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Title
A hidden human resources for health challenge: personnel posting and transfer

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Introduction and outline of methods

Achieving universal coverage requires adequate numbers of skilled health care workers (HCWs) in functioning health facilities. However, in many countries, there are too few skilled personnel in the public sector, and the existing public sector workforce is inequitably distributed. This maldistribution results in part from poor posting and transfer (P&T) practice. Even when governments have P&T policies that are intended to guide the distribution and movement of health personnel, these policies are not always followed. Policy may not be followed because the policies are unknown to those tasked with implementing them, because of management and communication challenges, or because their enforcement would interfere with entrenched informal practices. While further research is required, existing quantitative and qualitative data suggest that irrational P&T practices contribute to maldistribution and absenteeism, undercuts proficiency and health worker morale as well as governmental efforts to improve access and quality. Often, the poorest regions are the most affected by irrational P&T. These challenges are widespread; irrational P&T is prevalent among different cadres of health workers in many different countries (Schaaf and Freedman, 2015; La Forgia et al. 2014).

Given its determinative role in reaching universal health coverage, P&T is a fundamental health systems governance function, necessitating political and resource commitment among stakeholders at sub-national, national, and global levels. Providers and patients on the frontlines of the health system attest to its relevance. Yet, perhaps due to the fact that actual P&T practice often comprises a “parallel system” (La Forgia et al. 2014), and because national level data often fail to capture the actual distribution of health workers, P&T remains largely below the radar in research regarding human

Posting and transfer, or “P&T” encompasses initial health worker and administrator deployment, and subsequent transfers. In general, posting “Irrational P&T” refers to P&T that is inconsistent with population health needs. While a provider obtaining a post in a more desirable area may be rational from the provider’s point of view, it is not rational from the perspective of health system requirements for meeting health goals.
resources for health (HRH). Consequently, the informal rules and patterned practices that constitute such a “parallel system” – although well-known and intimately understood by those workers who participate in it – are rarely seriously considered when opportunities to develop new strategies and policies arise. As the SDG era begins and the Global Workforce Strategy 2030 takes shape, this policy brief aims to consolidate and synthesize existing data about irrational P&T practice, and propose ways to promote P&T as a crucial element of health systems and health workforce stewardship.

This brief is based on a comprehensive literature review to uncover the actual practices and the informal regulations characterizing P&T in LMICs. To do this, we searched Google Scholar and Pubmed for terms related to posting and transfer in the health sector, including “posting,” “deployment,” “turnover,” and “transfer.” We started with a broader review some of us conducted in 2012 (Schaaf & Freedman, 2013), and then added resources published in the intervening 4 years. We consulted both peer-reviewed and “grey” literature, as much of the existing data and conceptual work on P&T and related issues has not been published in peer-reviewed journals. We also consulted relevant global health strategies, particularly the Global Strategy on Human Resources for Health. Though our findings refer to related phenomena, such as maldistribution and absenteeism, we did not conduct separate reviews on these topics. Thus, these phenomena have determinants and implications well beyond the scope of the discussion here.

We also conducted limited academic and grey literature reviews of policy interventions that emerged in the initial review or that were identified as part of an ongoing transnational discussion among researchers and policy-makers on P&T. We looked at approximately ten peer-reviewed articles related to each area; we did not conduct systematic reviews. These areas included transparency in deployment and transfers; public service reform; civil society engagement and social accountability; and the creation of new human resource processes, such as new cadres and emergency hiring.

Findings

HRH-related studies suggest that there may be significant gaps between policy and practice. Actual P&T of health providers and administrators is shaped by individual and health system level factors. Some of these factors, such as urban preference, are well explicated in the retention and HRH distribution literature; others are not. On the individual level, health providers and administrators may have locational preferences for several reasons, including standard of living, proximity to family, access to further education, access to promotion opportunities, opportunities to use one’s skills, opportunities to generate additional licit or illicit income, and access to development projects or other activities that might entail additional income and/or professional support (Blunt et al. 2011; Garimella et al. 2015; Harris et al. 2013; Sakyi 2008; Schaaf and Freedman 2013; La Forgia et al. 2014; Shemdoe et al., 2016; Wurie et al. 2016). Several studies report that providers fear being posted to a rural area, where they can be “forgotten” and overlooked for transfers or promotions. Thus, while some of these workers might be willing to spend two years in a rural area, they may be wary of posts that are theoretically two years, but much longer in reality (Harris et al., 2013; Lindelow and Serneels, 2006; Ramani et al., 2013; Wurie et al. 2016). WHO has developed global policy recommendations on how to address these challenges by increasing retention of health providers in rural areas (World Health Organization, 2010).
For their part, actual decision-makers (who may or may not be the person(s) with decision-making authority per official policy) may have preferences about posting and transfer, related, for example, to a desire to punish a particular worker, to make a dysfunctional system function better, or to ensure that an ally is well-placed (Abimbola et al., 2016; Garimella et al., 2015; Harris et al., 2013; Schaaf and Freedman, 2013).

P&T as it occurs on the ground goes well beyond the negotiation of individual preferences, however. Negotiation can occur in a context of official and informal regulations and incentives, lack of adequate HRH, political patronage and networks, personal networks, and corruption (Abimbola et al., 2016; Garimella et al. 2015; Harris et al., 2013; Ramani et al., 2013; La Forgia et al. 2014; Schaaf and Freedman 2013; Sheikh et al., 2015; Wurie et al. 2016). Thus, P&T is related to the distribution of power at multiple levels of governance. For example, individuals who hold power in a certain context, such as when their political party is in power, may be able to draw upon networks as resources, such as when they pay for a post or rely on a political ally to obtain a desired post (Harris et al. 2013; Schaaf and Freedman 2013). Indeed, in contexts where political figures exert considerable control over the public sector, the distribution of posts and transfers may actually be used as a tool in political contests. Harris et al. describe how, during the constitutional crisis, political parties in Nepal essentially sold posts to generate income. Professional unions were associated with political parties, and they systematically interfered with P&T (Harris et al. 2013). On the other hand, individuals lacking power in a certain context may have little room to negotiate their own or others’ placement, as they are arbitrarily moved to make room for someone else or because they were “forgotten” in a rural area where they were officially supposed to serve for a limited duration (Schaaf and Freedman 2013; Wurie et al. 2016).

Irrational P&T in the health sector has been described in many diverse LMICs, including the Dominican Republic (La Forgia et al. 2014), Ethiopia (Lindelow and Serneels 2006), Ghana (Sakyi 2008), Guatemala (Sheikh et al. 2015), India (Garimella et al. 2015; La Forgia et al., 2014; Ramani et al., 2013), Indonesia (Blunt et al. 2011), Nepal (Harris et al. 2013), Niger (Sheikh et al. 2015), Nigeria (Abimbola et al., 2016), Sierra Leone (Wurie et al. 2016) and Tanzania (Semdoe et al. 2015). National perception surveys conducted by the World Bank with households, businesses, and public officials revealed significant percentages of public officials report that purchasing posts in the health sector was relatively common, ranging from 9% in Benin to 50% in Zambia (Lewis and Petterson, 2009). The scope and breadth of the challenge is likely large, with articles from many other countries obliquely referring to irrational P&T.

Research in other (non-health) domains of the public sector has described irrational P&T, some of which has contributed to the understanding of how P&T may function in the health sector. For example, Wade illuminated the system for purchasing posts in India’s irrigation sector, with the price of posts being based on opportunities to generate income, with an adjustment for the standard of living (Wade, 1985). There are some anecdotal data suggesting that the dynamics of P&T may be different for women. First, women may experience different personal and social expectations around proximity to family (Wurie et al. 2016). Second, they may face greater threats to their physical security in rural areas (Harris et al. 2013; Mkoka et al., 2013; Rao et al., 2010; Shemdoe et al. 2016; Wurie et al. 2016). Third, they are often concentrated among lower level cadres. Existing data suggest that the deployment of many cadres of health care workers and administrators are affected by irrational P&T – from specialist doctors to
outreach workers - with some indications that there are fewer transfers among the lowest level cadres, who are often hired locally (Bonenberger et al., 2014; Harris et al. 2013; Nguyen, 2015; Shemdoe et al. 2016).

While there are sufficient peer reviewed articles that describe irrational P&T, there are no studies or reports that purport to provide prevalence figures for irrational P&T. Moreover, there are few articles that discuss informal P&T practice as a palliative practice of “making do” or as ways to correct staffing problems so that services function better (e.g. ensuring that a surgeon is posted with an anesthetist so that they can work as a team to ensure that safe surgery can happen). One recent article suggests that palliative practice may be significant in certain contexts; qualitative research in Nigeria showed that primary health care managers may redistribute existing human resources to put strong clinicians in sites that were in need (Abimbola et al., 2016). Lack of analysis stems in part from poor quality data. The system in reality may bear little resemblance to the system on paper, with there being people at posts who do not appear in formal statistics, the widespread use of public infrastructure and human resources for private services, and extensive absenteeism (Durham et al. 2015).

It is also important to highlight that P&T practice is overlaid on an official system that may not be capable of addressing population health needs. First, in many countries, even if all health care workers were equitably distributed, the health system would still suffer from inadequate numbers of health care workers. Second, the number and distribution of “sanctioned” or “established” positions may not correspond to population health needs. Thus, P&T can be both a means of exacerbating or of “making do” with inefficient HRH governance and workforce planning (Abimbola et al., 2016; Garimella et al. 2015).

Within the global health community, P&T is a largely unnamed health system governance function, though P&T more broadly is frequently discussed within the public administration world. Given its links to retention, equitable distribution, public administration reform, and corruption, P&T relates to many global and national strategies and policy-setting priorities. The fact that actual practice is often tacit and the fact that irrational P&T is not yet high on policy agendas, means that P&T is rarely explicitly addressed in these forums. Yet, given the increasing focus on HRH governance, health systems, universal coverage and delivery of quality care in the post-MDG era, there is ample opportunity to address P&T.

Discussion

Challenges

1) P&T practices are deeply ingrained

As a health systems governance function that is shaped by individual preferences and health systems attributes, actual P&T practice is deeply embedded and not amenable to “quick fixes” (Sheikh et al., 2015). For example, if obtaining better postings is tied to ability to pay (illicitly) for them, then providers may realign their efforts away from their public sector jobs towards the private practice that can generate revenue (La Forgia et al., 2014). In this context, attempts to better regulate absenteeism or
Dual practice are unlikely to be successful. Indeed, some researchers describe P&T as a “collective action problem” (Harris et al. 2013), i.e., in situations where irrational P&T practices prevail, there is little incentive for an individual to follow the official rules and refrain from participating in the informal, “irrational” system. The person who follows the formal rules will suffer by being assigned to the most undesirable posts, while those who continue to ‘play the game’ will do better.

In these contexts, mechanisms for supervision and accountability might perpetuate irrational practice, rather than disrupt it. For example, personnel evaluations may be perfunctory or biased (Harris et al. 2013; Schaaf and Freedman, 2013), or they may even be predetermined by a P&T decision that was already made (Schaaf and Freedman 2013). Similarly, actors in the system may utilize policies and procedures to their advantage, such as taking medical leave to avoid an unwanted post (La Forgia et al., 2014).

This is not to say that the system is so ossified that there is no subnational variation or that informal P&T is never positive. There are scattered examples of both, although the peer-reviewed literature in this area is slim (Harris et al. 2013; La Forgia et al. 2014). For example, P&T practice may vary significantly among different states in India, perhaps determined in part by degree of health worker scarcity, state-level laws and regulations, and the political party in power (La Forgia et al., 2014). Research in some contexts has found that health workers may ignore official deployment orders to work at adequately staffed facilities to instead work at a facility where they know they are needed. Particular cadres may be more likely to make these “prosocial” choices, even in a context where the majority of health providers overall are part of the P&T “game.” (Phiri et al., nd).

2) P&T is linked to sensitive questions of political power and corruption

Irrational P&T is often linked to broader dynamics of political competition and professional power (Harris et al., 2013; La Forgia et al., 2014; Schaaf and Freedman, 2013; Sheikh et al., 2015). Thus, there are powerful interests in maintaining the status quo, as well as potential stigma or fear in revealing corrupt and illegal practices. This undermines reform as well as research and learning.

3) Difficulties in balancing individual preferences with community needs

Individual health workers and administrators have preferences about where they live. In the context of significant human resource shortages, these preferences frequently clash with the needs of underserved communities. Health workers who lack power can end up languishing in posts they do not want, or be arbitrarily transferred, undermining their morale, professional satisfaction, sense of organizational justice and ultimately, their retention in the workforce (Sheikh et al. 2015). Though it may make short term rural postings more feasible, increasing the absolute number of health workers is likely insufficient to remedy the clash between individual preferences and system needs.

**Action underway and previous efforts: lessons learned**

1) Broad public sector reform
As a cross-cutting issue, efforts to address P&T can be part of a larger reform effort.

Starting in the 1980s, many countries implemented broad public sector reforms that aimed to promote better public sector governance, administrative devolution, enhanced management, customer service, and efficiency (McCourt 2008). These reforms are often guided by New Public Management (NPM), a philosophy and set of policies developed in the 1970s and 1980s in Nordic and OECD nations. A common theme was the transfer of responsibility from the core public sector to ‘agencies’. Key components of ‘agencification’ include the creation of mission-specific agencies, performance-based contracting, and deregulation (Moynihan, 2006). NPM was hypothesized to reduce political influence by distancing an agency from ministries, increasing decision-making autonomy, professionalizing management cadres, using data for planning, and focusing on results through performance contracts. Results have been mixed. For example, in 1997, Tanzania undertook NPM-inspired reforms in order “to create a smaller, affordable, efficient and effective civil service” (Sulle, 2010). However, evaluations highlight the lack of performance-based accountability, weak evaluation systems, and the continuing presence of the traditional civil service system. A lack of political will and commitment and weak public demand for better public services may explain, in part, this hybrid system (Sulle, 2010). On the other hand, more recently, Global Budget Support in Tanzania was conditioned on the improved distribution of nurses and midwives. Over the period assessed, the proportion of districts with 3 or more midwives or nurses per 10,000 improved (Budget Support Partners Group 2014; The United Republic of Tanzania Ministry of Finance, 2013).

Beyond NPM, policy makers have focused on reforming the governmental organizations that are usually charged with designing and implementing P&T across the public sector (often called ‘Public Service Commissions’ or ‘Civil Service Commissions’). These bodies were generally created to ensure fair and consistent recruitment, posting, and transfers. For example, in 2001, Sri Lanka’s constitution was amended to halt the ruling party’s influence in the Public Service Commission and permit involvement from opposition political parties (Parliament Secretariat, 2008). In Namibia, government posts are publicly advertised, and the Public Service Commission oversees appeals by individuals denied civil service appointments (McCourt, 2007). In Mauritius, civil sector employment has transitioned from focusing on ethnic group representation to merit (McCourt, 2006). These reforms suggest that there are a variety of policy options that may distance a Public Service Commission from political interference.

As is contextually appropriate, other labour and auditing authorities might be engaged to promote accountability between government agencies, and thus, stronger HRH governance (La Forgia et al. 2014). In some countries, Ministries of Labor or Local Government or auditing or ombuds institutions might be engaged productively to improve the P&T oversight process, particularly when the Public/Civil Service Commission is functioning poorly. For example, civil servants in Tanzania have brought disciplinary appeals to the ombudsman (Bana and McCourt, 2005).

2) Transparency
Given that whole system public sector reform is an ambitious and politically challenging undertaking, many propose ‘within system’ solutions.

For example, health care providers and administrators, researchers, and international agencies, including the World Bank, have advocated transparent recruitment and deployment (Henersen and Tulloch 2008; Manongi et al., 2006; Mathauer & Imhoff, 2006; Schaaf and Freedman, 2013; Lewis and Pettersson 2009). The draft WHO Health Workforce 2030 Strategy recommends transparent HRH regulatory mechanisms (WHO, 2015). Indeed, transparency is widely considered to be an integral attribute of robust health systems governance (Lewis and Pettersson, 2009; Siddiqi et al., 2009), and essential to development more broadly (UNDESA, UNDP, UNESCO, 2012). Some countries, particularly some states in India, have tried to introduce greater transparency into the process.

In the Indian state of Tamil Nadu, a ‘counselling’ procedure has replaced many mechanisms of the traditional posting and transfer process. Under the revised system, promotions are largely based upon seniority, and there is a transparent process of advertising vacant positions and explaining transfers (Schaaf & Freedman, 2013). Eligibility for transfers is determined by a transparent, detailed set of personal and district-specific characteristics. Counselling appears to have undermined parallel systems, due in part to strong leadership in the health department and a committed and powerful physician association (La Forgia et al. 2014). Yet, to some extent, health care worker maldistribution continues. In 2011, a division bench of the High Court ordered the government to repeat the counselling and transfer process for over 100 physicians, citing shortages in some areas. (“Government told to transfer doctors again - IBNLive,” 2011). La Forgia et al. studied a reform in a different – unnamed – Indian state, and found that “the incidence of de facto parallel HRM practices….where there is more specification of rules and processes… and special units to enforce disciplinary practices… displays only marginal differences from a pre-reform context” (La Forgia et al. 2014). It appears that high level commitment and capacity to implement this ‘within system’ reform is key.

3) Civil society monitoring

Civil society engagement in monitoring the delivery of government services is often recommended as one way of improving health systems governance (Lewis and Pettersson 2009; La Forgia et al., 2014; Lodenstein et al. 2013). In regards to healthcare worker posting and transfer, community monitoring most frequently entails tracking and reporting the related phenomenon of absenteeism and, in one example, transfers.

Several programs in Uganda and India have equipped citizens to monitor health centers and report provider absences. A variety of outcomes - ranging from lower absenteeism to no change - have been reported. Community members in Rajasthan, India were compensated for monitoring nurse-midwife attendance at a government health clinic. While individuals accurately recorded the absence rate, communities did not implement sanctions for absent workers, and absenteeism did not decrease, relative to a comparison area (Banerjee & Duflo, 2006). Similarly, in Udaipur, India an NGO monitored nurse attendance through unannounced visits and time/date stamping machines. While the program initially reduced absenteeism (compared to a control group), administrative changes from the local government weakened the program, leading to a rebound of absenteeism (Banerjee, Glennerster, & Duflo, 2008). In both instances, healthcare worker behavior was characterized by seemingly random,
non-predictable patterns of attendance and absence, as opposed to rejection of the assignment and total absence from the post. The sporadic presence of a healthcare worker may be more easily monitored by a community. However, if they have data on the number of providers who have been posted to a facility, communities should be able to monitor and report the complete non-appearance of workers as well.

In Uganda, similar programs had somewhat positive outcomes. A randomized field experiment enabled communities to determine priority health issues and monitor local facilities based on these priorities; compared to a control facilities, absences decreased, utilization of health services increased, and a wide variety of health outcomes improved (Bjorkman & Svensson, 2009). In northern Uganda, citizens used a toll-free number to report health center issues, including staff absences and “uncoordinated health workers transfers without replacement.” An evaluation conducted by the implementing agency concluded that the program led to a 30% decrease in staff absence, compared to pre-program figures (“ICT 4 Health Service Delivery: Project Results,” n.d.).

While it would be quite difficult to envision a community monitoring program addressing P&T in its entirety, the examples above addressed important manifestations of irrational posting. These community monitoring programs are consistent with the participatory principles of the SDGs (specifically, Targets 16.6 and 16.7). However, they may have to contend with several challenges that undercut citizen participation and program effectiveness, including citizen distrust and reluctance to engage with the health system, lack of citizen ability to levy sanctions, and lack of adequate knowledge about health system standards (Fox 2015, Dasgupta et al. 2015). For their part, health providers may feel that the community is inappropriately ‘policing’ them (Wurie et al. 2016). Integrating opportunities for trust and relationship building between communities and providers may be crucial to enabling accountability (Brinkerhoff, 2004; Gilson, 2003). Moreover, transparency programs are argued to be more effective when integrated into existing decision-making structures (McGee, 2014). As such, programs that streamline data into an operating system may be more successful.

4) Routine and extraordinary human resource interventions

Conventional best practices in human resource management have sometimes effected improvements in HRH. Such practices may include improving HR information systems, audits to identify ghost workers, supportive supervision, performance management, streamlined recruitment procedures, and career and development reviews (Waters et al., 2013; Badr et al., 2013; Hastings et al., 2014; Riley et al., 2012). While these techniques are widely regarded as necessary for overall organizational success, their ability to counter irrational posting and transfer practices depends upon multiple factors. First, they need to be fully implemented and integrated into existing decision-making routines. A systematic review of human resource information systems found that few countries actively used the information systems for staffing decisions (Riley et al., 2012). Second, existing political support and receptive staff are necessary for reforms to take root. This can be a challenge in contexts where there is interest among both political actors and health providers to maintain the status quo of irrational P&T. Unions may present a formidable obstacle to reform (Harris et al., 2013). On the other hand, it has been argued that some HR reforms (particularly supportive supervision) can garner effective political support, as politicians can easily understand the impact of supervision on organizational function (Rowe, de Savigny, Lanata, & Victora, 2005). Qualitative research in Kenya and Benin identified weak or non-functioning management structures (particularly supervision structures) to be related to staff motivation and self-
efficacy. Thus, if management reforms respond to the perceived needs of staff on the ground, then staff may embrace such reforms (Mathauer & Imhoff, 2006).

Due in part to the challenges in fully implementing best practices in human resource management, some countries have opted for special or emergency staffing procedures. The intent is to circumvent challenges inherent to national hiring protocols. Kenya, Malawi, Senegal, and Namibia have implemented unique programs characterized by financial incentives, greater staff flexibility, and the use of foreign healthcare workers (Gross et al. 2010; Collins and Perry, 2010; Zurn et al., 2010; Frelick and Mameja, 2006). There have been varying degrees of sustained success within these programs.

Beginning in 2005, an Emergency Hiring Plan (EHP) was instituted in Kenya to quickly hire, train, and deploy previously unemployed nurses to areas experiencing a high disease burden and reduced workforce (Gross et al. 2010). Working with the Kenyan Ministry of Health, Deloitte & Touche Kenya supervised recruitment, deployment, and payroll responsibilities, while the African Medical and Research Foundation, the Kenya Medical Training College, and the Kenya Institute of Administration assisted with training (Gross et al. 2010). Nurses were recruited from geographic areas experiencing staff shortages, thus reducing long-distance deployments (Adano 2008). After one to three years of donor-funded contracts, nurses were integrated into the Kenyan MOH system. The average recruitment time decreased from approximately 12 months to less than 3 months. After three years, 94% of the EHP nursing staff were retained in the program; qualitative interviews suggest that nurses recruited locally were motivated to remain at their post (Fogarty et al. 2009). Facility data demonstrate that, following EHP, family planning, HIV, and child health services were offered more frequently in health clinics, as compared to the pre-deployment period (Fogarty et al. 2009).

Emergency and special hiring procedures address healthcare worker postings in rural areas without modifying existing legislation on hiring and transfer. These temporary programs have clear policy implications. First, the programs have focused national attention on professional human resources departments, routine HRH planning, and leadership development (Fogarty et al. 2009). Successful elements from the hiring programs (recruitment from rural areas, special financial incentives) may be incorporated into permanent policies.

Policy Options

1. Improve health worker deployment as a core system function, particularly in the context of strengthening public sector health systems. This involves advancing norms for effective and accountable workforce deployment that build on promising practices on the ground and on professionalism among providers. In other words, rather than creating new policies that may encounter fierce resistance and implementation challenges, reformers might seek to identify and expand promising practices and professional norms. These may be expanded using problem driven iterative approaches, which entail learning by doing and local level experimentation (Andrews, Pritchett, and Woolcock, 2013). For example, empirical evidence suggests that commitment to serving patients and the community can be – though is not always - widespread among health workers (Ramani et al. 2013; Saini et al., 2011; Shemdoe et al., 2016; Wurie et al., 2016). The pervasiveness of these sentiments suggests
that health workers would be willing to serve in rural areas – if they knew it was time bound. Working with unions and health care workers to leverage these values for reliably short-term rural postings might dilute the resistance to rural postings.

2. Introduce direct accountability to communities around HW deployment, rather than looking at deployment only as a top down function. Engage existing decentralized and local governance mechanisms that are accountable to local communities in the local deployment and, where relevant, monitoring of health workers. As described, many of the top down efforts to reform P&T and the public sector more broadly have faced significant resistance. Bottom-up community monitoring and accountability approaches address some of the intractable determinants of irrational P&T. For example, Village Health Committees, Facility Committees, locally elected officials, and other entities can be engaged in addressing absenteeism and other P&T related concerns. Health systems should be accountable to people for the delivery of responsive, equitable services, and communities should have a say in who serves them.

3. Work with national and provincial/state labor departments, Public/Civil Service Commissions, and other related bodies. As noted, policies regarding public sector recruitment and P&T are often made by labour authorities. Yet, in general, there is inadequate expertise about the particularities of the health sector among those making guidelines on public sector recruitment and P&T, and vice-versa (McCourt, 2008). Health actors, such as MoH officials, international organizations, and NGOs, may not engage broader authorities in public administration. Yet, P&T practices should be fit-for-purpose for the health sector. Issues such as skill mix, retention in rural areas, gender-specific security concerns, and access to further education may be considered by revised P&T guidelines. In brief, collaboration across health-specific and broader public administration actors could improve P&T related policies and practice.

**Implementation considerations**

- There are little data about actual P&T practice, and in some cases, little transparency about formal P&T policies. Effective HRH information systems would be the most effective way of learning about the actual distribution of the workforce and informing reforms. In the absence of such systems, national and subnational data gathering may be advised in certain contexts. Data collection is challenging due to the hidden nature of prevailing practices. Partly for this reason, bottom up approaches may be particularly appropriate.
- In some contexts, actual P&T practice may be linked to political factors and not openly discussed. Any efforts at assessing the situation and proposing reform will need to navigate these challenges.
- HRH-related strategies and programs are an important site for addressing P&T. However, again, depending on the context, anti-corruption strategies, community participation strategies, broad public sector reform efforts, and other development initiatives may need to explicitly engage the actual dynamics of P&T practice.

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