to direct or influence the behaviour of others or the course of events” (Oxford Dictionaries) |

7.2 Background on politics and policies

Policy-making is an inherently political process, characterized by ambiguity, competition, limited windows of opportunity and decision-making, interests, incentives and disruption (Fieno et al., 2016). Underlying any policy-making are clear political dimensions – the relationships of stakeholders involved in the policy process, their interests and negotiating positions, and the broader political system in which these interactions occur. This section reviews key characteristics of HRH policy-making and the social science approaches that have been used to examine this topic.

HRH policy is differentiated from other forms of health policy-making by the direct involvement of various organized forms of professions and occupations, the implicit and explicit hierarchies within and across health worker cadres, and the interests, skills and social positioning (gender, class, ethnicity, sexuality and race) of these groups (AbuAlRub and Foudeh, 2017; Blaauw et al., 2014; Daniels et al., 2012; Ditlopo et al., 2014; Pick et al., 2012). Beyond representatives of the health workforce, several other state and non-state actors are involved (Table 7.2), including ministries, central government agencies, local government, educational institutions, international agencies and civil society (Fieno et al., 2016; Martinez and Martineau, 1998; Mitchell and Bossert, 2013). The role of power in stakeholder engagement is also deeply intertwined in the policy process. Further, the influence of these stakeholders is driven by context, including regime type, political and economic stability, and nature of reform (Healy and Mckee, 1997; Mitchell and Bossert, 2013; Witter et al., 2016).
Table 7.2 Stakeholders impacting on human resources for health policy (adapted from Martinez and Martineau, 1998; Mitchell and Bossert, 2013)

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<tr>
<th>Government</th>
<th>Health (national, regional, local government)</th>
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<td></td>
<td>Executive leadership (president, prime minister, cabinet)</td>
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<td>Legislative bodies</td>
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<td>Education</td>
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<td>Defence and military</td>
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<td>Civil service agencies and commissions</td>
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<td>Statutory professional councils</td>
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<td>Employers</td>
<td>Private for profit businesses</td>
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<td>Public–private partnerships</td>
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<td>Voluntary or non-profit-making organizations</td>
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<td>Representatives of health</td>
<td>Professional and occupational associations</td>
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<td>workers</td>
<td>Professional and occupational unions</td>
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<td>International stakeholders</td>
<td>Bilateral and multilateral agencies</td>
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<td></td>
<td>Philanthropic organizations</td>
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<td></td>
<td>Professional and occupational organizations</td>
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<td>Civil society</td>
<td>Community-based organizations</td>
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<td>Patients’ rights organizations</td>
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<td>Other stakeholders</td>
<td>Media</td>
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<tr>
<td></td>
<td>Pharmaceutical and medical device companies</td>
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The diverse stakeholder interests that drive HRH policies mean there are various overlapping spheres of policy content – health policy, health workforce policy, broader civil service policy, and other social policies (Figure 7.1). Most health policies have implications for the health workforce (Dussault and Dubois, 2003; Rigoli and Dussault, 2003). For example, introducing new financing mechanisms, integrating health services and enforcing standards of care all have a direct impact on health workers and therefore require HRH considerations during the policy-making process. Next are those health workforce policies that impact directly on entry (recruitment, selection and induction), training, supervision, promotion and performance (Dussault and Dubois, 2003; Vujicic et al., 2009). Such policies might be specific to public-sector employees but could also involve the regulation of health workers in the private or non-profit sectors. For example, while ministries or departments of health might coordinate or set policy pertaining to remuneration, supervision, performance and dual practice for public-sector workers (De Geyndt, 2017; Kiwanuka et al., 2010; Pierantoni and Garcia, 2011), professional councils might set training or ethical conduct policy for both public-sector and private-sector health workers (Hongoro and Kumararanayake, 2000). Following this are civil service policies that apply to central, state or local government employees, such as policies pertaining to recruitment, remuneration, benefits, posting and transfer and ethical conduct (De Geyndt, 2017; Vujicic et al., 2009). Finally, broader social policies strongly influence the development of the health workforce, including education, emigration and decentralization (Clemens, 2014; Martinez and Martineau, 1998).
One way of trying to understand the policymaking process, and its underlying politics, is to view the process as a series of phases, otherwise known as the stages heuristic: agenda-setting, formulation, implementation and evaluation (Walt et al., 2008). This framework has been criticized, however, for assuming a linearity in policy-making that is rarely found in practice (Walt et al., 2008). Some studies have examined HRH policy-making during the agenda-setting phase, when certain policy issues rise to the top of decision-makers' agendas – for example, the development of a lay community health worker programme in South Africa (Daniels et al., 2012) or the initiation of pay for performance in the Tanzanian health sector (Chimhutu et al., 2015). Other studies have examined the agenda-setting and formulation phases in conjunction; examples include nursing education reform in South Africa (Blaauw et al., 2014) and overtime allowance for public-sector health workers in Ghana (Agyepong et al., 2012). Strikingly, despite their centrality to the policy process, research on the perspectives and involvement of frontline health workers in agenda-setting and policy formulation is more limited (AbuAlRub and Foudeh, 2017; Agartan, 2015; Ditlopo et al., 2014; Scott et al., 2012).

A greater proportion of HRH policy studies have explored the implementation of particular HRH policies. Some studies have examined the perspectives of health workers in interpreting and implementing policy objectives. Relevant examples include participation in a new community health worker programme in Ethiopia (Maes et al., 2015), implementation of a health financing intervention in South Africa (Walker and Gilson, 2004), and experiencing decentralization policy in Uganda (Kyaddondo and Whyte, 2003) and South Africa (McIntyre and Klugman, 2003). Others have used systems thinking to explore the intended and unintended impacts of decisions taken during the policy process, such as around overtime allowance for Ghanaian public-sector health workers (Agyepong et al., 2012). In addition, researchers have examined how health workers develop informal mechanisms for addressing policy-deficient human resource issues, such as posting and transfer in the Nigerian health sector (Abimbola et al., 2016).

Finally, a variety of social science approaches have been applied to various research questions concerning HRH policy, allowing us to broaden the discourse from the “technical” nature of policies to the complex factors underlying policy-making at each stage, and the intended and unintended consequences that emerge as a result (Fieno et al., 2016). The stages heuristic emerged from political science, and other theoretical frameworks rooted in that discipline allow...
for further depth in examining policy-making (Berlan et al., 2014; Erasmus, 2014; Kingdon, 1995; Shiffman and Smith, 2007; Walt and Gilson, 1994). Closely related are those studies drawing upon political economy frameworks to understand HRH policy-making by exploring the interplay between structure (institutions and context) and agency (actors, incentives and behaviours) (Bertone and Witter, 2015; Chimhutu et al., 2015; Fieno et al., 2016). Sociology provides an array of theories by which to understand professions and occupations, shedding light on how these groups interact and organize, and how they use their power to engage in policy-making (Freidson, 1970; Saks, 2016), although such analyses in low- and middle-income countries are less common (Jeffrey, 1977). Finally, historically grounded analyses have helped trace the evolution of HRH policy, for example in Brazil, India, Sierra Leone and Mexico (Bertone et al., 2014; Buchan et al.; 2011; Maru, 1985; Nigenda and Solorzano, 1997).

7.3 Illustrative primary research articles

The six articles presented below illustrate health policy and systems research (HPSR) methodologies that unpack the politics involved in brokering HRH policy-making. These articles were selected from a pool collated from a doctoral seminar at the Johns Hopkins School of Public Health, a crowdsourcing exercise supported by Health Systems Global and subsequent searches using the bibliography of key articles and on relevant databases and search engines (PubMed and Google Scholar). The main criteria used to select the articles included diversity in region, cadre and methods, as well as the quality of the studies based on standard guidelines.

7.3.1 Historical and political analyses of human resources for health policy-making


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<th>Health workers</th>
<th>Physicians</th>
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<tbody>
<tr>
<td>Geographical area</td>
<td>Mexico</td>
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<tr>
<td>Research methods</td>
<td>Qualitative: Historical and political analysis using historical data, document review and interviews</td>
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<td>Research inference</td>
<td>Explanatory</td>
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Nigenda and Solorzano (1997) provide a rich analysis of the development of the medical profession in Mexico, vis-à-vis its relationship with the state. The dynamic between the medical profession and the state strongly influences issues of health worker training, performance and quality. A key dimension of this dynamic is the organization of the medical profession – the degree to which doctors are organized into associations or unions, their lobbying power with the state, and the state’s control over key health workforce issues, such as medical education and licensing. Critical explorations into these aspects of the medical profession remain underresearched in the context of low- and middle-income countries. In this article, the authors describe the shifting interactions between the state and the profession during three time periods from 1917 to 1988, finding that efforts taken by the medical profession to influence medical education, licensing, market forces or workplace policies were met with “continuous and systematic interference by the state”, resulting in the fragmentation of the profession into multiple, relatively weak organizations with minimal power and cohesion. Their findings are a notable departure from the dominant literature on the topic from high-income settings, where organized medicine has a major, often unified role in influencing policy. Drawing on historical data, available literature and select interviews, the authors carefully construct a case study of each of these time periods, detailing the interests and power base of each stakeholder involved in the process. Their research helps shed light on more contemporary issues facing
the profession, such as intraprofessional class imbalances and high rates of unemployment or underemployment. This study is therefore a strong example of using in-depth longitudinal case studies, grounded in historical analysis, to explain the current scenario of a particular health workforce by tracing its evolution through time.


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<th>Health workers</th>
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<tr>
<td>Geographical area</td>
<td>Sierra Leone</td>
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<tr>
<td>Research methods</td>
<td>Qualitative: political economy, stakeholder mapping workshop, document review, key informant interviews</td>
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<td>Research inference</td>
<td>Explanatory</td>
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Bertone et al. (2014) address a key gap in the HRH policy literature - the evolution of HRH policy in post-conflict settings. In this comprehensive, in-depth case study of the HRH “policy story” in post-conflict Sierra Leone, the authors explore the period between 2002 and 2012 to understand the nature of decision-making and the factors and actors influencing these processes. Importantly, this paper seeks to deepen our understanding of whether HRH policy in post-conflict Sierra Leone developed due to path dependency or due to windows of opportunity. This study was also part of a comparative assessment of post-conflict HRH policy-making with three other countries – Uganda, Cambodia and Zimbabwe (Witter et al., 2016). The study is qualitative in nature and uses policy analysis to examine the dynamism between contextual factors, such as the political system and historical factors, the actors involved and their power bases, and changing formal and informal institutional contexts. To do this, the authors draw upon varied sources of information, including a stakeholder mapping workshop, document review and in-depth interviews. The authors helpfully describe the iterative use of these three data sources, noting that each source builds upon the other and allows for both comparison and triangulation, important particularly due to lack of available documentation and the difficulty of participants in recollecting details about the period. The findings are structured by time period, allowing readers to immerse themselves in the details of the case, before delving into the intricate analysis. A weakness of some policy analyses is the lack of interpretive analysis of data; this article represents a strong example of looking deeper into the data and connecting threads to hypothesize why policy scenarios evolve in certain patterns, and what this might tell us about existing theories of policy development in post-conflict settings.
A good example of HRH policy analysis is a comprehensive qualitative case study pertaining to the development of a nursing profession practice law in Lebanon conducted by El-Jardali et al. (2014). The authors use the Walt and Gilson (1994) triangle to outline key facets in the 13-year development of the law and build on the framework by examining multiple stages of the law’s development, the role of power, and issues such as the role of gender and sectarianism in policy-making. This study represents an excellent example of applying policy analysis in the context of a legislative process, detailing the interests and positions of a variety of stakeholders (ministries, professional orders, educational institutions, private hospitals and parliamentarians) in a manner that explains the basis for current inaction and delay in passing the law. The case study is also strongly grounded in context, with richly detailed information on the political and health-care systems. The authors are also reflective on their own position as researchers, particularly on how their insider status may have facilitated access to high-level stakeholders. To address potential resulting biases, they involved “outsiders” and those from other disciplines. Finally, the use of a stakeholder panel discussion as a methodological technique appears a useful validation technique. Other studies using similar qualitative policy analysis of HRH policy making processes include research by Daniels et al. (2012) and Blaauw et al. (2014), both on health worker policy in South Africa.

### 7.3.2 Contemporary human resources for health policy dynamics


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<th>Health workers</th>
<th>Multiple health workers</th>
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<tr>
<td>Geographical area</td>
<td>China, India and Viet Nam</td>
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<tr>
<td>Research methods</td>
<td>Qualitative: comparative case study analysis of policy coherence across countries and between policy spheres</td>
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<td>Research inference</td>
<td>Explanatory</td>
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This study involves comparative analysis of coherence between health policy and human resource strategy. Using data from a comparative analysis of maternal health policy across Viet Nam, India and China, the authors examined the level of coherence between the development and implementation of maternal health policy and human resource strategy in each country. The authors also explored the various factors that influenced coherence in the cases. The analysis is anchored by a framework from Torrington et al. (2002) that categorizes the relationship between organizational and human resource strategy (separation, fit, dialogue, holistic, human resource-driven). Drawing upon country reports that used semistructured interviews, document review and participatory stakeholder workshops, researchers on the team analysed human resource data pertaining to human resource planning and workforce deployment, training and financing, continuing professional development and performance management. The authors present a comparative analysis based on the Torrington framework during both
the policy development and implementation stages, and then they discuss the various factors that could explain the reasons for the levels of coherence found in the analysis. This paper represents an excellent example of using analytical frameworks from diverse disciplines, in this case from human resource management, to provide a robust comparative analysis. The authors also make a compelling case for integrating human resource questions into broader health systems and health policy studies.


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<tr>
<th>Health workers</th>
<th>Public sector frontline workers and district managers</th>
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<tr>
<td>Geographical area</td>
<td>Malawi, Zambia</td>
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<tr>
<td>Research methods</td>
<td>Mixed: cross-country comparative analysis using health facility data and in-depth interviews</td>
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<td>Research inference</td>
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This study represents a solid example of using a mixed-method comparative approach to understand the impacts of policy shifts on health workers, specifically the impact of global health initiative funding for human immunodeficiency virus (HIV) services. The authors hypothesize that countries with more coordinated global health funding would experience fewer barriers to a coordinated national human resource strategy compared with countries with a more crowded global health funding landscape. To test this hypothesis, the authors compared Malawi, with HIV funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), and Zambia, with funding from both the Global Fund and the United States President’s Emergency Plan for AIDS Relief (PEPFAR). The careful use of health facility data in this study demonstrates the value and also “messiness” of using routine data, strengthened by extensive interviews with a range of frontline and district staff. The intent behind the mixing of methods is evident, as the qualitative data were used to deepen the quantitative findings, highlighting the issues and challenges perceived by health workers regarding scale-up of HIV services. In doing so, the authors bring forward clear evidence for the different impacts of Global Fund and PEPFAR funding on human resources for health, suggesting that the power dynamics emerging from more contested policy environments have direct consequences on governments’ abilities to coordinate human resource policy more effectively. Other HPSR studies exploring the impact of global health initiatives on the health workforce include qualitative policy analysis (Chimhutu et al., 2015; Hanefeld and Musheke, 2009), systematic document review (Vujicic et al., 2012) and comparative case analysis (Witter et al., 2016).

Purohit B, Martineau T, Sheikh K (2016). Opening the black box of transfer systems in public sector health services in a Western state in India. BMC Health Serv Res. 16(1):419

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<th>Health workers</th>
<th>Public sector physicians</th>
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<tr>
<td>Geographical area</td>
<td>India</td>
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<tr>
<td>Research methods</td>
<td>Qualitative: interview and document review, contrasting policy architecture with practice</td>
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<td>Research inference</td>
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A key governance challenge impacting health workers in low- and middle-income country settings remains the ambiguity around their posting and transfer; however, the deeply sensitive nature of these issues makes research efforts challenging (Abimbola et al., 2016; Schaal and Freedman, 2015). Purohit et al. (2016) make a valuable contribution to the literature by opening
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up the “black box” of posting and transfer policy in one Indian state. Specifically, the authors set out to unpack the linkages between human resource policy as intended, human resource policy as practised, the perceptions of frontline medical officers regarding these policies, and the connection between these policies, staff behaviour and organizational policies. The authors use a two-step approach. First, they developed a “systems map” consisting of existing transfer policies; second, they conducted a “systems audit” through in-depth interviews with medical officers. The interview data were used to construct job histories to examine how posting and transfer policy is actually implemented. The findings as presented are compelling, indicating considerable ambiguity in terms of transfer policy, and even further ambiguity and dissonance in their actual practice. Specifically, the information provided on the interplay between Public Service Commission policy and the Health Department is illuminating, given the scarcity of research on civil service agencies in HPSR. The findings are interwoven with numerous quotes, giving readers insight into how medical officers perceive and experience the system. The authors also engage with highly sensitive issues of political and financial influence during postings and transfers. Finally, the multifaceted nature of the issue comes through clearly, including the complicated hierarchies of health workers in the public sector, and the myriad push and pull factors underlying decision-making on postings and transfers.

7.4 Research challenges, gaps and future directions

Despite growing recognition regarding its importance, research on HRH policy-making and its underlying politics in low- and middle-income country settings remains sparse. The following methodological challenges in conducting this type of research were noted in the articles reviewed in developing this chapter.

Researchers focusing on national- and state-level processes that require input from high-level policy-makers might also run into obstacles in gaining access and obtaining permission for interviews, document review or observation. Related ethical challenges include respondents possibly revealing highly sensitive data, necessitating that researchers adhere to the strictest standards of confidentiality in their reporting. These sorts of challenges also lead us to question the positionality of researchers working on policy and politics (Walt et al., 2008), and one could argue that researchers who are junior or who do not belong to elite institutions might face unfairly disproportionate difficulties in accessing possible informants. Similarly, senior researchers with good access to, and trust with, policy-makers or other stakeholders might be challenged in reporting findings that could negatively impact these relationships.

Studies on this topic are primarily qualitative and often rely solely on in-depth interviews as a data source. While such an approach may be valuable, and sometimes the only feasible way forward, the studies in this section suggest that thinking innovatively about complementary data sources can lead to richer findings and analysis through triangulation across data sources. Broadening data sources is particularly important, as respondents do not always recall or reveal key details about HRH policy-making. In addition to triangulating interview sources (due to the issue of stakeholders often having divergent and competing perspectives), triangulating interview data with a robust document review, media reports, routine staffing data, auditing data, stakeholder panels or non-participant observation can greatly strengthen data quality and trustworthiness (Bryman, 2004; Gilson et al., 2011). Such approaches may also be used iteratively, adaptively building on one another to sharpen research questions and analysis, and could be strengthened further by prolonged engagement, contextual analysis and other techniques to improve rigor (Gilson et al., 2011).

The importance of the social sciences to research on HRH policy-making has been discussed previously; from a methodological standpoint, expanding the use of social science theory and methods will be critical to strengthening the knowledge base in this area. For example, ethnography might be valuable in determining the underlying parameters for decision-making
in policy-making or understanding the institutional and organizational contexts in which health workers are situated (Maes and Kalofonos, 2013; Ruddock, 2016); sociology can help us examine the interests and interactions of various health worker organizations, groups and associations; and political science can unpack the linkages between political systems, regulatory systems and HRH policies (Fieno et al., 2016).

Finally, using mixed-method approaches may also be highly appropriate for many research questions. Quantitative or mixed-methods approaches can add critical perspectives. For example, social network analysis is increasingly being applied to questions of policy-making, strengthening our understanding of the positioning and relative power of various stakeholders (Jessani et al., 2016). Data pertaining to more latent performance variables, such as satisfaction, stress and burnout, can contribute to examining impacts of policy implementation on health workers. Mixed-method approaches, such as studies by Brugha et al. (2010) and Bowser et al. (2014), can qualify quantitative indicators, such as those measuring service delivery or financing, with the perspectives of key policy actors, including frontline health workers, managers and policy-makers, in order to make inferences about the broader policy environment.

From a thematic perspective, further research on the politics of HRH policy-making could proceed in several exciting directions.

HRH policy represents several policy spheres (as noted in Figure 7.1), and research on policy-making in each of these domains is vastly underrepresented in the literature, particularly health worker policy, civil service policy and social policy. Researchers can make significant contributions by conducting studies that examine policy-making in these spheres from a range of perspectives – civil society organizations, patients’ rights organizations, professional associations and unions, a multitude of government agencies, and multiple types of cadre (informal to formal, lay to specialized, public to private, allopathic to non-allopathic) (Sheikh et al., 2017). Applying an approach that is grounded in a people-centred understanding of health policy and systems would also allow us to integrate questions of power (Sheikh et al., 2014), a driving force in policy-making of any kind.

Regulation is a key aspect of health workforce policy but remains understudied in low- and middle-income country contexts. The nature of health worker regulation involves critical questions around the involvement of the state, the role of professions and occupations, and the nature of formal and informal regulatory mechanisms. For methodological guidance, researchers may look towards the rigorous work of Hongoro and Kumaranayake (2000), in their research on regulating private providers in Zimbabwe; Sheikh et al. (2013), in their mapping of health sector regulation in two Indian states; and Doherty (2015), in her document review of regulatory legislation from southern and eastern African countries.

Finally, studies concerning accountability and transparency in the policy process are important but often sensitive topics for empirical work. For example, examining the ways in which health workers, community groups or patients’ rights advocates are involved in HRH policy is poorly understood, perhaps reflecting the relatively exclusive and elite nature of these policy-making processes (Daniels et al., 2012). As another example, studies regarding corruption in HRH policy-making are still largely untapped due to the highly sensitive nature of the topic (Rispel et al., 2016; Vian, 2008). Such studies, while challenging to implement, are essential to providing a more accurate and grounded understanding of the power dynamics embedded within policy-making and to facilitating improved accountability and transparency in health policy-making.

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References


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