

## **COUNTRY CASE STUDY**

### **Malawi's Emergency Human Resources Programme**

#### **Summary**

Human resource shortages in Malawi's health sector are among the severest in sub-Saharan Africa, even though political commitment to address the crisis has been strong since the late 1990s. Limited financial support of the country's 1999-2004 human resource development plan prompted the Ministry of Health to focus specifically on pre-service education with an emergency training plan beginning in 2002.

Shortly afterwards, development partners began to recognise staffing as a key bottleneck to delivering health services that required special attention, and this allowed the Ministry of Health to launch a more comprehensive programme in 2004. The six-year Emergency Human Resources Programme (EHRP) was developed based on a situational analysis, consultation with key stakeholders and lessons learnt from domestic and international experiences concerning working conditions, industrial relations, the use of different cadres and an awareness of resource constraints.

The EHRP falls within the human resources pillar, one of the six pillars of the Joint Programme of Work for the health sector-wide approach (SWAp), drawn up for the period 2004-10; it focuses on retention, deployment, recruitment, training and tutor incentives for 11 priority cadres (doctors, nurses, clinical officers, medical assistants, pharmacists, laboratory technicians, radiographers, physiotherapists, dentists, environmental health officers and medical engineers). It sits alongside other innovative approaches to addressing the HR crisis in Malawi's health sector, such as the expansion of the health surveillance assistant cadre.

Malawi faces tight fiscal constraints. Major funding for the programme comes from the Malawi Government, DFID, the Global Fund to Fight Aids, Tuberculosis and Malaria and the health SWAp. Despite traditional donor concerns regarding the sustainability of funding salaries, partner support includes salary top-ups due to the acute need to improve retention, along with other incentive measures such as improved staff housing, and support to expansion of training capacity and quality. The non-profit Church Health Association of Malawi is providing a significant proportion of training places.

The initial goal of the EHRP is to scale up staffing to Tanzanian levels by 2010, which are below WHO minimum standards but thought to be a more attainable goal. The programme includes both short-term 'quick wins' and longer-term interventions. The former includes attracting unemployed or retired staff back into service, the use of expatriate staff to temporarily fill gaps on a volunteer basis, and the initiation of salary top-ups and in-service incentives, particularly for rural service (housing, transportation, priority for professional development training and so on). Scaling up of pre-service training is a longer-term goal, as the impact is not felt immediately due to training lag-time, and because expanding training capacity requires investment in people and infrastructure that itself takes time. The plan is to expand overall pre-service training capacity by 50%. A detailed model links staffing targets for the priority cadres with current recruitment and training levels.

The EHRP includes plans to strengthen information and monitoring systems, and some preliminary results are available to demonstrate the programme's impact. There is, for example, some evidence to suggest a reduction in nurse emigration. Enrolment on basic clinical courses was two and a half times higher in 2007 than in 2003, and on post-basic courses it has almost doubled. There were 40% more doctors, 50% more clinical officers and 30% more nurses in post in 2007 than in 2003. There is an increase in medical school applications, potentially due to improved future salaries. Management capacity remains an issue within the health system, and four zonal support offices have been established to improve supervisory structures.

## **Introduction**

Malawi's health human resources initiatives since the late 1990s provide a good example of a comprehensive national scale-up plan for the health workforce. Its Emergency Human Resources Plan (EHRP), introduced in 2004, has shown modest but promising results. Health worker attrition remains high and tutor supply low, but training capacity has been substantially expanded and Malawi is expected to begin meeting training output targets in 2008.

## **Plan development**

The EHRP's roots, go back to 1997, when Malawi's Ministry of Health recognised the growing health workforce crisis and demonstrated a commitment to tackling it by beginning formal workforce planning. The resulting 1999-2004 Human Resources Development Plan aimed to mobilise resources for a range of activities, including training, deployment, and information systems, but was met with a poor donor response.

The Ministry of Health then decided to focus on pre-service training, the single biggest challenge, with a six-year Emergency Training Plan beginning in 2002. When the crisis continued despite the apparently successful implementation of this plan, development partners began to recognise staffing as a key bottleneck and to show interest in providing the investment needed for a comprehensive response.

Although short-term incentive payments have long been common in the health sector, most donors have traditionally been reluctant to fund long-term incentive packages or salaries in light of concerns about donor dependency, even after a shift in the late 1990s from project funding to programme- and outcome-based aid instruments. Intervention from the Permanent Secretary of DFID and Executive Director of UNAIDS in 2004, however, authorised local offices to back this kind of funding in Malawi and support a comprehensive plan including health workforce hiring. By 2004 the Emergency Human Resources Programme was in place, supported by the Ministry of Finance, DFID and the Global Fund.

An Essential Health Package (EHP) is outlined in the health section of the current Poverty Reduction Strategy published in 2002. A Joint Programme of Work for the health sector-wide approach (SWAp) was then drafted for 2004-10, aiming to deliver the Essential Health Package free of charge to all Malawians. Human resources is one of six components of the programme. The initial goal of the EHRP was to train the staff required to deliver the Essential Health Package (EHP). The plan was later revised to target staffing levels similar to those of Tanzania, which fall below WHO standards but were felt to represent an attainable interim goal. Implementation of the EHP remains a longer-term goal.

The EHRP focuses on retention, deployment, recruitment, training and tutor incentives for 11 priority cadres (doctors, nurses, clinical officers, medical assistants, pharmacists, laboratory technicians, radiographers, physiotherapists, dentists, environmental health officers and medical engineers). Additional funds requested from the Global Fund (GFATM) will support training to scale up health surveillance assistants.

The EHRP design was based on a situational analysis led by the Ministry's planning department, using policy reports and research including national surveys that showed shortages and uneven distribution across all professional cadres. There were no international models of similar large-scale, comprehensive scale-up programs to draw on, but the EHRP planning process did consider lessons learnt from initiatives elsewhere in the region. It also built on earlier work in Malawi, such as the longstanding use of expatriate doctors for key posts and targeted incentive packages for nurse tutors.

A lack of detailed data meant that the design drew heavily on consultation with a wide range of stakeholders, including the Church Health Association of Malawi (a major non-profit

owning 50% of the country's health facilities), NGOs, professional associations, and the Public Service Commission. Those consulted universally agreed on the urgent need to tackle pay issues, but also underscored the importance of tackling longer-term, more complex issues including human resources management capacity, career structures, staff deployment and working conditions. The consultation process promoted a variety of collaboration between stakeholders. In particular it highlighted the need to strengthen the new Health Services Commission (HSC) and ensure better coordination between this body and the Ministry of Health.

Industrial relations were also an important consideration in decision-making. There was limited scope for using volunteer expatriates to fill nursing gaps, for example, because of a high risk of industrial action by Malawian nurses.

The goals of the EHRP are to expand domestic training capacity by over 50% overall, including doubling the number of nurses and tripling the number of doctors in training. The model links progressive staffing targets across 11 professional and technical cadres with recruitment and training requirements. It has factored in an attrition rate of 1.25% due to death, and of 2.5% to 3.5% for resignations, emigration and retirement. Health surveillance assistants are also to be increased from 5,000 to 11,000, a ratio of 1 per 1,000 population.

### **Implementation process**

The Ministry of Health is implementing the EHRP with the Health Services Commission under the oversight of the Human Resources Advisory Committee for Health. Important partners include Church Health Association of Malawi (which provides large proportions of health worker training), the Nursing and Midwifery Councils and other professional associations. DFID and the Global Fund have been the most active international actors, with SWAp partners also providing technical support and funding.

The six-year EHRP was initially costed at around \$198.8 million – limited mainly by what donors were able to commit – but additional funding has since grown this to around \$270m over the six years. A major challenge was ensuring the programme, especially proposals for salary top-ups, was sensitive to the country's tight macro-economic situation. It was therefore designed to be fully funded by donors, with a small contribution from the government raised by taxing the salary top-ups.

In deciding on the use of salary top-ups, stakeholders predicted that Malawi would receive aid for the foreseeable future, which would provide the resources to finance the EHRP beyond the current six-year time frame. The government has also committed to donors that the proportion of the national budget spent on health will be maintained or increased over the course of the six years. The top-ups have been detailed in the government's pay policy.

Implementation was slow to start while the Ministry of Health sought permission from other government branches to engage new staff and arranged to re-contract those who had reached the previous compulsory retirement age. By the last quarter of 2005, 591 staff had been recruited and 1,100 promoted internally. Many of the latter were nurses whose promotions were previously blocked by the civil service following a change in the nursing curriculum, which had frustrated the staff and hurt retention rates.

A tracer survey of qualified Malawian health professionals who had retired or resigned from government service was completed in 2006, and of over 700 respondents, nearly 600 indicated a willingness to return to public employment given the offer of salary top-ups, more flexible deployment decisions, and opportunities for further training. Of the 465 that were recruited, less than 300 have reported for service; the remainder need to be followed up.

Significant progress has been achieved as a result of the EHRP, but implementation capacity could be improved. A recent needs assessment by Malawi health sector partners, led by GTZ, provided a number of recommendations for strengthening the programme. The Global Fund has agreed to release additional funds to tackle some areas in need of particular strengthening. The money will be used to import nurse tutors, train health surveillance assistants and other clinical and lab staff, support regulatory bodies, provide technical assistance in planning and management, bolster the Health Services Commission, and support information systems and strategic policy development.

### **Expansion of education and training capacity**

The EHRP programme is aimed at achieving short-term improvements while pursuing longer-term goals. The results of its activities in several areas related to education and training are outlined below.

#### *Temporary overseas recruitment*

Training capacity was expanded through the recruitment of volunteers. In the short term, volunteer doctors and nurse tutors are filling critical posts while more Malawians are being trained. By April 2005, international organisations such as VSO and the United Nations Volunteers had made progress on recruitment, with 19 expatriates already in Malawi; by 2006 this had risen to over 70. Some problems arose around orientation, language difficulties, remuneration, and differences in medical background.

#### *Pre-service training capacity*

Between 2003 and 2007, Malawi recorded a 165% increase in pre-service training and 79% increase in post-basic training, including a quadrupling of medical training places between 2003 and 2006. The College of Medicine has become an example of good practice through its participation in SWAp and its focus on government targets.

By 2008, outputs are expected to meet targets in all cadres. New training institutes such as Mzuzu University are now able to help with pre-service training, and a WHO review has shown that educational quality is being maintained.

A tutor incentive scheme is also in place to increase the number of tutors to match a larger student intake, particularly those deployed to remote training institutions. Progress has been difficult in this area, however, prompting the Global Fund to provide additional funds for a short-term increase in the recruitment of senior tutors from abroad.

#### *International technical assistance*

Two temporary international human resources experts were recruited to bolster capacity and build skills within the Ministry of Health's human resources planning, management and development functions and to support implementation of the EHRP. Technical assistance is expected to be phased out over the next 10-15 years as Malawian capacity develops.

#### *Expanding health service infra-structure*

The first phase of construction of clinics and other health service infra-structure began in January 2006 and is ongoing.

#### *HIV*

The WHO has adapted the 'basic care package' for people living with HIV so it can be delivered by less skilled staff. In Malawi, this is taking place in the context of the 'Treat, Train and Retain' initiative and there are plans to utilise health surveillance assistants, community health nurses and clinical officers in its implementation.

## **Employment and retention**

### *Incentives*

The EHRP aims to improve incentives for recruitment and retention of Malawian staff in government and mission hospitals through a 52% taxed salary top-up for the 11 priority cadres. Implementation challenges for this initiative included setting the top-ups at an appropriate level, legitimizing them through a special agreement with the International Monetary Fund, and politically managing their implementation.

There were 40% more doctors, 50% more clinical officers and 30% more nurses in post in 2007 than in 2003. However, at the start of the scheme in 2005 only one of 22 doctors graduating went into public service. Nursing and midwifery council figures do show a small decrease in migration to the UK in 2006 compared with the previous year, but migration within Africa and out of the public sector remains a problem. The 2007 needs assessment led by GTZ recommended that top-ups be increased annually and that they be graded so that staff in remote areas can be additionally rewarded. This strategy is being costed.

Work on developing further policy for staffing underserved areas has also begun. One hundred and thirty eight hardship health facilities have been identified, and incentives including housing, communication and transportation have been developed. The programme has been timed to coincide with the implementation of the Essential Health Package, which will include better facility maintenance and adequate and timely provision of essential drugs and supplies. This combination is expected to reinforce worker satisfaction and retention.

### *Professional development*

Policies on promotions, training, and career development are being developed with a longer-term view. These include scholarships and incentives to complete higher education or in-service training; however, the development of clear professional development continuums with periodic salary increments remains a neglected area.

### *Bonding*

Bonding programmes are still under discussion, but as training costs are covered by the Ministry of Health and SWAp partners, there is some justification for a move towards mandatory public service.

## **Management and leadership**

A chronic fragmentation and lack of capacity in the Ministry of Health's human resources functions affected Malawi's ability to recognise and respond to the growing difficulties until long after they reached crisis proportions. When the Ministry entrusted programme design and early implementation to a small core of competent and dedicated staff, answering directly to senior officials, speedy progress was made.

Weak capacity is also evident in the difficulty the Ministry faced in establishing programme monitoring and evaluation capacity to demonstrate progress in terms of outputs and outcomes. In general, there are not clear guidelines on the roles of the many authorities involved in human resources for health.

The EHRP only addresses human resources in service delivery; an institutional capacity development strategy was not in place at the start. Efforts to provide the Essential Health Package have also concentrated on individual components, such as drugs or facilities, rather than an integrated approach. A recent evaluation highlighted a need for training in health service management at all levels. Steps have been taken, however, to strengthen supervisory and support structures through the establishment of four zonal support offices throughout Malawi.

## **Monitoring and Evaluation**

All six pillars in the SWAp programme of work, including the EHRP, are reviewed twice a year. Although all partners are consulted and various sources are used, a lack of data (due in part to management issues) is an ongoing problem: for instance, the 2007 HR census, a snapshot of staff in post, due to be published in early January 2008, is still not finalised in late April. The programme itself includes establishing more robust monitoring and evaluation capacity for human resources for health, nested within existing health management information systems that are being strengthened to support the implementation of the Essential Health Package. A full evaluation of the EHRP is now being designed.

## **Lessons learnt and policy recommendations**

### *Political/donor commitment*

One of the most significant factors in the success of the EHRP was donors' willingness to support wage subsidies and the Ministry of Finance's willingness to allow differentiated pay scales by sector. Malawi's experience recognizing its need and negotiating with the IMF to meet it could provide a model for other low-income countries. Some concerns remain about the long-term sustainability of such funding, but these may yet be addressed.

### *Comprehensive approach*

In Malawi, major investment in human resources only made sense within the context of a broader programme to improve health service facilities and management systems; without it, attrition and low morale might have undermined the training and retention investments.

### *Phased approach*

The combination of short- and long-term measures, as well as improving immediate capacity to deliver health services, appears to be helpful in maintaining commitment to the programme, by using rapid improvements to build political support while laying the groundwork for future change. Salary top-ups, for example, had immediate impact while the effect of expanding training capacity will take time to be realised.

### *Deployment*

Many issues must still be addressed, including the time lag between professional and academic exams, delays in getting new recruits onto payroll; both lead to demoralisation and the loss of recently deployed, recently qualified health staff. In addition, a strategy to incentivise staff to fill challenging posts has yet to be finalised.

### *HIV*

The government has ambitious plans to expand HIV/AIDS related services, but the provision of Anti-Retroviral Therapy (ART) for HIV/AIDS patients was not included in the Essential Health Package when it was originally developed in 2002. There is a danger that implementation of the Essential Health Package will be undermined by scale-ups in other programmes, such as ART and some maternal health interventions that were not factored in either, which have serious staffing implications.

### *Pre-service versus in-service*

Balancing the increase in numbers with improving the knowledge and skills of existing employees needs to be carefully managed.

### *Institutional capacity*

Weak institutional capacity is at the heart of Malawi's human resources situation. Clear guidelines on the roles of the many authorities involved in human resources for health, as well as provisions for management training at all levels, are needed for the coherent implementation of the plan, which requires senior staff commitment from the Ministry of Health.

### *Industrial and cultural relations*

Malawi's experience highlights the impact of industrial relations, both within the health sector and in relation to other sectors. Having a good map of country-specific sensitivities proved crucial to successful implementation at the start of the programme.

### *Additional components*

No strategy has been developed to explore the possibility of recruiting Malawian experts from abroad, or to support Malawians who want to work abroad for limited periods and then return, in a move towards controlled circulatory migration. Both these strategies may have a role to play in addressing the human resources for health crisis.

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### *Interviews*

Interview with Cynthia Rowe, Governance Advisor DFID Malawi

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