Human Resources for Health Country Commitments:
Case Studies of Progress in Three Countries

August 2014
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FOREWORD

This paper, *Human Resources for Health Country Commitments: Case Studies of Progress in Three Countries*, was developed for The Health Workforce Advocacy Initiative (HWAI) by IntraHealth International (HWAI secretariat) and supported by the Bill & Melinda Gates Foundation via the Frontline Health Workers Coalition.

As an international civil society network addressing the global health workforce crisis, HWAI amplifies the voice of civil society to influence human resources for health (HRH) strategies and policies at the global and national levels. HWAI works in collaboration with the Global Health Workforce Alliance (GHWA) to advocate for actions to address human resources for health (HRH) challenges, including and beyond the health-related Millennium Development Goals, and for universal health coverage. HWAI advocates for stronger HRH policies on the global, regional, and national levels and informs issues such as migration, HRH financing, and HRH integration through its topical working groups.

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**Malawi:** Maziko Matemba prepared the Malawi case study. Special thanks are due to representatives of the following stakeholder agencies for taking the time to participate in interviews: the Ministry of Health and Ministry of Finance, the World Health Organization (WHO), the United States Centers for Disease Control and Prevention (CDC), the US Agency for International Development (USAID), the United Kingdom Department for International Development (DFID), the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), VSO International, and the Clinton Health Access Initiative (CHAI).

**Senegal:** Cristina Bisson prepared the Senegal case study with financial support from IntraHealth. The authors are grateful to Mr. Soukandella Diouf, head of health workforce management in the Ministry of Health, who organized all stakeholder interviews, and to Dr. Moussa Dia of IntraHealth, who facilitated the interviews and provided documentation and references.

**Uganda:** Heather Teixeira (IntraHealth) prepared the Uganda case study. Special thanks go to Dr. John Odaga, consultant to the Uganda CapacityPlus project, for his insight and assistance in arranging interviews, as well as Dr. Vincent Oketcho, chief of party for the Uganda CapacityPlus office. The authors would also like to thank all of the key stakeholders interviewed for their valuable time and insights.
**EXECUTIVE SUMMARY**

Health outcomes depend on health workers, who offer a broad range of services. More than 80 countries across the globe do not have enough doctors, nurses, and midwives to reach the WHO’s recommended minimum of 22.8 health workers per 10,000 population to provide basic health services. This is a crisis level shortage.

In recognition of the magnitude of the health workforce crisis, the Global Health Workforce Alliance (GHWA), in coordination with the World Health Organization (WHO), the government of Brazil, and the Pan American Health Organization (PAHO), convened a high-level health conference in Recife, Brazil in November 2013—the Third Global Forum on Human Resources for Health. During the conference, over fifty WHO member state governments made public, political commitments to strengthen their country’s health workforce. This report tracks the progress made to meet the commitments in three countries: Malawi, Senegal, and Uganda.

**Malawi**

There are shortages of nearly all cadres of health workers in Malawi, with just one doctor for every 70,000 Malawians, and 51% of general doctor positions unfilled. These shortages are exacerbated by the unequal distribution of health workers, with most choosing to work at central and district hospitals, leaving severe shortages in rural areas. Malawi’s Recife commitment is robust and focuses on: Human Resources for Health (HRH) funding, planning, and management; collaboration; education of health professionals; incentives for health workers; and building capacity at the Ministry of Health to deliver essential health services. Malawi has made progress toward meeting its commitment on several fronts:

- Stronger education for health workers
- Improved HRH management: the government completed an audit of civil servants working in health in early 2014, and district health management teams are receiving additional training
- Active civil society organizations: CSOs are influencing the development of stronger health workforce policies, including the recruitment policy for rural areas.

However, barriers to progress exist. The major obstacle identified in Malawi is lack of coordination between development partners and the Ministry of Health in monitoring health workforce initiatives.

**Senegal**

Senegal also suffers from health worker shortages, with doctors, nurses, and midwives all numbering below the WHO’s recommended minimum. Senegal’s HRH commitment made at Recife focuses strongly on the need for more health workers in underserved and rural areas, and outlines plans to better attract health workers to these areas. It also includes the goal of a “massive” recruitment of health workers by 2015.
To date, discussions have taken place to begin formulating an action plan and to create an HRH technical working group. Additionally, the Ministry of Health has:

- Committed in 2013 to the recruitment and training of 1,000 new health workers.
- Required health workers to respect the legal hours of health facility operation (8 a.m. to 5 p.m.) as opposed to the abbreviated hours (9 a.m. to 3 p.m.) previously observed.

However, major barriers remain: political will and planning are strong in Senegal, but implementation is weak. While Senegal has made strides in training more health workers, few health workers are able to find acceptable positions in the government health system. Senegal’s public sector health system did not recruit any new health workers at all for the seven-year period from 2004-2011.

**Uganda**

Uganda also suffers from a severe health worker shortage, with only one health worker for every 600 people. However, Uganda’s HRH commitment made at Recife builds on preexisting political will. In the past decade, Uganda has tripled the number of medical schools and increased the number of annual graduates from 120 to 300. In 2012, Uganda’s national budget allocated increased funding for health workers allowing for significant health worker recruitment.

The Uganda HRH commitment focuses on four critical areas: availability of health workers, especially cadres in scarce supply; attraction of health workers; productivity; and coordination with the private-not-for-profit sector.

Uganda has made strides toward policy change called for in the commitment. A fully-costed plan for meeting the commitment has been designed and presented to the Ministry’s Health Policy Senior Committee, and funding has been allocated in the 2015 budget for building residences for health personnel, a key measure to attract workers to rural areas. Barriers to progress do remain, especially around funding. Health nationally ranks below other priority areas like electrification for the Ugandan government, and donor funding is uncertain.

**Recommendations:**

Across all three countries, stakeholders interviewed suggested some core recommendations. These include:

- Strong civil society, able to hold governments to account on their commitments.
- Strengthened political will for HRH, both in terms of funding and implementation of existing policies.
INTRODUCTION

The Third Global Forum on Human Resources for Health—which took place in Recife, Brazil in November 2013—provided a fantastic opportunity to review the progress of the global HRH movement and incite further action. With over 1,800 participants and attendees from 93 member states, including over 40 ministers and deputy ministers, the Forum was the largest-ever global assembly focusing on human resources for health. During the event, the message that the health workforce is central to achieving universal health coverage (UHC) echoed loudly. The vital importance of HRH was evident in country representatives’ adoption of the Recife Political Declaration on Human Resources for Health and their development of specific country commitments to achieve global health goals.

The Forum represented a key milestone toward building sustained recognition of the essential role of the health workforce. Increasingly, global and national leaders understand that solid investments in the health workforce lead to greater availability of quality health services and more equitable coverage. Ultimately, these investments will not only accelerate achievement of the Millennium Development Goals (MDGs) but also spur progress toward realization of UHC and the four WHO pillars of availability, accessibility, acceptability, and quality.

Human Resources for Health Challenges

Over the past decade, HRH progress has been made. Challenges persist, however, including:

- Shortages of some categories of health workers, with more shortages forecast: 100 countries fall below the threshold of 34.5 skilled health professionals per 10,000 population, and the global deficit is estimated to rise to 12.9 million midwives, nurses, and physicians by 2035
- An aging health workforce and replacement challenges
- Skill-mix imbalances
- Wide variation in HRH availability and accessibility within countries
- A lack of tailored education content and strategies
- A need for strategies to motivate health workers and foster enabling work environments
- Insufficient prioritization of performance and quality assessment
- Variable capacity to estimate future needs and design longer-term policies
- Lack of systems for reliable and updated HRH information and data.

-Report of the Third Global Forum on Human Resources for Health
Now—nine months after the Third Global Forum—it is a good time to take stock of the commitments made in Brazil and to ask:

- What is the status of the HRH country commitments?
- What actors, partners, and donors are involved in supporting HRH commitments?
- What enabling factors lead to further action behind country commitments?

This paper examines progress in three countries (Malawi, Senegal, and Uganda), drawing on face-to-face interviews with over 30 stakeholders and partners. The case studies provide insights into key factors moving HRH country commitments toward operationalization and highlight the vital role of civil society organizations (CSOs) in pushing the HRH agenda forward. We hope that the paper will serve as an advocacy tool to advance implementation of country commitments, foster development of policies to strengthen the health workforce, and disseminate recommendations about the part that CSOs and networks such as HWAI can play in ensuring ongoing attention to health workforce issues and needs.
MALAWI

Health Workforce Context

The shortage of trained health workers is the most significant barrier to improving health status and achieving the three health-related MDGs. Although the number of health workers posted has increased since 2009, current staffing levels still do not meet minimum requirements to support the health care system. There are shortages of nearly all cadres, with just 1 doctor for every 70,000 Malawians (Ministry of Health/Malawi 2012). In 2010, there were 0.24 nurses and 0.016 generalist doctors per 1,000 population (Republic of Malawi 2010), below the WHO-recommended threshold of 2.28 health care professionals per 1,000 population (WHO 2006). Half (51%) of general doctor positions remain unfilled, along with 80% of specialist doctor positions and 68% of nurse technician positions. These shortages are partly due to the failure to train adequate numbers of health workers but are exacerbated by challenges with retention.

Health workers are disproportionately located at the central and district hospital levels. This means that rural areas—where 80% of the population lives—are underserved, and primary or community-based services are not always available. Health workers find little reason to work in rural areas due to inadequate housing and lack of incentives. But the reality is that rural areas are where services are needed most.

As a consequence of health workforce shortages, task shifting has become a necessity but does not always follow national policy. For example, clinical officers, medical assistants, registered nurses, and nurse/midwife technicians (NMTs) deliver most district health services, although these would ordinarily be provided by qualified doctors or specialists. Similarly, the health workers known as health surveillance assistants (HSAs) provide some services that, according to policy, should be delivered by more highly trained health workers (see box).

Malawi lacks capacity in HRH planning, management, training, development, and leadership—including implementation of structural, management, and policy-related reforms. More partnerships as well as monitoring and evaluation at all levels are needed. The lack of evidence-based planning impedes the country’s ability to project long-term HRH needs.

Task Shifting in Malawi

Health surveillance assistants (HSAs) receive 6-12 months of on-the-job training to carry out disease surveillance. Increasingly, HSAs also provide immunization and other services. HSAs account for over 60% of facility-level Ministry of Health staff, although no regulatory body recognizes the HSA cadre. While task shifting is suitable in many cases—certainly when there is a critical shortage of trained health workers—there is concern that HSA competencies and supervision are inadequate to support their increased service delivery responsibilities. This situation has an impact on the quality of health services.
HRH Country Commitments
The development of HRH commitments involved a number of stakeholders—spearheaded by the Ministry of Health—including the Health and Rights Education Programme (HREP), the Christian Health Association of Malawi (CHAM), WHO, DFID, German Technical Cooperation-Malawi (BMZ/GIZ), CHAI, and USAID. The commitments evolved after stakeholders analyzed health workforce gaps and identified weaknesses in the Human Resources Strategic Plan.

HRH Country Commitments: Malawi
1. Ensure adequate funding to scale up the health care workforce.
2. Enhance HRH planning, development, and management among all HRH institutions, including CHAM, through the introduction and strengthening of HRH management principles and structures.
3. Build the capacity of human resources for health at the institutional (governance/regulation), organizational (Ministry of Health, accreditation bodies, teaching hospitals), and individual levels.
4. Strengthen the collaboration between the Ministry of Health HRH department and regulatory bodies (e.g., Medical Council of Malawi, Nurses and Midwives Council of Malawi, Pharmacy and Poisons Board).
5. Produce an appropriate number of tutors with required qualifications in conjunction with larger student intakes and facilitate their continuing professional development.
6. Enhance the effectiveness of the Malawian human resources information system (HRIS) through the introduction of a web-based, performance-oriented integrated HRIS.
7. Ensure quality of care through the introduction of an efficient performance appraisal system for health personnel, within both public and private health facilities (e.g., CHAM).
8. Deploy health workers in accordance with WHO staffing norms for health institutions, and in line with established geographical human resources needs.
9. Create incentives for health workers in rural and hard-to-reach areas to enhance equity in the distribution of health personnel.
10. Enhance mutual accountability between the health workforce and civil society organizations and community stakeholders.
11. Strengthen the capacity of the Ministry of Health to deliver its essential health package through the use of technical assistance.
HRH Progress

Regarding HRH funding (*commitment #1*), donor support for provider training has increased for several cadres. Donors include the East, Central, and Southern African (ECSA) Health Community; CDC; the Nursing Education Partnership Initiative (NEPI) funded by PEPFAR (President’s Emergency Plan for AIDS Relief); EGPAF; and the Norwegian government. Some highlights:

- The CDC aims to train 1,266 new providers (nurses and midwives) over a five-year period and invest in reconstruction and maintenance of some training colleges.
- Norwegian government support is targeting tutor training and clinical instructors for selected training institutions.
- EGPAF is supporting nurse and medical assistant training in seven districts. Rural community members (chiefs and members of local development committees) select students who receive scholarship support to study and are then deployed to work in their communities of origin.

Several activities address HRH management (*commitment #2*) and capacity (*commitment #3*). The government completed an audit of civil servants in government health facilities in early 2014, and a similar audit of CHAM facilities is planned. Capacity building for the Ministry of Health is also underway. District health management teams are receiving leadership and management training from Support for Service Delivery Integration (SSDI) in the Northern and Southern regions and from EGPAF (with technical input from the University of Cape Town) in the Central region. Training for senior Ministry of Health managers is also envisioned.
The NEPI program is supporting tutor training and clinical instructors at Kamuzu College of Nursing (commitment #5). Clinical instructors are also being trained. An improved incentive package for rural workers (especially nurses/midwives and HSAs) may be forthcoming after the July 2014 budget session (commitment #9). A web-based integrated human resources information system (HRIS) has been rolled out to districts in the Central and Northern regions after a successful pilot, with plans to scale up the system to Southern districts (commitment #6).

There has been substantial increased accountability from civil society to help ensure political will for a strong health workforce (commitment #10). HREP and the National Organization of Nurses and Midwives of Malawi (NOAM) are advocating for development and implementation of robust HRH policies. Civil society was particularly effective in advocating for changes to the policy guiding training for underserved and hard-to-reach areas. This type of training now selects trainees from the communities where they will work after graduation.

Decentralization is a core component of the Ministry of Health strategy to improve health worker efficiency, although the administrative shifts that accompany decentralization are a work-in-progress. The Ministry of Local Government has issued an establishment warrant with guidelines for district-level decentralization, but challenges remain with regard to infrastructure, office space, qualifications of personnel, and payroll disbursement at the district level.

Overall, the HRH country commitments have played a clear role in influencing HRH national policy. The recruitment policy for rural and hard-to-reach areas now includes local and civil society perspectives. Decentralization of HRH decisions is moving ahead, which will support improved performance assessment and deployment. Finally, a policy concerning task shifting in hard-to-reach areas is being discussed to strengthen the community health workforce and address UHC goals on equity and quality of care.

**HRH Commitments in the Context of Universal Health Coverage**

The primary strategy to align the HRH country commitments with UHC is to create incentives for health workers in rural and hard-to-reach areas to bring about a more equitable distribution of the health workforce. The Ministry of Health, in partnership with EGPAF and Doctors Without Borders, is creating incentive packages and tools to retain health workers in hard-to-reach areas. In additional, CHAM—which provides about 35% of Malawi’s health care—is reviewing its incentive policies for hard-to-reach areas. Plans are underway to deploy more clinical officers to rural areas, and CHAM is tracking the number of health workers in hard-to-reach areas.

**Barriers**

A major barrier to achieving the HRH country commitments is poor coordination between partners and the Ministry of Health in monitoring implementation of health workforce initiatives. The ministry’s HRH Department does not have earmarked financial resources to regularly monitor HRH partner activities or partner adherence to commitments. Government needs to take a leading role by providing adequate financing to follow up on implementation of HRH commitments. Most HRH partners follow their own monitoring frameworks.
CSO Engagement

CSOs were the driving force in promoting the development of HRH commitments and HRH policies and guidelines. Moreover, CSOs are monitoring progress through the HRH technical working group and supporting HRH financing through involvement in discussions about the HRH share of the national budget. Civil society was active in organizing advocacy activities during 2014’s health worker week. Moving forward, civil society has a variety of roles to play:

- CSOs can continue to engage in debates about the share of public funds allocated to the health sector.
- Civil society is also well placed to ensure that resources are equitably allocated to the areas with the greatest need.
- Civil society can serve as a watchdog, making sure that allocations for local primary health care services are not misappropriated or misdirected to benefit tertiary hospitals.
- Civil society can advocate for a more equitable health workforce and challenge strategies that would create separate risk pools for more privileged groups.

Recommendations

To consolidate existing gains and sustain momentum, we share five recommendations:

1. **Continue involving civil society in the implementation of the HRH commitments.** Building civil society’s capacity to engage in strengthening the health workforce could include the creation of a platform for CSOs working in HRH, including organizations that collaborate with the HRH technical working group and those advocating for national HRH policy formulation and implementation to ensure a strong health workforce for all.

2. **Maintain the Ministry of Health’s strong leadership role.** Adhere to the HRH commitments made in Recife, as reaffirmed in February 2014 by ECSA health ministers.

3. **Seize opportunities to keep HRH country commitments on the regional HRH agenda.** For example, progress on achieving HRH country commitments should be an agenda item at meetings of the ECSA Directors’ Joint Consultative Committee.

4. **Ensure that Ministry of Health partners adhere to the HRH country commitments.** This can be accomplished by sharing interventions that partners are implementing and jointly supporting all efforts to monitor and strengthen the health workforce.

5. **Update the HRH technical working group on progress.** The Ministry of Health should share updates about the country commitments during the group’s regular meetings.
SENEGAL

Health Workforce Context

Senegal’s public sector health workforce totals 14,463 health workers spanning various cadres (Ministry of Health & Medical Prevention 2009). (Community health workers are not recognized government providers but receive ad hoc and unregulated in-service training.) According to the National Health Development Plan 2009–2018, the country requires 17,173 providers to meet needs until 2018. *The State of the World’s Midwifery 2014* report (UNFPA 2014) confirms the shortage of skilled health personnel, including midwives and specialists (e.g., obstetricians, anesthetists, pediatricians). As of 2009 (WHO 2009), the health workforce coverage was:

- 1 doctor per 12,373 habitants (versus recommended standard of 1 per 10,000 habitants)
- 1 nurse per 4,320 habitants (standard = 1 per 3,000)
- 1 midwife per 2,426 women of reproductive age (standard = 1 per 300).

Government health workers deliver services through a system of regional hospitals, district health centers, health posts, and, at the lowest level, health huts (staffed by one or two health agents and a midwife). However, there is only one hospital for every half million inhabitants, one health center for 152,492 inhabitants, and one health post per 9,953 inhabitants (Ministry of Health/Senegal 2009).

From 2006-2009, Senegal produced 559 doctors and 3,155 paramedical professionals. However, the public sector does not absorb all health workers who complete preservice training. Unemployment among key cadres (doctors, nurses, midwives) is high. Some providers leave the public sector to work in the weak private sector or with nongovernmental organizations or CSOs. After a seven-year period (2004–2011) in which the government recruited no new providers at all, government recruitment is increasing. In 2012, the government recruited 500 providers and, in 2013, committed to 1,000 additional providers. Even with recruitment on the upswing, however, turnover averages approximately 200 health workers per year.

Clément Tardif, courtesy of IntraHealth International
Health worker shortages have given rise to task shifting. Midwives’ role now includes emergency obstetric and newborn care and family planning services, while nurses are transitioning from nursing to midwifery roles. Responsibility for contraceptive supplies and logistics has shifted from health workers to private sector logisticians (Daff et al. 2014).

**HRH Country Commitments**

Senegal’s delegation to the Third Global Forum was led by Mr. Soukandella Diouf, head of health workforce management at the Ministry of Health, along with key government stakeholders. Representation was funded by the Japan International Cooperation Agency (JICA). The HRH country commitments are aligned with Senegal’s National Strategic Plan for the Development of HRH 2009-2018. Prior to the Global Forum, the Ministry of Health held a two-day planning meeting to examine the national HRH plan and formulate draft HRH commitments.

**HRH Country Commitments: Senegal**

1. Increase the quota of military/paramilitary personnel assigned to the health professions, with emphasis on female personnel, to compensate for the lack of health workers in remote areas.
2. Allocate additional resources to local government to enable recruitment of at least two health professionals per year for three years.
3. Assign health workers to difficult areas over the next three years to ensure that maternal and child health care is a priority.
4. Arrange health services to improve their productivity, by extending facility hours in accordance with 2014 regulations.
5. Expand current results based financing at all health facilities from 2016.
6. Establish incentives for providers working in difficult areas continuously, with “difficult” defined as isolation, conflict, or distance.
7. Strengthen governance at health facilities (continuous).
8. Increase the number and amount of educational scholarships to specialist doctors to make training more attractive and have sufficient expertise in all areas from 2014.
9. Complete a massive recruitment of health personnel (at least 5,000) by 2015.
Senegal has also made global commitments to women and children. The Senegal Every Woman, Every Child commitment (2011) states that Senegal commits to increasing its national health spending from 10% of the budget currently to 15% by 2015. It also proposes to increase the budget allocated to maternal, newborn, and child health (MNCH) by 50% by 2015.

**HRH Progress**

Most stakeholders reported being aware of the HRH country commitments, although the commitments had not yet been formally shared and transformed into an action plan. One fear is that the commitments remain a broad advocacy statement and border on being a slogan rather than a tool for true alignment with national HRH policies and UHC strategy. Nonetheless, discussions are underway to formally share the commitments, develop an action plan, establish a mechanism to track the commitments, and possibly form an HRH technical working group. Financial constraints affect Senegal’s ability to attain the HRH commitments, given the reliance on donors for health workforce support. Major donors supporting

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**Senegal’s Commitments to Women and Children**

The country commits to improving coordination of MNCH initiatives by creating a national directorate for MNCH, reinstating the national committee charged with implementation of the multisectoral roadmap for the reduction of maternal and child mortality, and accelerating the dissemination and implementation of national strategies targeting a reduction of maternal mortality. Through these efforts, the government hopes to offer a full range of high-impact MNCH interventions in 90% of health centers, increase the proportion of assisted deliveries from 51% to 80% by increasing recruitment of state midwives and nurses, and increase the contraceptive prevalence rate from 10% to 45%, among others.
HRH include The Global Fund, USAID, the World Bank, and JICA. At present, the health budget line is 10% of the national budget, targeted to increase to 15%. There are discussions about having the additional 5% be allocated solely to HRH.

The government committed in 2013 to the recruitment and training of 1,000 new health workers, including 500 midwives (commitment #9). Increased demand for some services has also prompted the Ministry of Health to require health workers to respect the legal hours of health facility operation (8 a.m. to 5 p.m.) as opposed to the abbreviated hours of operation (9 a.m. to 3 p.m.) previously observed (commitment #4). The increased demand came about in part due to recent policy changes that eliminated user fees for preventive and curative services for children under five to increase access to services.

Furthering recruitment and deployment efforts (commitments #2 and #9), Senegal has begun to use an HRIS. A system was piloted in two regions in 2013; in July 2014, training for the HRIS was brought to scale for all regions. The HRIS, supported by USAID, tracks public-sector health workforce recruitment and deployment, and projects health care needs. These projections are not based on population size or WHO standards (provider per inhabitant) but rather on numbers of providers for each health structure according to national policy.

Senegal’s HRH progress is evident in family planning, which is experiencing a significant upsurge. The political will for family planning is nationally palpable and internationally recognized, as evidenced by an award given to Dr. Bocar Daff (the ministry’s reproductive health manager) at the 2013 International Conference on Family Planning. The ministry’s ambitious goal is to increase prevalence from 16% to 27% through a variety of effective innovations. These include a recently launched National Strategic Plan for Family Planning Promotion; nationwide scale-up of the Informed Push Model (IPM); and introduction and approval for Sayana® Press injectable contraceptives. These innovations are working. The IPM initiative, a Bill & Melinda Gates Foundation-supported supply and logistics project implemented by IntraHealth, uses a push system to ensure zero stockouts, while supporting government cost recovery and successfully shifting supply and logistical tasks from providers to logistics specialists (Daff et al. 2014). The project is an excellent example of integration of HRH policy changes (task shifting) with family planning goals.

“In Senegal, we are bringing women greater contraceptive choices through the innovative Informed Push Model of product distribution. Now more women can trust that the contraceptive method that best meets [a woman’s] needs will be available every time she needs it.”
—Dr. Awa Marie Coll-Seck, Minister of Health

**HRH Commitments in the Context of Universal Health Coverage**

Senegal is making strides to embrace UHC, as evidenced by its hot-off-the-press Strategic Plan for the Development of Universal Health Coverage (2013–2017). Although there are elements of convergence between the national strategic plans for HRH and UHC, there is room for
The Four Elements of Senegal’s UHC Plan

1. Institutionalize a national insurance system for the sick.
2. Develop basic UHC through community-based insurance schemes.
3. Strengthen existing policies for free health services.
4. Implement new initiative providing free care for children under 5 years.

improvement. For example, the ambitious UHC strategy does not include the HRH projections needed to reach UHC, nor does it explicitly reference the national HRH strategic plan. One interviewee observed that the notion of UHC is “respectable” but the reality of achieving it is difficult, requiring enormous resources to ensure a strong health workforce and infrastructure, equipment, and medicines. JICA has transitioned its support from HRH to UHC; in addition to supporting the development of the UHC strategy, JICA recently sent a delegate to Tokyo for UHC training and verbally committed to supporting Senegal’s UHC efforts until at least 2018.

Barriers

Political will and planning are strong in Senegal, but implementation is weak. Stakeholders agreed that existing policies are not consistently followed. Efforts to strengthen the health workforce must also address recruitment and retention problems. Senegal is good at producing providers, and preservice education is available in all four corners of the country, but only a select number of trained personnel enter into the government recruitment system due to lack of funded positions and more attractive options in other sectors. For those that do, deployment tends to be ad hoc, with minimal assurance that government deployment guidelines will be followed. The central government has sought to decentralize recruitment and encourages regional and district governments to plan, recruit, and deploy their own providers, but local governments face budgetary constraints that make it difficult to recruit providers on a regular basis. As a result, both central and local recruitment occurs in a sporadic manner. While the need for equitable distribution of health workers is evident, there is no easy fix. In all fairness, deployment and retention are linked to quality of life considerations for health workers. A hardship post may not only be challenging for providers but also for family members, particularly where educational opportunities for children and other resources are limited. Stronger adherence to government deployment policies and firmer engagement by local governments may help set the precedent and clarify where and for how long health workers should be deployed to rural (or otherwise less desirable) posts.

CSO Engagement

National CSOs are primarily seen as political organizations and do not come across as particularly likely HRH proponents. Moreover, Senegalese CSOs did not participate in the development of the HRH commitments prior to the Brazil Forum. However, CSOs’ capacity to advocate for HRH can be strengthened, and GAVI and Save the Children have already sought to build CSO involvement. The Health, AIDS, and Population Network (Réseau Santé Sida et Population or RESSIP) affiliated with the Council of Nongovernmental Organizations (Conseil des Organisations Non Gouvernementales or CONGAD), a national CSO operating in the health arena, has expressed willingness to support Ministry of Health direction regarding HRH issues (which are normally outside of their domain). In addition:
Civil society may be helpful in promoting dialogue with local governments or working in support of quality improvements or community involvement.

CSOs may be able to demystify HRH—helping relate HRH needs to efforts to improve maternal and child health, for example—or articulate linkages to national policies.

**Recommendations**

There are a number of recommendations that can help Senegal continue to make HRH progress:

1. **Share Senegal’s HRH country commitments widely.** This will engender further steps such as formulating an action plan, developing a system to track commitments, and forming an HRH technical working group. These steps may help inform and then engage donors to further commit to health workforce strengthening opportunities for the alignment of policies toward UHC.

2. **Never lose sight of quality.** Ensure that government and donor-funded projects include elements that increase the quality of health services and also allow for a system to monitor and improve provider performance and service quality, including stronger systems for accreditation.

3. **Think beyond recruitment.** As already discussed, there is a need to adhere to government deployment and retention policies to achieve equitable distribution of the health workforce (particularly in difficult or rural zones) and ensure a health workforce that can meet community needs. Senegal’s “Guide to mobility” focuses on deploying and retaining health workers but is typically not implemented. Although fantastic strides have recently been made, such as the recent government commitment to recruit 1,000 additional health workers, these can easily be undermined by other actions. Developing a clear plan can ensure that deployment policies are not ignored or unduly influenced.

4. **Develop and put in place an HRH technical working group.** A technical working group led by the ministry’s HRH team could examine HRH issues and develop a way forward. A working group might look at projections using the already piloted HRIS, develop and track an HRH action plan, and spearhead coordination of the HRH national strategic plan within the framework of UHC. The national strategic plans for HRH and UHC would benefit from being reviewed by government officials so that convergences are apparent for planning and implementation.

5. **Validate frontline health workers.** At present, community health workers are not recognized government providers and the in-service training offered to CHWs is unregulated. Efforts should be made to retain higher-level community health workers who have the capacity to retrain, validate, and deploy CHWs.

6. **Implicate national civil society.** CSOs have the potential to support dialogue with local governments, quality improvement, community involvement, demystification of HRH issues, and articulation of linkages to national policies. National civil society and international organizations should join forces—international nongovernmental organizations and multilaterals can build national CSOs’ capacity for HRH advocacy.
Uganda

Health Workforce Context
The health workforce remains woefully inadequate, with only one health worker for every 600 people in aggregate. Reports indicate that health workers are also inequitably distributed. About 71% of doctors and 44% of nurses and midwives work in urban areas, although only 13% of the population is urban. A recent HRH biannual report (Ministry of Health [Uganda] 2013) revealed that only 61% of established public sector district positions are filled; this number actually reflects massive health worker recruitment in 2012/13; before 2012, the percent of filled positions was even lower (45%) (Ministry of Health [Uganda] 2011).

Uganda has expanded its physician workforce over the past decade, tripling the number of medical schools and increasing the number of annual graduates from 120 to 300. However, many doctors rely on other cadres that remain in extremely short supply. For example, surgeons cannot perform surgery without an anesthesiologist and theater assistant. These shortages have an impact on working health professionals’ ability to fulfill their duties.

The government health delivery system suffers from dual management. Urban facilities and tertiary hospitals are managed centrally by the Ministry of Health. District governments manage district hospitals and health centers II, III, and IV, but many districts lack the financial and human resources for effective management. This means that health centers are not always fully operational, sometimes lacking necessary equipment or funds to pay electricity bills. Many health professionals find it challenging or even impossible to work under such conditions, contributing to absenteeism. Another management challenge is that government positions are essentially tenured without performance reviews, and payments come from the central government while workers are managed at the district level. The dual management system has at times negatively impacted public health sector performance, especially in hard-to-reach areas. Increasingly, those who can afford to seek care from private providers do so.
The private-not-for-profit (PNFP) sector provides close to 50% of all health services, maintaining hospitals and health centers across the country. These operate separately from government-run clinics, although a small amount of funding comes from the government budget. Management differences between the PNFP and government sectors include variations in salaries (doctors are paid more in government facilities, whereas nurses and midwives are paid more in PNFP settings), availability of equipment, and practices such as performance reviews. To ensure that everyone has access to a health worker, Uganda must examine the PNFP and government sectors together and consider the impact that changes in one sector may have on the other. For example, if the government increases salaries, health workers may flood the public sector and leave the PNFP sector destitute, distorting the placement of health workers across both systems. Recognizing the need for strong coordination, the government included greater cooperation and relationship-strengthening with the PNFP sector as one of its HRH commitments.

**HRH Country Commitments**

Uganda’s HRH technical working group developed the country commitments over the year leading up to the Global Forum. First, the group examined the commitments made by Uganda at preceding Forums in Kampala and Bangkok and assessed progress toward meeting those commitments. They also examined strategic documents, primarily the Health Sector Strategic and Investment Plan 2010-2015 (Ministry of Health [Uganda] 2010a) and the Second National Health Policy (Ministry of Health [Uganda] 2010b). From their review of HRH goals and guidelines, the group pulled out critical areas in need of support, described by one interviewee as “the priority of priorities.” The Recife commitments—notable for their specificity and focus on four main areas—are timely, as the primary health policy document guiding the ministry’s work (the Health Sector Strategic and Investment Plan) is set to expire in 2015 and will be revised in the coming 12 months. Several stakeholders mentioned the key advocacy opportunity this offers to make the commitments the guiding policy on HRH for the next five-year window.

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**Two Barriers to Scaling Up the Health Workforce in Uganda**

**Salaries:** Salaries have long been recognized as a major barrier. In the past two years, Uganda significantly increased the salaries of doctors working in government facilities in designated hard-to-reach areas. Although this measure increased the number of doctors working in health centers III and IV, many recruitment and retention challenges remain. Moreover, the government has not increased salaries across the board, meaning that many nurses and midwives still prefer to work in urban areas or the private sector.

**Housing:** The government elected not to build staff housing when it constructed most of its health facilities. As a result, many health personnel are unable to find suitable housing in hard-to-reach areas, and when they do it is often at a distance from the health facility. Personnel on duty during nighttime shifts are either unable to return home during the night or are too far away to attend to medical emergencies. Building staff housing will be a key method to improve attraction and retention of health workers in hard-to-reach areas.
HRH Country Commitments: Uganda

1. **Improve availability of health workers.**
   - Scale up the training of cadres in scarce supply:
     - Anesthetic officers (increase annual enrollment from 20 to 60)
     - Laboratory technologists (increase annual enrollment by 100 by 2015)
     - Midwives (increase annual enrollment by 200 per year through 2015).
   - Work with professional councils to enhance the quality of preservice education through synthesis and implementation of harmonized standard guidelines for establishment, accreditation, licensing, and operation of health training institutions.

2. **Provide incentives for attraction and retention.**
   - Ensure that at least 60% of technical staff at health centers (levels III and IV) and general hospitals have decent institutional accommodations at the place of work.
   - Enhance salaries of health workers at health centers (levels III and IV) and general hospitals by 50% of current gross pay, and ensure that salaries are paid in a timely manner.
   - Provide full tuition support for post-basic professional training to health workers who serve in remote rural facilities for at least two years.
   - Complete establishment of village health teams in all districts and institute appropriate mechanisms for maintaining them.

3. **Improve health workforce productivity and accountability.**
   - Strengthen performance management by institutionalizing individual performance planning, monitoring, and appraisal for all staff at health centers (levels III and IV) and general hospitals.
   - Apply the Workload Indicators of Staffing Need (WISN) methodology nationally for determining staffing requirements and efficient deployment of staff at health centers (levels III and IV) and general hospitals.
   - Apply appropriate measures to reduce absenteeism (estimated at 50%) by 60% at all levels.

4. **Strengthen partnerships with PNFP service providers.**
   - Increase financial support to PNFP service providers to achieve 100% established staffing standards at health centers (levels III and IV) and general hospitals.
   - Strengthen the HRH technical working group to effectively embrace the functions of Country Coordination and Facilitation (CCF) and health workforce observatories.
HRH Progress

Health workforce shortages are a well-known issue and have been politicized in the recent past. The Recife commitments thus come out of a context where HRH was already being championed. In 2012, the Minister of Health made a strong public push for greater resource allocation toward HRH in the overall government budget. She worked closely with several Ministers of Parliament, who collectively refused to pass the overall budget until resources were brought up to a level where funding would be available to fill 65% of all health worker positions. At the time, only 45% of approved positions were filled, primarily due to insufficient resources for more health worker salaries. This shift significantly improved attraction to rural areas (commitment #2), although the government was not quite able to effectively utilize all available funding. Primarily due to delays at the district level in advertising for, interviewing, and filling new positions, the funding allocated for new health workers was not fully spent. In June 2013, a senior worker in Uganda’s Parliament passed away in childbirth in a private Kampala hospital. Her death outraged many in Parliament and prompted further advocacy for increased HRH funding. To date, however, the HRH funding levels have been maintained at 2012 levels.

The government, according to key stakeholders, is taking its Recife commitments seriously and views them as part and parcel of its ongoing health workforce strengthening efforts. The political commitments established in Recife build on the health workforce guidelines and standards outlined in the Health Sector Strategic and Investment Plan (expiring in 2015) and the National Health Policy ending in 2020—both of which are designed to help Uganda meet the MDGs. Other global-level health commitments such as the reduction in child mortality required by Every Woman, Every Child have had little impact on HRH planning.

Since Recife, Uganda has taken several critical steps toward implementation. Much of this progress has been driven by IntraHealth’s Uganda CapacityPlus office, which has convened several meetings of the HRH technical working group. The group, which includes key members of the Ministry of Health, decided in March 2014 to form a task force to examine what is needed to meet the commitments. A fully costed plan for meeting the commitments has been designed and presented to the ministry’s Health Policy Senior Committee, which is in a position to choose how much of the commitments will be formally adopted into the ministry’s future plans. Uganda’s 2015 budget, presented in June 2014, contained slightly higher funding levels for health as a percent of the total budget than in previous years. Some of this additional funding is being allocated to build residences for health personnel in the hard-to-reach areas where health centers III and IV are located (commitment #2). This funding, designed to attract and retain rural health workers, will directly contribute to meeting the goals included in the Recife commitments.

HRH Commitments in the Context of Universal Health Coverage

Uganda has been adopting significant reforms toward meeting the goal of UHC for some time. Notably, Uganda abolished user fees for government health centers in 2001 (Xu et al. 2005). The elimination of user fees has had both positive and negative impacts; the poorest quintile of Ugandans has increased its utilization of government health services, but the richest quintile has shifted away from government care and toward private health services (Orem et al. 2011). Unfortunately, catastrophic health expenditures have not changed since the elimination of user
fees, as significant out-of-pocket expenditures remain (Xu et al. 2005). Several stakeholders mentioned, moreover, that the elimination of user fees has deprived district and central health budgets of much-needed revenue, making it more difficult for health centers to obtain basic supplies and pay bills. These challenging working conditions have proved to be a deterrent for health workers, who instead choose to work in for-profit or PNFP health facilities, where user fees have been retained.

The Recife commitments were in some ways a reaction to the changes within the health system that have taken place as a result of UHC financial reforms. Public sector challenges in attraction and retention relate to competition with the private sector, and inadequate funding and incentives relate to inadequate district-level funding, exacerbated by the lost user fee revenue stream. Increased access has also driven up the demand for health services, particularly in rural and underserved areas, and as a result more health workers are needed in these areas.

**Barriers**

To meet the Recife commitments, funding levels must be maintained and even expanded. The 2015 budget allocated some additional funding to health, but health ranks behind several other key budget priorities, including infrastructure development, electricity, and education. Health receives less than 9% of the overall government budget, an insufficient amount to fully meet the country’s health needs. Several stakeholders mentioned that health would need to represent 11% to 12% of the budget to fill all available government health positions.

Effective health system management is critical for effective implementation of the HRH commitments, but Uganda suffers some management challenges. The government in 2012 scaled up funding for health worker salaries to increase the health workforce by 20%. Despite having enough funding and health workers, district governments were not efficient enough to effectively use all of the funding—and a portion remained in the government’s reserve fund at year’s end. Some stakeholders expressed concerns about occasional corruption as well as high-level management changes that decrease accountability and efficiency. It remains to be seen how these challenges will affect the commitments’ eventual success.

**CSO Engagement**

It is clear that CSOs as well as other stakeholders such as nongovernmental organizations had a large impact on the development of the HRH commitments, and their follow-up advocacy has shaped Uganda’s progress since Recife. The HRH technical working group played a critical role in developing the commitments and advocating for HRH in the 2015 budget. Going forward, CSO advocacy is essential to holding the government to its commitments.

**Recommendations**

The progress toward meeting Uganda’s HRH commitments can largely be attributed to active CSOs (including nongovernmental and faith-based organizations and the private sector) and to a government already strongly engaged in improving HRH. The Ministry of Health has responded well to the advocacy carried out by members of the HRH technical working group,
and especially the Uganda CapacityPlus team. To further this momentum, we recommend the following:

1. **Ensure that CSOs continue to strongly advocate for the commitments.** There is a critical opportunity in the coming year for advocacy as the government develops its next five-year health sector strategic and investment plan, building on the 2010-2015 plan. With effective advocacy, the Recife commitments can be included as strong priorities.

2. **Recognize the critical role of civil society and nongovernmental organizations in advocating for maintained funding levels and priority emphasis on HRH.** Advocacy for HRH is becoming more important in light of recent shifts in donor aid. In response to Uganda’s 2014 Anti-Homosexuality Act, donor governments, specifically the United States, are examining their provision of aid to Uganda. If donor funding for health shrinks, the competition for government funding for different health priorities will increase.

**Conclusions**

The three countries’ dedication to health workforce strengthening, visible through past actions and policy decisions and in their Recife commitments, is commendable. Work remains, however, to ensure that health workers are sufficiently attracted to difficult areas and retained. Strong advocacy remains critical to ensure that the three governments continue to move forward with the changes needed to strengthen HRH and meet their commitments.
REFERENCES


# Stakeholders Interviewed

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<tr>
<th>Name</th>
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