Human Resources for Health leadership and management: a prototype curricula package

Case studies
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### Abbreviations

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<th>Abbreviation</th>
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<tr>
<td>ADHA</td>
<td>additional duty hours allowance</td>
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<tr>
<td>BSc</td>
<td>Bachelor of Science</td>
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<tr>
<td>CHW</td>
<td>community health worker</td>
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<tr>
<td>CU</td>
<td>curricular unit</td>
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<tr>
<td>DDG</td>
<td>Deputy Director-General</td>
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<tr>
<td>DMC</td>
<td>designated microscopy centre</td>
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<tr>
<td>DPI</td>
<td>Department for Planning and Information</td>
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<td>EPWP</td>
<td>Extended Public Works Programme</td>
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<td>GMA</td>
<td>Ghana Medical Association</td>
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<tr>
<td>HP</td>
<td>health promotion</td>
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<td>HRH</td>
<td>human resources for health</td>
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<tr>
<td>HRIS</td>
<td>human resources information system</td>
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<td>HWF</td>
<td>health workforce</td>
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<tr>
<td>IMA</td>
<td>Indian Medical Association</td>
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<tr>
<td>MoU</td>
<td>memorandum of understanding</td>
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<td>NGO</td>
<td>nongovernmental organization</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NHWA</td>
<td>national health workforce accounts</td>
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<td>NHWF</td>
<td>national health workforce strategy</td>
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<tr>
<td>NQF</td>
<td>National Qualifications Framework</td>
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<tr>
<td>PBF</td>
<td>performance-based financing</td>
</tr>
<tr>
<td>PPM</td>
<td>public–private mix</td>
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<tr>
<td>RNTCP</td>
<td>Revised National Tuberculosis Control Programme</td>
</tr>
<tr>
<td>SARA</td>
<td>service availability and readiness assessment</td>
</tr>
<tr>
<td>SPA</td>
<td>service provision assessment</td>
</tr>
<tr>
<td>TB (DOTS)</td>
<td>tuberculosis (directly observed treatment, short-course)</td>
</tr>
<tr>
<td>UHC</td>
<td>universal health coverage</td>
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<td>WHO</td>
<td>World Health Organization</td>
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The role of actors, interests and politics in the implementation of HRH policy: Introduction of the Additional duty hours allowance in the Republic of Ghana

Learning objectives
Characterize the role of policy, politics, stakeholder engagement and evidence-informed policy dialogue for shared decision-making.

Tasks and questions
1. Carefully read the case study below and discuss the following questions in your group:
2. What were the key contextual factors that impacted both policy agenda-setting and implementation?
3. Identify the different spheres of human resources for health (HRH) policy that impact on this policy’s design and implementation.
4. Identify the most important actors/groups in the case study. How would you characterize:
   a. their leadership style?
   b. the power they hold?
5. Discuss the most important disjunctures between policy intent and implementation and what caused them.
6. Which policy decisions and actions advanced or undermined the agenda for universal health coverage (UHC) and how?
7. Drawing on your own experience, what might have been alternative strategic policy levers and courses of action for policy-makers to generate better outcomes? Consider this question from the perspective of specific policy-makers (national or provincial/state/local) you identify in your discussion.
8. What stakeholder engagements would have been necessary to achieve these alternative strategic policy levers and courses of actions?

Key insights and lessons will be shared and discussed in plenary.

Case narrative
Introduction – Ministry of Defence
In 1998, the 37 military hospitals in Ghana, under the Ministry of Defence, introduced allowances that effectively translated into wage increases for its doctors. The military hospital decision-making is autonomous of the Ministry of Health and the hospitals respond to the Ministry of Defence as part of the Armed Forces. However, while minor allowances can be introduced autonomously, salary rises need the approval of the Ministry of Finance.

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Historically efforts tended to provide adequate privileges to the military to pre-empt dissent. Officers of the Ministry of Defence – including health workers – are not allowed to go on strike.

**Public sector doctors’ strike**

There had been long-standing discontent among doctors in the public sector, mainly employees of the Ministry of Health, over their extremely low wages. Junior doctors, who on average work longer hours than senior doctors and are unlikely to have their own private clinic, were particularly restless over the issue. Not surprisingly, they were the first to agitate for and initiate industrial action, using the disparity created between the pay of doctors employed by the Ministry of Defence and that of other public sector doctors as a trigger to take action. This action received the backing of their senior colleagues, and the Ghana Medical Association (GMA) declared a nationwide doctors’ strike to back their demands for pay reform. The GMA presented the government with three options: salary increases; compensation for work overload; or compensation for long hours worked beyond the standard 40 hours per week in the form of an additional duty hours allowance (ADHA). The GMA had been floating all three ideas for some time as possible solutions to the simmering discontent over conditions of service.

Doctors employed in the public sector represent a large part of health service provision. The thriving licensed private sector is predominantly in the metropolitan and larger urban areas, but not affordable for poorer people. In rural areas, apart from the Christian Health Association of Ghana, the only service delivery options are those provided by the Ministry of Health/Ghana Health Service. The strike therefore effectively brought health service delivery in Ghana to a near standstill. There was a public outcry, with the press and the public generally sympathetic to the doctors, demanding that the government appease them rapidly so that services could be restored.

**Introduction of ADHA**

The government entered into negotiation with the GMA and selected the option of payment of an ADHA, ostensibly to buy time and because the Ministry of Finance felt that given their low numbers, such a payment for doctors only (instead of all categories of health workers) would not make a noticeable difference to the government budget for the year. In addition, it was felt that doctors were indeed working extremely long hours. A memorandum of understanding (MoU) was thus signed between the government and the GMA, to take effect from 1 January 1999, in which it was stated that the ADHA was intended to be “an incentive to compensate for the abnormally poor basic salaries of the medical and dental practitioners in the public sector”, and that the agreement was for “160 hours as the average annualized number of hours per month for the payment of the allowance.” Since the GMA represents doctors as well as dentists, the arguments were made for both groups and the ADHA was to be calculated on an hourly rate, derived from the salary of the medical or dental practitioner in question. The GMA called off its strike, but with the proviso that if by 1 March 1999 the promised allowances had not been paid, they would resume the industrial action without any warning.
In early February 1999, the Ministry of Health released a memo to all regional directors and other administrative levels containing guidelines for implementing the ADHA policy. The guidelines stated that payment of ADHA was to be done at the facility level with retrospective effect from 1 January 1999. Facilities were to prepare monthly duty rosters for doctors and dentists to ensure 24-hour service. Regional directors of health services and heads of facilities were to monitor implementation arrangements. A review of implementation experiences was planned for May 1999.

Funds for the ADHA were approved and released on 26 February 1999 to all 10 regions and the two teaching hospitals. However, administrative and procedural delays meant that by 1 March ADHA had not been paid. A new cycle of dissatisfaction was thus created, and on 1 March, junior doctors across the country laid down their tools at what they perceived as a breach of the agreement. They resumed work, however, on the appeal and reassurance of the GMA (who had been working with the government to resolve the administrative problems) that the money had been released and payment was about to commence.

**Nurses’ and other health workers’ grievances**

The decision to give ADHA to doctors now became the trigger for unintended consequences by further worsening already low nurse satisfaction over their remuneration. Nurses had been watching the doctors strike and its outcome from the sidelines as they also had longstanding grievances over inadequate wages. In April 1999, junior nurses began a strike requesting that nurses also be included in the ADHA. They were supported by the Ghana Registered Nurses Association and the Nurse Anaesthetists Association. A seven-day nationwide strike by nurses ground the health sector to a near halt. The strike ended with an agreement between the government and the nurses unions to include nurses in ADHA payments, also with effect from 1 January 1999. Administrative requirements were introduced requesting that overtime payments be calculated based on duty rosters, authorized by the head of an institution and verified by information from the attendance books.

The decision to include nurses in the ADHA not only created improved nurse satisfaction, but became the trigger for reduced satisfaction and related strike action by other health sector workers. Recognizing that their fragmented nature and small numbers made them ineffective in any negotiation in ADHA payments, the less powerful health worker unions – such as the Government and Hospital Pharmacists Association, the Medical Assistants Association, the Association of Laboratory Scientists and the Association of Health Service Administrators – joined forces with the Ghana Registered Nurses Association. They labelled themselves the “representatives of health workers other than doctors” and demanded that the Ministry of Health include them in the ADHA or else they would strike en masse.

By September 1999, in response to the strikes and agitations, virtually all permanent workers in the health sector were included in the ADHA. The MoU for ADHA between the government and other health worker associations was based on three conditions: payment would be for hours beyond the standard 40 hours per week; timesheets should be kept by each staff member; and these should be verified by management before payment. The MoU was signed on 30 September 1999.
While medical doctors working in teaching hospitals as employees of the Ministry of Health were included in the ADHA, those working as full-time lecturers in medical schools, and thus employees of the Ministry of Education, were not. Doctors teaching in medical schools threatened to stop teaching and go back to practice in the Ministry of Health to improve their salary. In response, an MoU was also signed between the Ministry of Health and medical schools to include them in the ADHA.

**High cost of ADHA and payment delays**

The expanded ADHA scheme, including almost all permanent staff in the health sector, did not lead to industrial peace despite the fact that ADHA payments were often more than the staff salaries themselves and led to a doubling or more of staff incomes. This was because of repeated delays in payment, leading to further strikes by doctors, nurses and other health workers. As ADHA claims rose steadily, the Ministry of Health introduced regional and institutional financial ceilings on the amount of ADHA to be paid, to limit the rapid growth in costs. This was not completely successful and the ADHA bill continued to rise, with the government continuing to struggle with prompt payment leading to threats of, or actual strikes by health workers. The health sector entered a vicious cycle of payment delay followed by strikes to enforce payment, followed by payment to end strikes and back again. The cycle appeared to have the additional side effect of creating in the mind of health workers and their unions the idea that the only language the government responded to was industrial action rather than dialogue and trust that agreements would be honoured.

The repeated delays in payment of ADHA were attributed by government to the non-submission of the verified time sheets by the respective administrative levels to enable payment. While there were indeed delays in submission of some returns, this did not appear to be the full story as some claims, submitted with full justification, were still not paid on time. It appeared that some, if not all the delays were due to government challenges in meeting the mounting bills. For example, on at least one occasion when a delegation from the GMA came to the Ministry of Health because of ADHA arrears, they were directed to the Minister for Finance, who did not appreciate not being informed of the problem. However, technical staff were told to look carefully at the Ministry of Health budget and identify from where the funds could be taken. Their answer: that year no new capital project could be undertaken.

ADHA management problems within regions and facilities also fuelled discontent and unrest. ADHA ceilings often remained constant and did not necessarily adapt to changes in staffing. Uneven application of rules on limits and time accounting meant that while some institutions had enough to pay the ADHA, others did not. Staff compared notes and found that similar categories of staff doing similar work in different institutions sometimes received widely varying amounts. Further widening the discrepancies, institutions that generated funds from out-of-pocket fees could use those funds to make up for the deficit payments for their staff to keep services running; while less well-endowed institutions had to make do with whatever they got. Many institutions had locally-recruited staff paid from internally generated funds, and these (often low paid and unskilled or semi-skilled) staff members were not included in ADHA payments. These inequities generated by the management of ADHA created staff dissatisfaction alongside the satisfaction of the better remunerated.
Filling of individual time sheets and vetting of hours claimed proved an impossible and unpopular task and a major administrative burden. Many institutions implemented unofficial local ADHA committees to try to manage the administrative burden and reduce staff discontent related to perceived unfairness in allocation. The ADHA budget rose from about US$ 1.5 million to over US$ 84 million by 2005. The percentage of the recurrent Government of Ghana budget spent on health rose from 10.2% in 2001 to 14% by 2006, with salaries accounting for the bulk of the rise. The percentage of the recurrent budget spent on non-salary items fell slightly over the same period from 8.1% to 7.0%. Salaries accounted for over 75% of central government allocation to the health sector and once capital investments were also taken into account, less than 10% of central government funds remained for recurrent expenditure. Effectively, non-salary recurrent expenditure was running on donor funds, internally generated funds from user fees in the health facilities and, once the National Health Insurance scheme became operational in 2004, on national health insurance reimbursements to the facilities. Several donors were uncomfortable with this, as they perceived that their money was substituting salary increases.

In addition to the simmering discontent, industrial unrest and a rising wage bill in the health sector due to ADHA implementation problems, there were mounting concerns that the overall increase in health expenditure did not seem to translate into improvements in key health sector indicators as witnessed by the stagnating/slow decline in maternal and under-five mortality rates. Health sector indicators are influenced by several variables and it is difficult to attribute one particular reason for the observed levels; however, given this legitimate concern, all policies in the sector during this period – including ADHA – were under scrutiny.

Consolidation of ADHA into salaries
The government therefore initiated discussions to consolidate ADHA into salaries. Following an evaluation in February 2005 on the various health sector job portfolios, the government issued the report "Restructuring the ADHA" in September 2005, and a circular formalizing the consolidation of ADHA into salaries. The last ADHA payment was to be in December 2005.

The process of this consolidation became the next trigger for industrial action by doctors, nurses and other health care workers, who were unhappy with the terms of consolidation and delays in the first new salary payment. There were conflicts and strikes over the creation of two pay scales – Health Sector pay Scale 1 (HSS1) for doctors, and Health Sector pay Scale 2 (HSS2) at a lower level for everybody else. Doctors, satisfied for the time being with their negotiated pay scale, went on no further strikes. However, all other workers in the sector were aggrieved over what they perceived as an unfair policy. They formed a coalition called the Health Workers Group and went on crippling strikes demanding a single pay scale and higher consolidated salaries. Between 2006 and 2007 the health sector went through a stormy period as the government and health worker unions conflicted over the issues. The latter employed the services of the Chief Executive Officer of a labour consulting group to represent them before the Labour Commission and negotiate with the government on their behalf.

\[\text{In 1998, the exchange rate was 2250–2350 cedis to the US dollar; in 1999, 2350–3550 cedis to the US dollar; and in 2005, it rose to 8900–9500 cedis to the US dollar.}\]
In June 2008, the negotiations were finally completed to everyone’s acceptance, if not full satisfaction. There were still two pay scales but the gap had narrowed. The first payment of consolidated salary, backdated to January 2006, was made. The cycles of ADHA-related strikes and industrial unrest reached an uneasy calm with unions keeping a watchful eye on the implementation.

Some context

Ghana’s gross domestic product (GDP) per capita is estimated at US$ 1542. It is an agricultural country and its main exports are cocoa, timber and gold. Most of its estimated 24 million population is employed in the non-formal sector, and about half the population is under 15 years old. A little under 15% of the public sector budget is allocated to health. Mortality of children under 5 years declined from 155 per 1000 live births in 1983–1987 to 108 in 1994–1998; stagnated at 111 in 1999–2003; and is now declining once more: the 2008 Ghana Demographic and Health survey estimated under-five mortality rates at 80 per 1000 live births. Maternal mortality declined from 503/100 000 in 2005 to 451/100 000 in 2008.

Brain drain and shortages of highly trained and skilled HRH have been and remain a problem. Hagopian et al. found that more than 23% of America’s 771 491 physicians received their medical training outside the country, mostly (64%) in low-income or lower-middle-income countries. A total of 5,334 physicians from sub-Saharan Africa were in that group, a number that represents more than 6% of the physicians practicing in sub-Saharan Africa now.

The average monthly basic salaries for junior and senior doctors in Ghana were US$ 199 and US$ 272, respectively, at the start of the ADHA saga in 1998. Client to public sector health professional staff ratios were and remain high and workloads heavy, because of staff shortages. Witter et al. in their 2005 survey of health workers providing maternal health-related services in two regions of Ghana found mean hours of work per week ranged between 129 for medical (physician) assistants to 54 for community health nurses. Public sector midwives carried out an average 19 deliveries per week compared with four for private sector midwives. In 2002, Ghana was estimated to have 6.2 physicians per 100 000 population compared with 279 in the United States and 164 in the United Kingdom.

Prior to the passage of the Ghana Health Service and Teaching Hospitals Act in 1996, the Ministry of Health regulated both the public and private sector; was the body responsible for health sector policy direction, coordination, monitoring and evaluation; and the provider of public sector services. Act 525 of Parliament created an agency model in the health sector, while the Ministry of Health became a small civil service ministry with responsibility for overall sector policy-making, coordination, monitoring and evaluation. The Ghana Health Service and Teaching Hospitals became autonomous agencies of the Ministry of Health responsible for public sector service delivery.

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There was a lot of expectation among health workers that the autonomous status would enable the Ghana Health Service to negotiate salary increases outside the constraints of the civil service; however, this did not immediately materialize as the legislative instrument was never approved by the various ministers who could not deal with the concept of autonomy.

There was no labour law at the start of the ADHA saga. It was several years later, in 2003, when Labour Act 651 was passed by parliament to “consolidate the laws relating to labour, employees, trade unions and industrial relations”. The labour law more or less formalized mechanisms that already existed, and created a Labour Commission to mediate disputes. The law allowed strikes and lockouts under certain conditions, but made it illegal for employers or workers engaged in essential services to resort to lockouts or strikes in connection with any industrial dispute. It was unclear how the illegality clause was to be enforced. Non-complying union leaders could not be arrested by police and neither could the courts cause their arrest. It was also unclear what alternative redress mechanisms considered mutually satisfactory were now provided for essential workers if they still felt their issues had not been addressed, despite following the dialogue and conflict resolution mechanisms prescribed by the law.
The role of actors, interests and politics in the implementation of HRH policy: Implementing new community health worker policies in the Republic of South Africa

Learning objectives
Characterize the role of policy, politics, stakeholder engagement and evidence-informed policy dialogue for shared decision-making.

Tasks and questions
Carefully read the case study below and discuss the following questions in your group:
1. What were the key contextual factors that impacted both policy agenda-setting and implementation?
2. Identify the different spheres of human resources for health (HRH) policy that impact on this policy’s design and implementation.
3. Identify the most important actors/groups in the case study. How would you characterize:
   a. their leadership style?
   b. the power they hold?
4. Discuss the most important disjunctures between policy intent and implementation and what caused them.
5. Which policy decisions and actions advanced or undermined the universal health coverage (UHC) agenda, and how?
6. Drawing on your own experience, what might have been alternative strategic policy levers and courses of action for policy-makers to generate better outcomes? Consider this question from the perspective of specific policy-makers (national or provincial/state/local) you identify in your discussion.
7. What stakeholder engagements would have been necessary to achieve these alternative strategic policy levers and courses of action?

Key insights and lessons will be shared and discussed in plenary.

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1 Based on Lehmann U, Matwa P. Exploring the concept of power in the implementation of South Africa’s new community health worker policies: A case study from a rural sub-district. Discussion Paper 64. Regional Network for Equity in Health in East and Southern Africa; 2008 (https://www.equinetafrica.org/sites/default/files/uploads/documents/DIS64POLLehmann.pdf, accessed 14 June 2021); adapted from a case study developed by Professors L Gilson and U Lehmann for teaching health policy analysis at the University of Cape Town and the University of the Western Cape, South Africa.
Case narrative

Introduction

This case narrative presents an experience of implementing new community health worker (CHW) policies in a rural area of South Africa. In the early stages of the process, responsibility for implementation (including funding) was delegated from national to provincial departments. In this narrative, the implementation process is traced from provincial down to sub-district, clinic and community levels.

The case narrative draws on research undertaken in one province in 2007. The study sought specifically to understand how new CHW policies had been implemented and what forces had shaped implementation practice. Detailed qualitative interviews and group discussions were undertaken with respondents at all levels of the provincial health system – within one sub-district, and from three clinics and communities located in different areas within the sub-district.

Policy history

In South Africa, the role of CHWs and their relationship with the formal health system has seen numerous ebbs and flows over the years. CHW programmes run by nongovernmental organizations (NGO) existed in the mid-1970s, and during the 1980s a few programmes flourished with support from international donors. New policy documents in the early 1990s, most notably the African National Congress (ANC) Health Plan, identified CHWs as an important resource for primary health care: as catalysts for community development, they could mobilize people around a broad range of health and environmental issues. This enthusiasm waned in the late 1990s. Support for CHW programmes remained uneven, although they continued to run in most provinces. However, the early 2000s saw a change in the policy environment with regard to CHWs, partly in response to the increased care needs created as a result of the global HIV/AIDS epidemic. Growing concerns regarding the impact of HIV/AIDS on the public health system and the needs of affected patients, emphasized the importance of home- and community-based care. Simultaneously, concern about the growing number of unemployed youth led to the development of a broad job and skills creation strategy, which included various forms of community-based workers.

Two key policies informed CHW programmes at the time of this study, namely the Extended Public Works Programme (EPWP) and the National Community Health Worker Policy Framework (NCHWPF). Both policies were developed in 2003–2004, but are very different in focus, content, and structure. The EPWP “belongs” to the Ministry of Labour and covers a wide range of public works initiatives, including infrastructure development, education, and social sector activities. The NCHWPF was developed by the Ministry of Health in the tradition of earlier CHW initiatives. While the policies showed some overlaps, they did not “talk to” or build on each other and so provided policy implementers with two quite different sets of guidelines and rules.
Policy design

Expanded Public Works Programme

The EPWP has its origin in the agreements of the Growth and Development Summit between organized labour, business and government in June 2003. Its broad aims are to create “temporary work opportunities for the unemployed, using public sector expenditure” and to ensure that all of these work opportunities are “combined with training, education or skills development, with the aim of increasing the ability of people to earn an income once they leave the programme.” Within the social sectors, the EPWP employs people, through NGOs and community-based organizations, to work on home-based care and early childhood development programmes.

Fig. 1 illustrates the intended training, work and career opportunities within the sector.

Fig. 1 Home community-based care overview

<table>
<thead>
<tr>
<th>Work opportunity</th>
<th>Exit opportunities</th>
<th>Work opportunity</th>
<th>Exit opportunities</th>
<th>Work opportunity</th>
<th>Exit opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Care Worker</td>
<td>Nurse aid</td>
<td>Community Health/ Development Support Worker</td>
<td>Child/youth care worker</td>
<td>Child and Youth Care Worker</td>
<td>Community development worker</td>
</tr>
<tr>
<td>HCHC post</td>
<td>Continue training</td>
<td></td>
<td>Peer educator</td>
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<td>Counsellor</td>
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<td>Field worker</td>
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<td>HCBC post</td>
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<td></td>
<td></td>
<td></td>
<td>Nurse aid</td>
<td></td>
<td>Trainer</td>
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<td>Assessor</td>
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<td></td>
<td></td>
<td></td>
<td>Continue training</td>
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<td>Continue training</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>HCBC post</td>
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The EPWP Social Sector Plan recommends a minimum of 10 home-based carers per site offering home-based care and estimates that 35 000 CHWs at the National Qualifications Framework (NQF) level 4 are needed nationally. The plan indicates that while home-based care programmes at all levels should be organized through skills programmes (according to the Skills Development Act) and funded through the National Skills Fund, generic health worker training should be organized and funded through the Department of Health (DoH).

**National Community Health Worker Policy Framework**

The DoH developed a new CHW Policy in 2003, aimed at institutionalizing CHWs and bringing uniformity to the diversity of previous schemes. This policy was being implemented at the time of the study. The implementation framework for the policy made provision for the appointment of generalist CHWs, to be paid a stipend by respective provinces through appointed NGOs and who, attached to primary care facilities, should perform a wide range of community-based care and support functions. These included community mobilization, advocacy, health education, basic counselling services, referrals and specified primary care activities. The policy stipulated that fully trained generalist CHWs should receive a minimum stipend of R1000. Each CHW should cover between 80 and 100 households in rural areas and between 100 and 150 households in urban areas. CHWs were to be trained based on registered unit standards, training providers should be accredited, and learnerships should be established. Community health committees were charged with providing a governance mechanism for CHWs.

**Profiling the CHWs**

The sub-district chosen has a tradition of CHWs. Village health workers were first introduced in the area in the 1980s and then again in the mid-1990s. All three clinics visited for this study had had large numbers (12–32) of volunteer CHWs prior to the implementation of the new policies.

The CHWs based at these clinics, thus, fell into two fairly distinct groups. The larger group was made up of mature women with different levels of schooling, but little formal education. Some of them were receiving stipends, but the majority were volunteers, both active and inactive. Most of them were very experienced as CHWs, articulate (in their home language) and vocal. The much smaller group was made up of young people in their late teens and early twenties (mostly women), all of whom were on stipends. Most had a grade 12 qualification, and many had become CHWs because they could not get into or afford nursing or other formal tertiary education. They saw the job of a CHW as a second-best and temporary alternative. Many made no secret of the fact that they were planning to move on, should the opportunity arise. Not one of them had heard of a possible career path from CHW work into nursing or other health sciences.

The clear generational gap between the CHWs, but also between some local managers and the younger CHWs, led to an underlying tension. Given the cultural norms in this rural area, the younger CHWs did not feel free to speak in front of their older “colleagues” and huddled together in their own age group on all occasions. In contrast, the older group of women were generally confident and engaged in lively debate during meetings.

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Policy implementation

Overview

Both policies were clear about the provincial government’s responsibility for the CHW programme, but provided no specific guidance on where within provincial government this responsibility should lie. In the study province, responsibility for the programme had been lodged with the HIV Directorate of the DoH which held the budget for the programme and saw itself as the ultimate “owner” of the policies. Indeed, within the DoH, access to the written policies, the actual documents, appears to have been confined to this Directorate, which had also been invited to workshops where the policies were discussed. Only the NGO contracted to manage stipend payment had similar knowledge of the policy; indeed, only staff in the NGO seemed to know about the policies’ stipulations regarding training and NQF levels.

Nonetheless, staff at the provincial Health Promotion Directorate were interested in the programme and indicated that they had some responsibility for programme coordination. Although they had not seen the primary policy texts, they had been able to pick up information about the broad scope and intent of the policies. The generalist health roles outlined for CHWs in the policy documents suggest their claim of responsibility has some merit. But in practice there was little or no collaboration between the different directorates and, as holder of the budget, the HIV Directorate had clear influence over implementation practice. Although the policies outlined a range of generalist and specialist functions for CHWs, the CHW programme was essentially understood as an extension of the HIV/AIDS programme focused on HIV/AIDS activities. Indeed, the fact that tuberculosis directly observed treatment, short-course (TB DOTS) supporters were being paid from the CHW budget was regarded as purely down to the generosity of the HIV Directorate.

Despite the complexities of the policy, the HIV Directorate essentially played an oversight rather than hands-on role in programme implementation. Indeed, it had very little knowledge or understanding of arrangements for supervision, training or task allocation at sub-district level.

Particular emphasis had, however, been given to payment of CHW stipends. In line with policy guidance and national practice, a local NGO had been contracted to administer these payments. This arrangement outsourced the formal relationship with CHWs and avoided making them state employees, subject to and eligible for provisions under general public service regulations. The NGO, however, considered itself simply “the paymaster of government”, charged with managing the payment of stipends. It neither saw itself as having broader responsibilities for the programme, nor as the employer of the CHWs. In its eyes, payment of the stipend did not constitute an employment contract:

The DoH wanted to thank the community health workers for the valuable role that they are playing because they were not paid, they were just volunteers, so they gave them a stipend … just something small and it is basically for food during the day and basically transport money (NGO representative).
Yet elaborate accountability and reporting mechanisms were involved in managing the stipend payments. CHWs had to sign a service level agreement, which specified their designation, minimum working hours (60 hours per month) and so on. They had to open a bank account in their own name and fill in a bank verification form in order to have their stipends transferred into the account. They submitted monthly log sheets, which needed to be signed by their facility manager. Failure to comply with any one of these provisions at any time could lead to non-payment of stipends. Given the paperwork involved, which formalized their relationship with the NGO, it is perhaps not surprising that CHWs essentially considered themselves employees rather than volunteers.

At sub-district level the new policies arrived by way of a communication (whether verbal or in written form is unclear) from the provincial headquarters that, in future, five CHWs per facility would receive a stipend from an NGO; and a request was made to clinics to forward the names of five CHWs to the NGO. The sub-district managers did not themselves have any direct role in selecting the CHWs who were to receive stipends, and so simply passed the information on to clinics together with the instruction they had received to involve community health committees in the selection process.

None of the four sub-district managers had seen either of the policies in writing, or were familiar with their key concepts with regard to NQF levels, entry and training requirements, career pathing or scope of activities. The extent of their information was limited to the fact that initially five, then seven, CHWs would receive stipends, that there were three categories of CHWs, and that they should all be trained in the basic 59-day home-based care course.

So the sub-district managers’ role in the policy implementation process was largely confined to being an occasional conduit of information between the provincial government and health facilities, and taking some responsibility for the training of CHWs. The junior of the two HIV/AIDS managers was formally responsible for the programme and specifically the training of CHWs, but this responsibility was difficult to fulfil as training budgets were withheld by the provincial health department (see below).

In this vacuum of activities at sub-district level, the new health promotion (HP) manager had decided to establish a monthly meeting with all CHWs in the sub-district. Like her provincial colleagues, she felt strongly that the CHW programme should fall under the HP manager, both because CHW tasks are relevant across all programmes and because HP staff work closely with community structures. The monthly meetings were used as feedback, report-back and continuing education sessions. They were run quite informally, with some input from various programme managers (HP, HIV/AIDS, TB) and questions and discussions involving the CHWs. The meetings had initially been resisted and undermined by the other sub-district managers. As a result, attendance had fallen from well over 100 participants to under 40; but as the HP manager persisted in her efforts, attendance began to pick up again.
At the time of the study the meeting was well established, well attended, and all programme managers were eager to participate as it provided a rare opportunity to share information with, and receive feedback from, the CHWs regarding activities in communities. The HP sub-district manager was recognized as the host of these meetings and had ensured that the CHWs and their activities were firmly within the vision and on the agenda of the sub-districts planning and management activities.

Tensions noted between directorates at provincial level were, therefore, mirrored in the sub-district. However, at sub-district level they revolved primarily around the new, energetic, knowledgeable and assertive HP manager coming into conflict with the old, powerful and not very energetic HIV programme manager. Although not feeling very confident, the acting sub-district manager asserted herself by supporting the HIV programme manager over the HP manager. The second and newer HIV manager was quite shy and withdrawn, and appeared to be the least powerful in the sub-district constellation.

These tensions in the sub-district office clearly had an impact on policy implementation. Both the HP and new HIV manager pursued their work with a real mission to improve health care delivery and make the best possible use of CHWs, while the two senior managers seemed to have neither the energy nor inclination to drive the policies. Instead they created stumbling blocks, particularly for efforts of the HP manager to implement innovation. For example, controlled by the senior HIV manager, the HP manager found it difficult to get access to the available transport, which is vital to visit outlying communities.

Nonetheless, three key factors contributed to the HP manager’s success in securing a position for herself in relation to the CHW programme. Firstly, she had an exceptionally energetic and optimistic personality, with a deep commitment and drive to improve service delivery in the area. Secondly, she had come into her post well qualified, with some relevant experience in the new HP portfolio and with a very clear vision of what she wanted to achieve in this portfolio. Thirdly, while she met resistance and was undermined by colleagues in the sub-district office, she nurtured relationships with facility managers and CHWs, which allowed her to build a sort of constituency in the communities of the sub-district.

Clinic managers played a crucial role in the implementation of the programme. Formally, their only role was to confirm and pass on the selection of CHWs to receive stipends and to sign the CHWs’ monthly log sheets. However, because they were a nodal point for information between sub-district, facilities, and communities, they played quite powerful informal roles. In two out of three clinics, the managers effectively selected the CHWs who were to receive stipends.

Once CHWs’ names had been passed on to the NGO, managers were essentially excluded from communication regarding contracts and stipends but still had the limited but potentially powerful role of having to sign off CHW monthly reports. This clearance role created the expectation that they would supervise CHWs, although they were not given formal responsibility for this activity. Indeed, none of them had received any instruction, training, or resources to support this supervisory role. It was essentially left to the managers to define their role and fill it to the best of their ability, given local circumstances. In all three facilities, this meant that supervision was limited to receiving reports and being available for questions CHWs might bring to them.
According to the policies, community health committees are also expected to play a key role in the initiation, running and supervision of the CHW programme. All three facilities had such a committee, albeit of different lengths of existence and levels of activity. However, none of the committees had been involved in the selection of CHWs to receive stipends or were actively involved in the running, coordination or supervision of the programme. Nor had the committee members received any training to prepare them for their role, although some had consulted previous members on its scope. Furthermore, no committee had received information of briefings regarding the policies or their intended implementation in the province or sub-district.

Finally, within the formal organization and hierarchy of policy implementation, CHWs had limited roles. Only in one clinic did they participate in the decision of who among them should receive a stipend. In practice, however, even clinic managers had very limited insight into their daily activities, as they never accompanied CHWs on their rounds, and relied on information from CHWs or community members, whether in their role as patients visiting the facility or as community health committee members. CHWs do, therefore, have some power over their daily routines.

**Policy impacts**

There is no doubt that the overall intent of both policies is to improve health service access and coverage in rural and underserved areas. However, the views and experiences of actors involved in the programme raised a range of concerns about the actual impacts.

Firstly, the policies were not really considered as “new”, particularly by actors at facility and community level. As a result CHWs and community health committees could not easily distinguish between old rules, requirements and practices, and new policies. In their minds the new policies were just a continuation of about 20 years of shifting official practices around the desire to have community members assist with health care delivery.

Secondly, in the eyes of all actors, the policies consisted essentially of the introduction of stipends to reward CHWs selectively and to regularize the activities of CHWs in certain categories. Indeed, CHWs often appeared to understand the present policy initiative as one of the many non-transparent and unpredictable ways in which government works.

I was elected in 1995. I was elected by the residents to become the community worker. We started in 1995 with others who were elected just like me. A nurse trained us how to engage individuals who consult. We went also to rural areas as well. Some people say being the community worker they discover that there is nothing much when they look back. We were promised that the government will provide us with the stipend. We carried on until 2000–2001. Round about 2004 we receive the stipend. In 2003 we were asked to sign every day and we shall receive the stipend and each month we shall earn stipends worth R500. In the meantime it was said that five people should be home-based care workers. These people were to be trained. … Some of us could not receive it. We waited in 2003, in 2004 it is only now that we would receive it. It is the payment for all of us whereas others have quit already. … Some of us could not bear it anymore but we persevered (CHW, clinic C).
Thirdly, among actors at all levels there was concern that the stipend had “destroyed” volunteerism. Even some of the CHWs on stipends raised unease about the impact that the introduction of money had had on their work and life.

About money: we are getting money now and we never used to bother about it before when we just worked with dedication. We were not waiting for anything. But when this money issue started we started to have some difficulties. It is the first thing that comes to our heads. You sometimes look and convince yourself that you are working for nothing. You compare your work to your electricity bill. We get so stressed towards month end and when you look at your colleague you imagine her neck twisted to the other side because of financial stress, and immediately feel my own neck twisting as well. The money we get is extremely stressful. Reality should be comparison with the time when we got absolutely nothing and now, and we should be happy to manage to buy at least a pair of shoes to walk with from this R1000 (CHW, clinic A).

This CHW, who received a stipend, argued that the stipend introduced an undue concern with money that caused stress unknown before they received a stipend. This appears to be a peculiar perception in a situation where monetary income was precious and hard to come by, but it may reflect a combination of conflicting feelings and tensions. Firstly, while the monetary income was undoubtedly welcome, CHWs on stipends were, of course, keenly aware of their colleagues who did not receive stipends. In fact this issue was so sensitive that in two of the three clinics, CHWs refused to discuss it at all. Secondly, since the stipend was predictably considered payment for work done, the money was inevitably considered insufficient (you compare your work to your electricity bill). Thirdly, many of the older women clearly experienced a tension between pride in their voluntary work as service to the community and resentment that the government was acknowledging their services (through money) either insufficiently or not at all. Fourthly, when asked about the impact of the new initiative, most actors recognized its good intention, but emphasized the considerable drawbacks it had produced in terms of divisions among CHWs, reduced coverage and, perhaps, CHW acceptability.

The divisions revolved around the stipends, and the fact that most of the CHWs with stipends were younger, better educated, but less experienced and, within the rural context, less respected, less vocal and less powerful. Most of the CHWs without stipends had withdrawn their services to communities, but were vocal, extremely experienced and powerful within their communities. “People are complaining a lot”, said an HIV manager in the sub-district. “They say with this stipends thing it came to divide them because it was a sort of pick and choose. It would be better if everybody was given at least a stipend.”

Sub-district managers and facility managers also raised concerns about the acceptability and quality of the younger CHWs, saying they lacked experience and did not know how to “conduct” themselves in communities. They said community members had complained about lack of confidentiality. It is possible, however, that such perceptions were exaggerated, particularly by older managers and CHWs who were unhappy about the appointment of younger, better educated CHWs. It also reflects a lack of adequate preparation and support for the younger CHWs.
While the older CHWs had the benefit of years of experience which included periods of training and support, the younger ones had had very limited training and hardly any supervision or support. Poor performance may thus reflect poor management rather than lack of suitability of young CHWs.

Nonetheless, sub-district managers also stressed the benefits of the new policies. In particular they emphasized that they enabled them to put systems in place where previously there had been none. They argued that the stipends necessitated a reliable database and committed CHWs to report on a regular basis through log sheets and narrative reports in clinics, something which they had not been able to enforce previously. Historically, information about actual CHW practices had only risen through the information chain intermittently and selectively.

Overall, however, there appeared to be a great deal of ambivalence about the impact of the stipend policy. Concern about its divisiveness and the de facto reduction of coverage it had generated was reinforced by uncertainty on its reliability and longevity.
The role of actors, interests and politics in the design and implementation of HRH policy: Separating drug prescribing and dispensing in the Republic of Korea

Learning objectives
Characterize the role of policy, politics, stakeholder engagement and evidence-informed policy dialogue for shared decision-making.

Tasks and questions
Carefully read the case study below and discuss the following questions in your group:

1. What were the key contextual factors that impacted both policy agenda-setting and implementation?
2. Identify the different spheres of human resources for health (HRH) policy that impact on this policy’s design and implementation.
3. Identify the most important actors/groups in the case study. How would you characterize:
   a. their leadership style?
   b. the power they hold?
4. Discuss the most important disjunctures between policy intent and implementation and what caused them.
5. Which policy decisions and actions advanced or undermined the meeting of the policy goals, and how?
6. Drawing on your own experience, what might have been alternative strategic policy levers and courses of action for policy-makers to generate better outcomes? Consider this question from the perspective of specific policy-makers (national or provincial/state/local) you identify in your discussion.
7. What stakeholder engagements would have been necessary to achieve these alternative strategic policy levers and courses of action?

Key insights and lessons will be shared and discussed in plenary.

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Case narrative

Policy issue

In all countries, expenditure on pharmaceuticals (drugs) impacts on the total cost of providing health care. A high and increasing cost of drugs puts pressure on national health budgets and often makes health care unaffordable for poorer groups.

Pharmaceutical expenditure levels are driven by:

- drug prices (which include the cost of drug production and the pharmaceutical companies’ profits); and
- drug prescription practice – particularly whether generic or brand name drugs are prescribed. Generic drugs and brand name drugs are equally effective, yet generic drugs are cheaper.

In the Republic of Korea as early as the 1980s drug prescription practice was identified as the key factor influencing what was considered an unsustainably high level of pharmaceutical expenditure. It was also noted that the population consumed more drugs than people in other high-income countries, particularly injectable drugs. This over-consumption resulted in an increased level of resistance to antibiotics.

These drug prescription problems were linked to the activities of two groups of actors:

1. physicians and pharmacists, who prescribed and dispensed drugs (which was traditional practice in oriental medicine); and
2. pharmaceutical companies, who attempted to influence which drugs were prescribed and dispensed.

The majority of health workers (pharmacists, physicians and hospitals) work in the private sector. They provide care on a “for-profit” basis. Within the national health insurance system, all health workers are paid on a fee-for-service basis. The fees are paid after the service has been provided and the rates for the fees are tightly regulated. Before 2000, the government set the rates at which it reimbursed health workers for drug provision, on the basis of information provided by pharmaceutical manufacturers and wholesalers.

To encourage health workers to prescribe their drugs, pharmaceutical companies sold drugs to health workers at prices that were lower than government reimbursement levels (and thus increased their sales). Therefore, health workers could generate a maximum profit by prescribing the drugs that cost them the least to buy (relative to the government-set reimbursement level) and by prescribing more drugs than were necessary.

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1 By the 1990s, the Republic of Korea spent 31% of the health budget on pharmaceuticals (rising to over 40% when physician fees for prescribing and dispensing were included) compared to the average of below 20% in other high-income countries.

2 In 1997, 62% of consultations in physician clinics included injections compared, for example, with only 8% of outpatient visits.

3 Pharmacists have traditionally played the role of primary health care providers in the Republic of Korea, given past shortages of physicians.
As a result of this financial incentive, pharmaceutical companies and health workers would often work together in illegal and unfair ways to sustain their own profit levels.

In reality, drug prescription practice was based on the drugs that gave health workers higher profits, rather than on the drugs that were the best quality or most cost-effective for the condition being treated. Nonetheless, government bureaucrats turned a blind eye to such practice for a decade or so. Even though the existing policy only allowed physicians to claim a maximum level of profit for drugs (24% of cost), this was not enforced.

The patients’ lack of knowledge was also seen as a factor affecting drug prescription practice. Lack of knowledge limited patients’ ability to challenge prescribing practices. In addition, patients’ preference for some form of medication, reflecting oriental medicine practice, encouraged health workers to over-prescribe drugs.

**Policy change**

On 1 July 2000 the Government of the Republic of Korea introduced a new health policy to prevent physicians and pharmacists from both prescribing and dispensing drugs. Under the new policy (in relation to drugs categorized as prescription drugs) physicians would only be able to prescribe, and pharmacists to dispense.

The reform aimed to reduce the overuse and misuse of drugs, and enhance the patient’s right to know about their medication. Under the new policy, physicians could prescribe either brand name or generic drugs. When dispensing, pharmacists could substitute a generic for a brand name drug provided that an equally effective generic drug (as verified by a bioequivalence test) was available.

**Chronology and experience of implementing pharmaceutical reform**

**Government actions to introduce reform**

Since 1963 attempts to amend the law in order to separate drug prescribing and dispensing had been made. However, these had been unsuccessful due to opposition from physicians and pharmacists, whose strong professional associations actively lobbied against the proposed changes.

However, the 1994 amendment to the Pharmacy Law specified that the separation of prescribing and dispensing would occur by 1999. In 1997 the proposed a model for separation, including a gradual implementation process between 1999 and 2005.

A new President came to power in 1998, after the demise of the previous authoritarian regime, determined to implement this reform as it had been one of the key elements of his presidential election campaign. In May 1998 the Ministry of Health and Welfare established a steering committee to prepare for the separation. To facilitate implementation, the committee made a revised proposal for the reform and classified drugs as either prescription or non-prescription. The civil servants made no special efforts to negotiate these proposals with the affected stakeholders. It appeared that they believed that they could implement policy by instruction, as under earlier authoritarian regimes.
Reaction from civil society
The democratization of the Republic of Korea society provided more opportunities for interest
groups to shape policy processes, and increase their bargaining power relative to the state.

In November and December 1998, the medical and pharmaceutical associations appealed to
Congress to defer the reform. They also appealed to the public for support by emphasizing that:
  • the new system would make it very inconvenient for patients to obtain drugs; and
  • it would not lead to reduced costs or other benefits.

Their activities were opposed by civic groups, mainly progressive academics and political
activists, who had previously opposed military rule and who were aligned with the new
President. These groups made pharmaceutical reform a major social issue, and deliberately
revealed the huge hidden profits made by physicians. This information initially caught public
attention and mobilized support. It also led Congress to reject the medical and pharmaceutical
associations’ appeal.

However, neither the civic groups nor the government put much effort into persuading patients
to support the reform. Little publicity was given to the reason for the reform and its potential
benefits to patients; and little effort was made to address the providers’ claim that it would make
patient access to drugs more difficult. The civic groups also apparently did not take account of
the possibility that revealing physician profit levels to the public would strengthen the physicians’
resistance to the new policy.

Negotiations
Although the medical and pharmaceutical associations’ appeal was rejected, their resistance
and obvious power led the ruling party to enter into negotiations with them. As a result, the
government accepted the professional associations’ request to defer final implementation until
2000. This was on the basis of:
  • an agreement made in March 1999 by the Korean Medical Association on behalf of
    physicians that they would work with civic groups to develop a final proposal for the reform;
  • the medical and pharmaceutical associations’ acceptance, in May 1999, of the civic groups’
    proposals, which had been discussed in five public hearings.

In December 1999 Congress passed the revised Pharmacy Law that provided the legal basis for
the reform.

Implementation of a “no margin” policy
In November 1999, the government implemented the “no margin” policy. This policy reduced the
drug reimbursement fee that the government paid health workers to almost the price that health
workers actually paid to the pharmaceutical companies. This strategy was intended to remove
the physicians’ financial incentive to dispense drugs and so encourage their compliance with the
separation reform. It was put through with little consultation or negotiation. The no margin policy
showed the physicians how great an impact the separation policy would have on their profit
margins (as the effects of the two policies were the same).
In February 2000 about 40,000 physicians demonstrated against the reform. They were led by a splinter group of physicians that rejected the authority of the Korean Medical Association. This was followed by a series of other strikes (on 4–6 April, 20–26 June and 11–17 August). In the second strike more than 90% of family medicine physicians participated. In addition, strikes by resident doctors in teaching hospitals (the vast majority of physicians in these hospitals) began in July and lasted for three months.

The Republic of Korea health system is extremely vulnerable to strikes by private sector physicians. It is heavily dependent on general and teaching hospitals for both inpatient and outpatient care. Only 7% of acute care hospital beds are owned by the government. Therefore, the government not only agreed to raise the physicians’ general reimbursement rates by up to 44%, but also to exempt many injectable drugs from the mandatory separation (although the latter was ostensibly to avoid patient inconvenience). At the same time, in order to offset the threat of further strikes, it increased dispensing rates for pharmacists.

The policy of separating drug prescribing and dispensing was, nonetheless, eventually implemented in July 2001.

Policy impacts
An assessment of the the full impact of the policy is not available. However, three points can be noted:

1. the increases in reimbursement rates secured by health workers will limit the impact of the policy on total health expenditure levels, and may raise total costs for patients;
2. patients will also have to bear the impact of reduced access, and this has already led to patient complaints about the policy;
3. physicians (in particular) have clearly demonstrated their power to influence the health policy process in the Republic – suggesting that the battle to contain the costs resulting from their practices is not yet over.
The role of actors, interests and politics in the design and implementation of HRH policies in post-conflict Republic of Sierra Leone, 2002–2012

Learning objectives

Characterize the role of policy, politics, stakeholder engagement and evidence-informed policy dialogue for shared decision-making.

Tasks and questions

Carefully read the case study below and discuss the following questions in your group:

1. What were the key contextual factors that impacted both policy agenda-setting and implementation?
2. Identify the different spheres of human resources for health (HRH) policy that impact on this policy’s design and implementation.
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6. Drawing on your own experience, what might have been alternative strategic policy levers and courses of action for policy-makers to generate better outcomes? Consider this question from the perspective of specific policy-makers (national or provincial/state/local) you identify in your discussion.
7. What stakeholder engagements would have been necessary to achieve these alternative strategic policy levers and courses of action?

Key insights and lessons will be shared and discussed in plenary.

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Case narrative

Introduction and background

This case study explores the development of policies on HRH in Sierra Leone over the decade after the conflict (2002–2012) to explore the specific features of the post-conflict policy-making environments. The case narrative is based on a study using quantitative and qualitative methods of data collection.

In 2002 Sierra Leone emerged from a 10-year period of war and social and economic unrest. During that time, about 50,000 people were killed and 2 million displaced, which amounted to almost half of the population. It is estimated that more than 20,000 children were conscripted as soldiers. The civil war lasted from 1991 to 2002 and, although it alternated between periods of higher and lower intensity and affected areas of the country in different ways, it paralysed the economy and the provision of public services and caused the destruction of infrastructures and governmental institutions throughout the country. Only 16% of health centres were still functioning in 1996, mainly in Freetown. The public health system in the aftermath of the conflict had practically collapsed.

The unfolding policy story: Immediate post-conflict context and HRH challenges

Concerning HRH, little data and documentation exist and those available are often unreliable and contradictory. As one respondent noted, this reflects the fact that all actors were primarily concerned with the pressing needs of an early recovery and little time was available to produce documents and reports, and even less for academic research.

The available information shows that the challenges faced at the time in Sierra Leone were not dissimilar to those in other post-conflict contexts. The basic health infrastructure was destroyed and services completely disrupted, especially in the eastern and southern parts of the country where most of the rebel activity took place. Health facilities were grossly understaffed as many health workers had left the country, particularly those in the higher cadres. Other health workers were employed by nongovernmental organizations (NGOs) or held dual positions with NGOs and the Ministry of Health and Sanitation. The majority of health workers who stayed in the government service preferred to work in Freetown or in the Western Area around the capital. The data available for that period clearly indicate a significant loss of qualified health workers in the public health sector in Sierra Leone, a gap that remained to be filled in the aftermath of the conflict. Of the 203 medical officers that were present in the country in 1993, only 67 remained in 2005, and of the 623 State Registered Nurses, 152 remained. While the private sector employed only a small minority of the health workforce (HWF), centred in the capital, many health workers in the public sector were working with NGOs in governmental facilities in the few years immediately after the conflict, for which they received incentives and training, with or without a formal agreement with the Ministry of Health and Sanitation. NGOs supporting public facilities also recruited and funded personnel, who were later absorbed in the Ministry of Health and Sanitation payroll.
In those early years, the extreme lack of coordination between the different actors in the health system appears to be an important feature of the policy context. The term “chaos” frequently emerged in respondents’ narratives during the stakeholder mapping:

After the war, it was complete chaos. The NGOs came and went. ... They employed the nurses directly, without even consulting the Ministry. ... They never presented any budget. But this was a war. We had to bend backwards in the Ministry” (Quote from stakeholder mapping – Ministry of Health and Sanitation).

This highlights the fragmentation of the health system at that stage and the struggle that the government faced through the Ministry of Health and Sanitation to create a system and establish control over the HWF. However, it seems that the Ministry of Health and Sanitation was able to maintain a certain leadership to start the process of reconstructing the public health system. For example, in contrast to other countries in similar post-conflict situations, in Sierra Leone health services were provided by public facilities and were not contracted out to other actors of the health system. This choice did not appear to be made explicitly by any of the actors, but was rather the consequence of the specific context; however, it clearly had lasting consequences that affected the future development of the health care system.

**The development of formal HRH policies: 2002–2009**

Against this backdrop, HRH reforms began to develop, although progress towards policy-making for a coherent restructuring of the HWF in 2002–2009 was not rapid or effective. Challenges were correctly identified by the Ministry of Health and Sanitation and potential solutions proposed, but very little was happening in practice.

Relatively minor changes were introduced to improve the management of health workers in order to keep the system functioning. For instance, in 2006–2007, the Scheme of Service was reviewed to ensure a clearer career path and health workers started to receive allowances for housing, remote area placements, and leave. However, the major reforms – suggested in the annual presentations of the Ministry of Health and Sanitation HRH Manager and in other informal Ministry of Health and Sanitation documents – remained unfunded and unimplemented and the response to the HRH challenges fragmented. At the same time, a series of broad policies and strategies were being drafted (Fig. 1). Similar to other post-conflict contexts, these documents tended to be relatively vague normative frameworks rather than operational documents to be reflected in changes at peripheral level. The lack of technical and implementation capacity within the Ministry of Health and Sanitation could explain why policies remained on paper.
External agencies played a significant role in this inaction, in particular because their mandate focused narrowly on production rather than implementation of the strategies. The piecemeal support of the international community did not allow for the strengthening of the Ministry of Health and Sanitation, especially as donors focused on their own programmes, supported one unit or another, which undermined the overall capacity of the Ministry of Health and Sanitation and created a fragmented Ministry with long-lasting consequences.

Among the reasons for the delay in the adoption and implementation of major shifts in HRH policy may also be the lack of clear political vision on the future of the health system more broadly. The consequence of the lack of political guidance and strategic vision was a general sense of “purposelessness”.

For the HRH sector, the drafting of broad policies without an overall vision on how to rebuild and strengthen the health system was a relatively static approach, which left little space for innovation and focused mostly on “fire-fighting”, as suggested by a respondent, i.e. tackling the most immediate issues with quick-fix solutions. The situation substantially changed with the introduction of the Free Healthcare Initiative (FHCI).

**Introduction of the FHCI: 2009–2010**

In September 2009, the President of Sierra Leone, Ernest Bai Koroma, announced at a donors’ conference in London his intention to launch a reform to introduce free health care for pregnant women, lactating mothers and children under 5 years of age. Soon after, the announcement was made in Sierra Leone to the Ministry of Health and Sanitation and partners and an official launching document was drafted. Without doubt, the introduction of the FHCI was a major event that informants consistently mentioned in their narratives about the reconstruction of the health sector.

Different factors emerge as the drivers of change for this reform. Certainly, the health status of the population, with one of the highest maternal mortality rates in the world, as well as emerging...
evidence of financial barriers to access health care, played an important part in promoting the policy. However, even more critical seems to be the role of the President and the lead he took to include his “flagship project” among the government’s priorities. The international environment and pressure from external actors also contributed to its success. Indeed, free health care was at the time an increasingly popular reform in many African countries, supported by some international donors such as the (formerly named) United Kingdom Department for International Development (DfID), which also made funding available tied to the implementation of this particular reform.

The launch of the FHCI provided an opportunity to strengthen health systems and to address in a more comprehensive and organic way the issues that were previously tackled with piecemeal changes. The design and preparation of the FHCI (much more than its implementation) represented an occasion to increase and improve coordination among actors and provide a broad, common objective for all stakeholders. Six technical working groups were put in place, of which one focused on HRH. This group held weekly meetings and was tasked with designing the necessary reforms and providing coordination among the different partners.

With reference to HRH, the launch of the FHCI played an instrumental and catalytic role in pushing reforms. It was explicitly recognized by all stakeholders that addressing issues affecting the HWF was critical for the success of the FHCI, for at least two reasons: firstly, health workers would have to deal with an increased workload; and secondly, both health workers and facilities would need to be compensated for the loss in revenues. With inputs from the Working Group, HRH reforms began, leading to an increase in salary for all health workers in technical positions by April 2010. The increase was substantial, ranging from 314% for the lower grades up to 705% for the higher grades. As a corollary to the salary increase, an in-depth verification and authentication of the Ministry of Health and Sanitation payroll was carried out to eliminate “ghost workers” and thus ensure that only legitimate staff were included. Additionally, a mobile programme was put in place at district level to fast-track recruitment of new health workers and those already volunteering in the facilities. Simultaneously, discussions began on a system to monitor the presence of health workers in the facilities, which was introduced in mid-2010 when staff absence began being monitored through the Attendance Monitoring System. This was complemented in January 2011 by the implementation of the Sanctions Framework.

The decision-making process that led to the choice, design and implementation of these reforms was less smooth and linear than it would appear from the end results. While the creation of interagency working groups undoubtedly increased coordination, some issues were hidden under the surface. As one NGO respondent recalls, “Of course we had our working group meetings and we would talk, but these were the ‘big lines.’ If you go to the little activities, we were not so well coordinated.” Similar concerns emerged around the role of the donors, their different views on FHCI and on how certain components of the health system could be reorganized to provide free health services. For example, an argument between two donors over the merits of a salary increase vs the introduction of a performance-based financing (PBF) scheme stalled the discussion for some time. As a key informant recalls, “These meetings [of the HRH Working Group] were completely dominated by [two donors] having their ideological fight effectively. I mean … when these two big donors are busy having a fight, week after week after week, not much else gets discussed.”
In the end, while conflicting agendas and ideologies may have played a role in the decision, the choice of policy approach (i.e. the salary increase) was ultimately taken on the basis of practical feasibility. Although it was recognized that PBF would have had the advantage of improving the accountability of health workers, it was also agreed that setting up a PBF scheme would have higher transaction costs and take longer than a salary increase. This was perceived as a major disadvantage given the urgency of the launch of the FHCI (donor respondent). Moreover, after a nationwide health workers’ strike for higher salaries in March 2010, this option became inevitable.

What emerged from the analysis is that the Ministry of Health and Sanitation perspective seemed trapped between the donors’ agendas and the funding possibilities that accompanied those agendas. It also appeared that the measures taken, such as the “payroll purge” and the Sanctions Framework were not only strategies to improve HRH management and performance, but also a conditional request from the donors funding the reform, particularly DfID, in order to protect their investment and minimize risk of misuse of their funds.

Several episodes confirm the influence of external actors, as well as the fragmented and serendipitous nature of policy-making at the time. Many respondents recognized the drawbacks of the technical assistance provided, characterized by high turnover and poor coordination, which resulted in the loss of institutional memory, duplications and incoherence in policy-making and implementation. This was, for example, the case with the review of the Ministry of Health and Sanitation payroll in 2009–2010, which had already been carried out a few years before for the entire civil service.

**HRH policy-making after the FHCI: 2011–2012**

Beyond the urgency of the FHCI launch, the momentum for the collaboration between the Ministry of Health and Sanitation and partners seemed diminished, if not lost, afterwards. The working groups were reported to meet much less regularly after the launch and were almost inactive by March 2013. Nevertheless, two major reforms were implemented after 2010, which in fact had been discussed or planned at the time of the FHCI design: a PBF scheme and a remote allowance for health workers in rural posts.

While the discussion of a PBF scheme became detached from the design and planning of the FHCI, since the salary increase option was preferred, meetings to plan the PBF continued, especially between the World Bank and the Department for Planning and Information (DPI) of the Ministry of Health and Sanitation. The scheme was designed and has been implemented since April 2011. Along with the World Bank – which, as the promoter and funder of the scheme is recognized to be the driving actor for its implementation – the DPI played a critical role and remains in charge of the operationalization of the policy. In contrast, the Department for HRH, which is in charge of the payroll management (supported, incidentally, by a different donor) is far less involved in the scheme and has surprisingly little overview of the working mechanisms of the PBF. The consequence of this is further fragmentation, not only in terms of the design of HRH policies and the package of incentives for health workers, but also in the implementation of the PBF scheme. This has been plagued with severe delays in payments to the facilities, which undermines the effectiveness of the scheme and may have had negative consequences on the performance of the health workers.
A similar story applies to the remote allowance for health workers that was introduced in early 2012. This policy had already been discussed before the launch of the FHCI; however, it was not implemented because of the lack of resources. As further support from the Global Fund became available, the policy was finally designed and introduced. Again, the DPI is mainly responsible for its implementation and, despite some collaboration with the Department of HRH to access payroll data, there appears to be a strict division of tasks between the two departments, with little transparency in its management. As a consequence, few actors seem familiar with the mechanisms for eligibility and funding. Furthermore, the remote allowance currently rarely reaches eligible health workers due to the discontinuity of the Global Fund support, as well as poor communication and coordination within the Ministry of Health and Sanitation. The separate management of the remote allowance creates further fragmentation of policies and activities, even within the Ministry of Health and Sanitation.

Beyond these two major reforms (and their implementation challenges), several HRH issues remain unsolved or only partially addressed. For instance, the mobile recruitment programme set up during the preparation for the FHCI remained a one-off exercise. For the routine recruitment of health workers, the establishment of a Health Service Commission was planned to replace the Human Resources Management Office. Despite the Commission being established by a Governmental Act in 2011 and the Commissioners being nominated, it appeared to be still not functional in March 2013. Similarly, pre-service training was overlooked in the rush to launch the FHCI, in order to focus on aspects that could be addressed faster (e.g. recruitment of health workers and in-service training). In-service training proliferated in an uncoordinated manner and only in early 2014 did the Department of HRH prepare an HRH Training Plan for the next 10 years, to ensure the standardization and coordination of both pre- and in-service training. The role of non-financial incentives for the motivation of health workers, particularly for those in rural postings, also emerged as largely ignored by policy-makers. In terms of official Ministry of Health and Sanitation policies, while the documents prepared before 2009 have remained mostly on paper, as described above, those approved following the FHCI launch – in particular the HRH Policy (2012) and the HRH Strategic Plan 2012–2016 – seem to have been prepared to give an official shape to the changes that had already taken place at operational level in HRH strategies.

**Features of the policy-making context**

The HRH policy trajectory in Sierra Leone shows the role played by historical events and contextual factors in defining future choices (the concept of “path dependency”). The emergence of the FHCI initiative, which acted as a catalyst with respect to both the internal political will and the external (political and financial) support, was critical to build momentum, open a political window of opportunity and create widespread support for radical reform in all aspects of the health system, including HRH.

It could be argued that some elements that are common in a post-conflict context facilitated this process. One of these is the fluidity of power relations and dynamics between influential actors that could facilitate reform. An example of this emerged in our study. While in other countries the professional boards are a powerful actor and the relations between these bodies and the Ministry of Health are entrenched in the system (often limiting the space for reform on HRH issues), in
Sierra Leone the power relations with the professional associations seemed much more fluid. The Nursing Board, for instance, is chaired by the Chief Nursing Officer (Director of Nursing) at the Ministry of Health and Sanitation, and is by definition aligned to the decisions taken by the Ministry of Health and Sanitation, so that there is little or no opposition to radical changes. No opposition to the introduction of the Sanction Framework came from any of the professional boards on behalf of their affiliates. Further, it is possible that because of the state of the health system, the launch of the FHCI could not be based on some relatively minor, incremental measure, but it required wider reforms, including for HRH. It could be hypothesized that in other non-post-conflict contexts, such reforms could be postponed or diluted over time. However, in a reconstruction context, the gravity of the situation and the general climate of reform, renovation and change could foster new initiatives and gather national and international support around them.

Other features of the policy-making environment highlighted by the analysis are less specific to the post-conflict context. It could be argued that they are not qualitatively different from those in other low-income settings, but that perhaps the differences are only quantitative (i.e. same issues but worse) or, in fact, negligible. One such feature relates to the role of external actors in influencing the policy-making processes, which occurs in non-post-conflict settings and is well documented in post-conflict where governments are under-resourced and weak. Also, HRH measures such as the reorganization and management of the payroll received high levels of donor-funded technical assistance, which may have allowed their realization, but raises concerns around their sustainability in the longer-term. Moreover, reforms remained incomplete as the adoption and implementation of other necessary measures (e.g. recruitment and deployment of health workers, improved pre-service training and development of non-financial incentives) were not pursued or pursued in a slow and partial manner.

Finally, the apparent success of Sierra Leone in addressing HRH issues by taking advantage of a window of opportunity for reform cannot hide the evident challenges of having HRH changes pushed forward by short-lived political pressure. As a consequence of the urgency of the reforms, preference was often given to one-off exercises such as the mobile recruitment programme, or shorter-term solutions such as the decision to overlook pre-service training or the postponed introduction of the remote allowance. The decision space for the reform of the health system did not open in the immediate post-conflict period, which was instead characterized by incremental policy-making and stopgap measures. A window of opportunity opened later on (eight years after the end of the war), making it difficult to link it directly to the features of the immediate post-conflict policy-making environment.

Similar to other settings, much attention was generated around the design of the policies, while far less was given to their implementation at local level. This remains problematic, despite some innovative features such as the use of civil society monitors at facility level.
The complex relationships among actors involved in the implementation of public–private mix for TB control in India

Learning objectives
Characterize the role of policy, politics, stakeholder engagement and evidence-informed policy dialogue for shared decision-making.

Tasks and questions
Carefully read the case study below and discuss the following questions in your group:
1. What were the key contextual factors that impacted both policy agenda-setting and implementation?
2. Identify the different spheres of human resources for health (HRH) policy that impact on this policy’s design and implementation.
3. Identify the most important actors/groups in the case study. How would you characterize:
   a. their roles and leadership style?
   b. the power they hold?
4. Discuss the most important disjunctures between policy intent and implementation and what caused them.
5. Which policy decisions and actions advanced or undermined the meeting of the policy goals, and how?
6. Drawing on your own experience, what might have been alternative strategic policy levers and courses of action for policy-makers to generate better outcomes? Consider this question from the perspective of specific policy-makers (national or provincial/state/local) you identify in your discussion.
7. What stakeholder engagements would have been necessary to achieve these alternative strategic policy levers and courses of action?

Key insights and lessons will be shared and discussed in plenary.

Case narrative

Introduction
Public–private partnerships are increasingly promoted in India and globally as an innovative strategy to strengthen local health systems. Such partnerships are specifically recognized to be important in the significant scaling up of essential services needed to achieve the national and the global visions espoused by universal health coverage (UHC), itself highlighted within the Sustainable Development Goals.

This case study explores the complex relationships of actors involved in the implementation of public–private partnerships within a district in southern India. It focuses on the implementation of the national policy to engage the private sector in tuberculosis (TB) control. It highlights that the relationship with the private sector is a crucial element of governance, and relationship-building is an important aspect of partnerships.

Background
As per the Global TB report 2017, India was among the five countries having the largest number of incident cases in 2016. In that year, the estimated incidence of TB in India was approximately 2.8 million, accounting for about a quarter of the global burden of TB. The Revised National Tuberculosis Control Programme (RNTCP) in India employs a comprehensive approach, involving a wide range of public and private providers previously not linked to the TB control programme. The national public–private mix (PPM) policy for engagement with the private sector has been a core component in the TB control strategy for more than a decade. The partnership initiatives under this policy broadly aim to strengthen the referral systems between the public, the private and nongovernmental (NGO) sectors to reach out to more patients and to provide standardized diagnosis and treatment. The RNTCP established designated microscopy centres (DMCs) across the country, but accessibility to these centres in hard-to-reach areas remains suboptimal. It is envisaged to establish NGO/private provider supported sputum collection centres to enhance equity and facilitate access for patients. This case study is set within a district in a southern state of India due to its decade old history of PPM for TB control. More specifically, it focuses on one of the nine TB units established within the district. Each TB unit covers an approximate population of 500,000 and each consists of 4–5 DMCs.

The role of actors in programme implementation
The RNTCP is one of the 13 national health programmes implemented by the Department of Health under the Ministry of Health and Family Welfare. The RNTCP is led by the Central TB Division that coordinates the implementation of the programme (Fig. 1). The state, district, sub-district and peripheral health institutions then implement the TB programme. At the district and sub-district levels, the RNTCP is well integrated into the general health system and can be considered the crucial level of health service delivery, where vertical health programmes and policy intentions are translated into practice. NGOs can collaborate with a programme and adopt schemes as large as running culture and drug susceptibility testing laboratories, to schemes as small as running a sputum collection centre. Similarly, private health workers can refer suspected TB cases for sputum samples to an RNTCP DMC and, if willing, can provide a Directly Observed Treatment Short-course (DOTS) for patients diagnosed with TB and initiated on DOTS.
Fig. 1. PPM-TB implementation at the study site

PPM-TB: public–private mix for TB control.

The PPM-TB policy guidelines encourage the public sector (RNTCP) to strengthen the referral systems between the public, private and NGO sectors, to provide standardized diagnosis and treatment service, and improve the quality of service delivery. Over the years, the PPM-TB policy has evolved and its scope has broadened to include actors across different sectors and at different levels having varying roles and responsibilities (Table 1).

<table>
<thead>
<tr>
<th>Actor</th>
<th>Role and responsibility</th>
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<tbody>
<tr>
<td>District TB Officer</td>
<td>Key person in programme implementation, holding crucial responsibility for: identifying the partners; developing links with them; and maintaining sustainable partnerships. The Officer is also responsible for calling the District TB Control Society meetings on a quarterly basis and for inviting the partner NGOs to these meetings.</td>
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</table>
| Health workers involved in the delivery of TB services (health workers)| Provide feedback to private sector health workers referring suspected TB cases:  
  • If the patient does not have TB, the health worker informs the referring private sector health worker accordingly.  
  • If the patient is diagnosed with TB, the health worker requests the referring private sector health worker to provide DOTS.  
  • If the private sector health worker is unwilling, the health worker, with consent from the referring private sector health worker, places the patient’s treatment box in another nearby DOTS centre. The health worker then counsels the patient to see the referring private sector health worker with any other problems, and for any drugs other than TB medicines.  
Identify a person who provides DOTS depending on the patient’s willingness and convenience:  
  • A person who provides DOTS could be anyone from a shopkeeper to a qualified medical practitioner.  
  • Once the patient shows stability in treatment, and if willing, the field staff moves the patient’s treatment box to the closest DOTS centre.  
  • The field staff further informs the person who provides DOTS that the patient needs to be given drugs on alternate days.  
Follow up with the person who provides DOTS:  
  • The health worker visits regularly to follow up on the case until treatment is completed.  
  • The health worker then reports the successful completion of the treatment to the Senior Treatment Supervisor (STS).  
Provide honorarium to the person who provides DOTS:  
  • The health worker updates the STS about the necessary supervision for the person who provides DOTS.  
  • The STS prepares a list of all such people every quarter and sends it to the District TB Office for release of the honorarium.  
  • Within 3 to 6 months, the health worker receives a cheque in hand, which is handed to the person who provides DOTS, in person against a signature, which is returned to the District TB Office. |
**Private sector health worker**

Private sector health workers can get involved in a single or in multiple activities depending on their capacity, interest and the requirements of the programme:

- Provision of DOTS – private sector health workers are expected to ensure follow-up on sputum collection and late patient retrieval, to maintain RNTCP patient records, and to permit on-site monitoring by RNTCP supervisory staff as per RNTCP guidelines.
- Referral of TB patients – they refer suspected TB cases for diagnosis and treatment, irrespective of whether the patient is diagnosed as having TB in a private laboratory or not.
- People providing DOTS can also refer suspected TB cases.

The person who provides DOTS receives an honorarium of Rs. 250 (US$ 3.9) per case that has successfully completed treatment, whereas in the case of multidrug resistance (MDR), the amount goes up to Rs. 1000 (US$ 15.9) per case.

**Nongovernmental organizations (NGOs)**

NGOs play an important role in supporting the RNTCP by making treatment more accessible to TB patients through various strategies and programmes, including community-based DOTS.

The RNTCP maintains a formal relationship with NGOs through signing a memorandum of understanding (MoU).

As per the revised schemes for private sector health workers/NGO involvement, NGOs can opt for single or multiple schemes depending on their experience and capacity:

- The RNTCP pays on a quarterly basis for the particular scheme chosen.
- The duration of an MoU is one year and is renewable.
- The NGOs need to re-apply to the District TB Office for funding each year.

Applications are made to the district TB offices, and are renewed only after being signed by the District Magistrate/Collector.

The policy guidelines for the involvement of private sector health workers and NGOs highlight the crucial role of the District TB Officer and the health workers in building and maintaining sustainable partnerships. In addition to district programme managers, health workers working in the TB units and DMCs are also seen as the “face” of the programme at the field level. They come into day-to-day contact with private sector health workers and NGOs to develop both formal and informal partnerships. Although the health workers’ role in involving private sector health workers may appear to be quite mechanical, it nevertheless requires a lot of time and effort to build, and subsequently maintain these relationships.
Individuals, roles and capacities

Individuals operating across the programme had varying roles and expertise: health workers were the ones who knew the ins and outs of the programme at the implementation stage. They identified themselves as “pillars of the programme”, and considered that their responsibility went far beyond the patients alone, towards society itself. The TB programme was not merely a workplace, but an opportunity to serve the community, to learn new things that would be treasured for a lifetime. A senior health worker, who had been a regular government employee, expressed his feelings of working with the TB programme:

… the TB service will remain as a memory. Apart from all government employees in all other programmes, I understand that the one who is working in TB is the one working hard and no one else works like him. Work happens promptly in the TB programmes [Interview, Multi-Purpose Health Supervisor].

All health workers saw the reward for their hard work in terms of the long-term relationships they developed with the patients.

However, the position of health workers was complex. They were trained to work in TB units and DMCs, yet also had to operate at the margins of the public–private interface. Having to engage with, and work within, the complexities of PPM-TB relations disempowered them. In the absence of cultural capital and knowledge of policy, as well as a lack of skills in dealing with private sector health workers, health workers feared that the authority and respect they possessed within the TB units was undervalued in the private sector, giving them a sense of inferiority. This inferiority complex was greater in dealing with allopathic practitioners, who were considered to be busy, arrogant at times, and lacked interest.

… as a Senior Treatment Supervisor, I cannot go directly to a private practitioner and tell him [to refer cases] … but if my Medical Officer comes with me and talks to the private practitioners, something may happen … our level is different; their level is different [Interview, Senior Treatment Supervisor].

Similarly, NGOs working in close proximity with the community and patients identified themselves as the vital link in the TB programme. NGOs perceived themselves as true partners and took pride in their contribution: bringing a high level of TB awareness among the community; establishing linkages between the community and the government; developing the community DOTS programme; and advocating changes in the RNTCP policy. In terms of the policy continuum, NGOs saw themselves positioned at the service end, working closely with “everyday people”. This also meant reaching marginalized and vulnerable patients, and those beyond the reach of the public sector.

… We have administrative machinery from top to bottom to deliver the services to the common man. Unfortunately, they don’t reach the right people who should benefit from such services. So we have a watchdog role, to see that these services reach the right man [Interview, NGO Chief Executive Officer].
However, lack of acknowledgment and support by the district authorities undermined their authority in the programme.

Partnering NGOs saw their role not only at the level of service provision but also at the level of policy revision. Over a decade ago, one NGO had initiated a pilot experiment establishing a sputum collection centre in a remote, hard-to-reach area. This initiative was part of one of their projects funded by an international donor. After an evaluation, they found the concept of the sputum collection centre practical and feasible, and later advocated for the initiative at state and national level. The NGO finally managed to include this concept as a policy component within the TB programme.

This said, some NGO partners felt that the system, including district programme managers, failed to recognize their efforts and hard work. In the absence of a proper referral recording system at the DMCs, partners felt demotivated, questioning the value of the partnerships and whether the government was truly committed.

The Indian Medical Association (IMA) was also considered an important partner. IMA’s involvement was spoken of and supported by national programme managers and policy-makers, and it was actively involved in training allopathic practitioners. A representative of IMA mentioned that the IMA was not running a parallel programme, but a support programme.

Private sector health workers saw themselves as key with different roles within the PPM-TB policy, such as to guide patients, to promote them, save them, or to show them the right direction. This was exemplified in an interview with an Ayurvedic practitioner, who noted that private sector health workers were more accessible and approachable to patients, who “… seldom go to big hospitals, corporate hospitals, and mostly they don’t prefer government institutions”.

Private sector health workers – along with health workers and NGOs – justified their own positions: their “self-representation” was not only a way to project their strengths but to highlight the weaknesses of others, and to complain about a lack of respect and recognition for their role and expertise (dislocation).

Private sector health workers felt that their educational background and professional status within the medical field was undervalued in the PPM-TB field. For example, the entire idea of referring suspected TB patients to government health facilities, and if diagnosed positive, to put them on standardized DOTS medicines, challenged the traditional medical role of private sector health workers as prescribers or the decision-makers for referrals. This was particularly perceived by private sector health workers unable to use their own system of medicine, including Ayurveda and homeopathy, as a supportive TB treatment. Private sector health workers felt that their diminished role in TB management not only decentralized the programme but also despecialized their skills. A senior physician who has long-term experience of managing TB patients in his own clinics within the private regimen asserted, “As a private doctor, I am not interested in Rs. 250. What I need is the freedom to prescribe for my patients.”
The impact of actors’ coping mechanisms on policy implementation

As a response to perceived and actual lack of recognition and respect in the PPM-TB field, and in order to maintain their positions, health workers used various coping mechanisms and strategies at the individual and organizational levels to navigate the programme and its relationships.

IMA professional partiality

The IMA played a powerful role in maintaining the primacy of allopathic (science-based, modern) medicine, to the extent of opposing anyone unqualified in allopathic medicine from practising allopathy. In recent years, the IMA strongly lobbied against the legalization of unqualified medical practitioners and their utilization in any health programme and even dismissed them as “qualified quacks”.

Non-allopathic practitioners remained sidelined from the policy stream. One policy-maker, commenting on the involvement of non-allopathic practitioners, acknowledged that they refer a large number of TB patients and make a substantial contribution to the programme. However, the policy-maker had reservations about legally incorporating non-allopathic practitioners into written policy documents due to pressures from the IMA.

...When we were writing up private practitioners schemes, we refrained from putting that [involvement of informal providers], because the moment it enters into the government document, the IMA will come down strongly against us, saying that we are legalizing quackery. So it will not be in any written documents, but the fact is that we are very well aware of it and we recognize their work in the field. A huge chunk of TB patients goes to them only, they are the first point of contact, so we always say and we always advise the programme officers, that they have to be included, they should be the person providing DOTS, or the referral points. But you will not find it in any of the schemes as such, because then it is against the ethics. [Interview, National level PPM-TB Consultant].

NGOs, based on their field experience of training non-allopathic practitioners, elaborated on this gap in policy: "We identify RMPs [rural medical practitioners], whether the government recognizes it or not [as] ... they don't count them as real partners in the RNTCP [Interview, NGO Programme Officer].

IMA maintained its authority based on its educational and professional profile, while this has hindered the potential to create a partnership policy that encompasses all health care providers.

Private sector health worker authority

In terms of the PPM-TB policy, allopathic practitioners did not participate fully because of the programme’s inflexibility in prescribing private treatment. As per the RNTCP guidelines, the person providing DOTS was expected to ensure follow-up sputum collection, late patient retrieval, maintain RNTCP records for the patients, and permit on-site monitoring by RNTCP supervisory staff. Health workers, however, had observed that the private sector health workers considered the updating of cards to be an additional task and were often unwilling to keep the DOTS boxes. In the interest of the patients, health workers negotiated with the private sector health workers and took the responsibility of updating the cards, leaving the responsibility of dispensing medicine with the private sector health workers.
Although private sector health workers referred patients to the DMCs/DOTS programme, they enjoyed autonomy in terms of which patients were to be referred. They supported DOTS in principle, but in practice made no efforts to counsel and encourage patients to go to the DOTS centres. Private sector health workers did mention their role in counselling and giving patients a choice to select their treatment provider based on affordability; however, patient decisions were mostly influenced by a private sector health worker’s individual judgements.

**Health worker discretion in approaching private sector health workers**

While health workers often worked in resource-limited settings, they were pressured by programme policies. A lack of human and financial resources not only hampered routine fieldwork, but also demotivated them from taking on new activities.

As a routine practice, and based on their experiences with private sector health workers in general, health workers only visited private sector health workers who had DOTS boxes in their clinics and often excluded those who did not. Furthermore, programme staff made no active attempts to sensitize private sector health workers to provide DOTS or refer cases, leaving a large number of them outside the purview of the programme.

The involvement of private sector health workers was seen primarily from the perspective of simply meeting targets, rather than building a long-term relationship to enhance capacities. In principle, health workers approved of the PPM-TB policy, however, in practice they had a negative attitude towards private sector health workers and NGOs and limited the number of field visits they made.

**The autonomy of NGOs**

NGOs, on the one hand, were undervalued by the public sector in the PPM-TB field, while the public sector and the funders still expected them to perform well. NGOs often struggled to strike a balance between fulfilling the expectations of the programme and meeting the performance targets of their funders. As coping strategies, they developed their own mechanisms to achieve the targets and, in order to maintain their identity, distanced themselves from partner NGOs with whom they had no collaboration.

**Conclusions**

The study found that programme managers, health workers, NGOs and private sector health workers all had a crucial role to play in TB partnerships. They were widely regarded as valued contributors with distinct social skills and capabilities within their organizations and professions. However, their potential contributions to programme implementation tended to be unrecognized at the bottom level of the policy implementation chain. These actors constantly struggled for recognition and used different mechanisms to position themselves alongside other actors within the programme, which further complicated relationships. As a result, all actors used different coping strategies to retain their positions in the shared field of PPM-TB: health workers approached private sector health workers selectively; private sector health workers avoided referring patients; the IMA forced measures at the policy level to disadvantage non-allopaths; and NGOs developed their own referral models.
The study contributes to our understanding of implementation of public–private partnerships for TB control and builds knowledge to help policy-makers and programme managers strengthen and effectively implement strategies to enable stronger governance of these partnerships. The actors entrusted with carrying out the implementation of a policy or programme operate within the capital resources available to them in their particular professional field. A policy or programme can only succeed by respectfully recognizing the positions of those implementing it, and by indicating that the programme depends on their active participation. Such recognition needs to go hand in hand by truly involving the different actors, which could include incentives (both economic and non-economic) for their efforts. This might increase their enthusiasm and responsibility towards the policy/programme they are involved in implementing. If this enthusiasm is supported by a strong, shared vision, through imparting adequate information about the policy intentions, it will bring meaning to their relationships with other actors, thereby contributing to a strengthened system.
Criworkhea health labour market analysis

Learning objectives

• Identify and describe the different components, dynamics and flows of the health labour market (HLM).
• Interpret findings of the analysis of HLM dynamics and articulate relevant policy options.

Tasks and questions

To guide the plenary discussion, you are tasked with preparing an analysis of the situation in Criworkhea in small groups (3-page written summary and presentation for each group) and with proposing policy options. The following questions should guide your proposals:

1. What is the role of the health sector, compared with other sectors, as a source of employment?
2. How attractive is the health sector for current and future health workers in terms of decent work/employment conditions?
3. What are the main challenges of the Criworkhea health education market? How do these challenges affect the HLM?
4. What is the mismatch between the supply and demand of health workers?
5. What immediate, medium- and long-term policy options do you recommend?

Case narrative

Background

The Prime Minister had asked the Minister of Health, Dr Anaky, to meet the Head of State, His Excellency Professor Tiktu earlier in the day. Professor Tiktu is unhappy with the growing concern of the population about the quality of public health services, especially for those living in the capital of Criworkhea, Belamoi. This ongoing concern is having a negative impact on his current re-election campaign. During the meeting, the Head of State made it clear that the strikes and the counterproductive press coverage were to stop immediately, urging Dr Anaky to resolve the situation. At his return from the meeting, Dr Anaky called all his senior managers to a meeting to find immediate, medium- and long-term solutions to resolve the crisis.

For the past month, the state of the country’s public health services has featured in the headlines of the daily newspapers. During the previous three months, public sector health workers (nurses, midwives, supported by the medical doctors) conducted recurring strikes because of their work conditions. According to the press, the population is not satisfied with the services received in the health facilities for the following reasons:

• lack of a referral system;
• unrespectful care and lack of personalized services;
• poorly maintained facilities and lack of diagnostic equipment in the hospitals;
• lack of drugs;
• service disruptions due to various trade union strikes;
• extended waiting periods, particularly for surgeries.

This morning, the weekly journal “Daily Press” published the following story:

“A man who is a low wage earner came to seek treatment at one of our many public hospitals. The hospital was overcrowded, and the waiting line was disturbingly long. He had to lose some of his wages for the day since this hospital only offered outpatient services during regular working hours.

Hours later, after his consultation, a new problem arose: the hospital did not have the supply of drugs the doctor prescribed to him, neither did it offer the laboratory services he needed. He had three options: forgo treatment, wait for months until the resources became available, or turn to private services, thus incurring heavy financial expenses.

This man is from one of the 65% of the country’s households who spend out-of-pocket for surgery, drugs, laboratory tests, specialized treatment and medical investigations. This means that many people are compelled to either forgo their health care needs or utilize private health care providers; and it is the poorest people who are the hardest hit by these financial burdens.”

**General situation in Criworkhea**

Criworkhea is a lower middle-income country in South Asia sharing a border with Chinrini. The country is home to many religions, ethnic groups and languages. The official languages are Malaki and English, which are widely used for education, scientific and commercial purposes. However, different ethnic groups speak other languages.

**Demographic and health situation**

The total population in 2020 was 21.4 million. The life expectancy recently rose to an average of 72.5 years for men and 78.0 for women. In 2021, 0.3% of the population fell below the poverty line because of debts connected to illness. The country has achieved remarkable economic growth in recent decades; its flexible and skilled workforce drives much of it. However, the fertility rate has dropped from 5.5 in 1975 to 2.4 in 2020 and continues to fall. In parallel, the proportion of the population over 60 years has increased steadily since 2001 and will continue to grow; some 40% of the population will be aged over 60 in 2030. This demographic shift leads to an ageing population with greater dependency and burden on the active workforce; and the gradual decline in the workforce poses a threat to the country’s economic growth.

This demographic change also contributes to a dramatic increase in noncommunicable and chronic diseases, which require longer hospitalizations. The inpatient hospital utilization was 250 per 1000 population in 2014 and 300 per 1000 in 2020, making the rate of inpatient care significantly higher than in most neighbouring countries.

Rising urbanization has led to increased unhealthy diets and consumption of alcohol, and reduced physical activity, which has increased the proportion of the population overweight and obese. This, in turn, has led to a higher prevalence of lifestyle-related diseases such as cardiovascular diseases, diabetes, cancers, chronic obstructive pulmonary diseases, and asthma. Noncommunicable diseases currently account for 80% of Criworkhea’s health problems and 65%
of deaths, and are reshaping demand for health care in the country.

Diseases such as viral fever, dengue fever and malaria generally increase during the rainy seasons. A third of women of reproductive age suffer from poor nutrition. The socioeconomic and health situation is comparably worse in rural and remote areas. Lower education levels also exacerbate the situation, together with difficulty accessing health care services for logistical reasons such as transport limitations, lack of good roads, ill-equipped health facilities and shortage of health workers. Table 1 outlines key information about the country’s macroeconomic situation.

Table 1. Macroeconomic and demographic situation

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2016</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population</td>
<td>19 597 301</td>
<td>20 331 276</td>
<td>21 398 000</td>
</tr>
<tr>
<td>Rural population (%) of total population</td>
<td>40.4</td>
<td>39.8</td>
<td>38.0</td>
</tr>
<tr>
<td>Urban population (%) of total population</td>
<td>59.6</td>
<td>60.2</td>
<td>62.0</td>
</tr>
<tr>
<td>GDP per capita, purchasing power parity (constant 2011 international $)</td>
<td>19 597 301</td>
<td>20 331 276</td>
<td>21 398 000</td>
</tr>
<tr>
<td>Unemployment rate (%) of adult population</td>
<td>7.8</td>
<td>6.1</td>
<td>4.7</td>
</tr>
<tr>
<td>Domestic private health expenditure (% of current health expenditure)</td>
<td>60.40</td>
<td>57.81</td>
<td>54.89</td>
</tr>
<tr>
<td>Out-of-pocket expenditure (% of current health expenditure)</td>
<td>53.30</td>
<td>52.93</td>
<td>52.69</td>
</tr>
<tr>
<td>Domestic general government health expenditure (% of current health expenditure)</td>
<td>38.44</td>
<td>40.8</td>
<td>44.09</td>
</tr>
<tr>
<td>External health expenditure (% of current health expenditure)</td>
<td>1.16</td>
<td>1.39</td>
<td>1.07</td>
</tr>
<tr>
<td>Labour force participation rate, total (% of total population aged 15+)</td>
<td>52.3</td>
<td>54.1</td>
<td>54.2</td>
</tr>
<tr>
<td>Labour force participation rate, male (% of male population aged 15+)</td>
<td>69.0</td>
<td>72.6</td>
<td>75.0</td>
</tr>
<tr>
<td>Labour force participation rate, female (% of female population aged 15+)</td>
<td>34.3</td>
<td>35.8</td>
<td>36.3</td>
</tr>
</tbody>
</table>
Economic growth in Criworkhea
Criworkhea's gross domestic product (GDP) per capita is US$ 3,835 (purchasing power parity). In 2016–2021, the GDP grew at an average of 6.2%. This growth is slightly lower than other South Asian countries, where GDP averaged 7% for the same period.

Criworkhea is transitioning from a rural agro-based economy to an urbanized one oriented around manufacturing and services. Growth in the capital and surrounding areas now drives around 45% of the country’s GDP, even though only 29% of the population live there.

The service sector is currently the largest employer of labour. In 2021, of the 7.9 million jobs in Criworkhea, 47% were in the service sector compared with 26% in industry and 27% in agriculture. The percentage of employment growth by sector between 2011 and 2021 was: 25% for service sectors, 10% for jobs in industry, and a 5% decrease in agricultural jobs. Job creation in the service sector contributed to a fall in the country’s unemployment rate, which was 4.7% in 2020 down from 14.5% in 1997. This said, youth unemployment is at 20% for those aged 20–24 years, the highest among all age groups in Criworkhea.

Around 60% of all employment is estimated to be informal; 54% of working females are employed in the informal sector. While this informal sector plays a crucial role in health care provision, information on the sector is very limited.

Female labour force participation rate
Criworkhea has one of the biggest gender-based labour participation gaps in Asia, with females less likely to have a formal job or be seeking paid employment. The overall labour force participation rate in 2020 was about 54%, 36% for females and 75% for males. The female rates lag the male rates despite a comparably high literacy rate.

In 2021, 62% of the jobs in the health and social sector were held by women. Most nurses in Criworkhea were female. Since 2005, more than half the medical students are female, and since 2011 around 70% of students enrolled in paramedical education are female.

Health system in Criworkhea
The Ministry of Health is responsible for providing comprehensive health services, which include services for preventive, curative and rehabilitative care. It is led by the Minister and Deputy Minister of Health, followed by the Director-General of Health Services. The Director-General of Health Services is the officer responsible for guiding policy-makers at a political level, policy-making, programme planning, and implementation for all health services in the country. There are several Deputy Directors-General (DDG) who serve under the Director-General. The DDG for Public Health Services is directly responsible for the delivery of all health care services. A Chief of Division leads the Health Workforce Unit under the DDG for Planning.

In addition to the Ministry of Health, the structure is further broken down to nine provincial ministries with an equal number of Provincial Directors of Health Services responsible for planning, implementing, and monitoring all health programmes, including public health programmes within the provinces. The 25 district level ministries operate under the leadership
of the Deputy Provincial Directors of Health Services, including the management of all hospitals (excluding teaching and specialized hospitals). The district levels will liaise with the provincial level ministries while the latter liaises with the ministries in central government.

The public health sector is under the responsibility of the government and its local representatives. The government spending budget for health has not increased in the last five years, and wealthier people are turning to the private sector.

The private sector health care institutions are expected to register with the Private Health Services Regulatory Council. The Council is represented by professional bodies such as Criworkhea Medical Council, Independent Medical Practitioners Association and Dental Association and is headed by the Director-General of Health Services.

Health care expenditures

Health expenditure in Criworkhea gradually declined from 4.5% of GDP in 2011 to 3.5% in 2021. Also in 2021, the general government expenditure on health as a percentage of total government expenditure was about 8%, a decline from the 10% average of the 2000s. Historically, expenditure on health care has trailed GDP per capita with a split between private and public sectors: private expenditure reached US$ 1084 million and the public sector US$ 891 million in 2020.

Government expenditure on health care is funded through general revenue taxation and other government receipts and channelled through the Ministry of Health. However, there is a growing challenge of fiscal constraints due to the low number of taxpayers. Private expenditure on health care is dominated by out-of-pocket expenditure (almost 96%), with the remainder relatively evenly split between private insurance, employer provision of private insurance and benevolent funds. Overall expenditure across public and private sectors is expected to grow by about 11% per annum on a nominal basis from US$ 2.0 billion in 2020 to US$ 3.2 billion in 2025. Over the same period, US dollar inflation is expected to range between 1.5–2.3% indicating real growth in health care expenditure of 8% by 2025. Although expenditure on private sector health care is likely to increase due to improvements in per capita income, there is significant disparity in levels of income in the country: 20% of the population hold 44% of the income share. Therefore, only a small percentage of the population can afford private health care. Only 29% of the population live in the capital, which is home to a significant share of facilities causing substantial competition among the private health care providers.

According to national health accounts, inpatient care is mainly funded by the state sector accounting for 76% of total national expenditure. The public sector also dominates health expenditure for capital formation of health care provider institutions accounting for 81% of total spending in 2018; it also dominates the financing of medicines used for inpatient care. Expenditure on supplying medicines for outpatient care in the public sector exceeds amounts for inpatient care by the private sector.
Public health sector

Public health care is provided and organized as primary, secondary and tertiary level hospitals based on the size of the facilities and the services offered. The public sector under the Ministry of Health operates the largest number of hospitals (593) in Criworkhea, although there are considerable disparities in perceived quality and availability of public health care provision. Consequently, patients tend to bypass their nearest primary and secondary public facilities in preference for tertiary public institutions and in some cases, private hospitals. The resulting imbalance of utilization has led to long waiting lists and overcrowding in tertiary institutions.

Facilities that offer non-specialist inpatient and outpatient care such as maternity homes, central dispensaries, rural hospitals, peripheral units and divisional hospitals are categorized as primary level hospitals. Secondary care institutions include district general hospitals and provincial hospitals. These hospitals have general surgical and medical units in addition to providing outpatient care. Tertiary care institutions are teaching hospitals and provincial general hospitals. These have all facilities of secondary care institutions as well as other specialities. Together these categories of facilities constitute about 75% of all hospitals available nationwide.

The public health sector is accessible to everyone in Criworkhea, and most treatment is free of charge. The number and density of public hospitals are good, especially in the urban areas where 62% of the population live. However, the quality of care offered, and the availability of staff and equipment vary across the country, with rural and remote areas being more disadvantaged.

At an earlier point, as in all health care systems, Criworkhea faced a choice between maintaining quality or increasing access to services. This challenge was most acute in the 1950s when there were often more than twice as many patients as beds in government hospitals. Faced with this choice, then and later, the unrelenting pressure of most voters forced the public sector to sacrifice quality to preserve access. For example, lower-level hospitals in Criworkhea typically lack X-ray equipment, apparatus that is almost universally available in comparable hospitals in the region of South Asia.

Currently, the public sector provides the bulk of inpatient care (<95%) but has ceded most outpatient provision to the private sector. Even then, it continues to be the predominant source of such care for the poorest populations, who cannot afford to see private doctors. This approach contrasts that of other countries, where the public sector focuses on primary care while leaving hospital services to the private sector.

Private health sector

While the public sector operates almost three times as many hospitals as the private sector, health care expenditure in the private sector accounted for nearly 60% of total health care expenditure in 2021. Total estimated private expenditure recorded a compound annual growth rate of 10.8% over the last 12 years, reaching US$ 1084 million for 2020. The private sector caters to most outpatients (68%) and currently only caters to 5% of inpatient numbers in the country. There are 125 private hospitals distributed over the country. However, the four biggest hospitals are concentrated in the capital.
The shortage of medical doctors and specialists has significantly enhanced their bargaining power, particularly in the national context where patients seek treatment from specific doctors. As a result, hospitals struggle to retain doctors on a permanent/resident basis and suffer from ceding pricing power and profitability to doctors.

**Health workforce situation in Criworkhea**

The national Human Resources for Health (HRH) Strategic Plan 2012–2021 had a primary objective to increase the number of students in health education programmes. The development and implementation of the health workforce plan were decentralized under six different DDGs working in silos. The local government at the provincial level did not participate in the development of the plan.

Due to a domestic shortage, the government of Criworkhea has been promoting the training of nurses. The policy to increase health workers substantially was illustrated by the Criworkhea’s Ministry of Health announcement in 2021 of its plans to create positions and recruit 20 000 additional nurses and 10 000 additional medical doctors. This would raise the nursing staff total to about 90 000 and to about 27 000 medical doctors by 2030. The nursing population has more than doubled in the last decade, with a 113% increase. There has also been a 79% increase in the number of medical officers; however, growth in other health worker occupations is only 37% since 2010.

According to the Ministry of Health, in 2021 there were 123 828 health workers, broken down into 18 243 medical doctors (of which 1 860 medical specialists), 76 852 nurses, 14 564 other health professionals such as pharmacists, laboratory technologists and physical therapists and 14 169 health management and support staff. Table 2 shows the progression in the number of health workers in the public sector from 2010 to 2020. The number of health workers per 1000 population (doctors, nurses and other cadres) increased from 3 in 2010 to 5 in 2020. By 2020 there were 4.2 nurses per medical doctor. The ratio of doctors is 0.85 per 1000, while the ratio of nurses is about 3.6 per 1000 population.

**Table 2. Health workers in the public sector**

<table>
<thead>
<tr>
<th>Health workers in the public sector</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total HRH</td>
<td>63 104</td>
<td>95 072</td>
<td>123 828</td>
</tr>
<tr>
<td><strong>By Cadre</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical doctors</td>
<td>10 179</td>
<td>14 104</td>
<td>18 243</td>
</tr>
<tr>
<td>Nurses</td>
<td>36 076</td>
<td>58 999</td>
<td>76 852</td>
</tr>
<tr>
<td>Other health professionals</td>
<td>10 539</td>
<td>12 462</td>
<td>14 564</td>
</tr>
<tr>
<td>Health management and support staff</td>
<td>6 310</td>
<td>9 507</td>
<td>14 169</td>
</tr>
</tbody>
</table>
Health workforce recruitment

Upon graduation, all medical doctors, nurses and midwives trained in the public sector can be fully employed in the health sector. Employment is dependent on the creation of positions by the Ministry of Civil Service.

The continued implicit policy to employ all recognized medical doctors, nurses and midwives is attributable to the fact that the demand for nurses and medical doctors, as measured by the number of approved positions, far exceeds the medical doctors and nurses available in the market. By the end of 2021, there were over 2100 unfilled posts for medical doctors, 6100 vacant nursing posts, and almost 500 midwifery posts.

Public sector funded three-year training programmes leading to a nursing diploma is the main pathway to work as a nurse in the public health system. Only a small minority of nurses in Criworkhea attend university and receive a Bachelor of Science (BSc) degree after four years of study. Although there is a clear international distinction regarding the recognition of nursing degrees and nursing diplomas obtained through the national training programme, in Criworkhea they are considered equivalent and follow the same pay structure. Nurses trained abroad (an estimated 250 applicants leave per annum to train abroad) and those trained in a private school (700 admissions per year) do not hold the recognized training diploma and therefore cannot be employed in the public health care system. About half of these nurses stay abroad.

Once a cohort of nurses and medical officers has completed the training in public schools, a list of vacancies is put forward by the Ministry of Health for the cohort to apply for the advertised positions. These positions are created to meet the perceived need of the national and provincial health facilities. Placement is based on a merit score and a national ranking for each applicant. Those higher up on the merit list can select their preferred posts, and those lower down are generally sent to the less popular posts, which tend to be more rural and remote posts. Once approved, the staff are posted to the respective duty station for four years. All public sector recruitment and deployment of nurses and medical officers is done at the national level. Provincial recruitment is not allowed in Criworkhea. Unfortunately, about 30% of the health workers selected do not join their posts in remote and rural areas.

Some 85% of the health and care sector jobs are held by health workers aged 40 and older. The retirement age in Criworkhea is 60 years old. All public sector health workers are required to leave at this age, and those who want to continue to practise must enter the private health care system.
Health worker wages in the public sector

In Criworkhea, medical consultants have the highest starting salary, fastest salary progression, and the highest maximum wage of the health occupations, as outlined in Table 3. It is of note that the salary for a medical consultant officer is similar to that of a lawyer, with a starting and maximum salary slightly lower, but a faster salary progression than for lawyers.

Table 3. Salary structure for the public service, 2021

<table>
<thead>
<tr>
<th>Job category</th>
<th>Starting salary (US$ monthly)</th>
<th>Years of service</th>
<th>Maximum salary (US$ monthly)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paramedic</td>
<td>206</td>
<td>10</td>
<td>380</td>
</tr>
<tr>
<td>Nurse</td>
<td>212</td>
<td>10</td>
<td>385</td>
</tr>
<tr>
<td>Nurse, special grade</td>
<td>327</td>
<td>10</td>
<td>500</td>
</tr>
<tr>
<td>Medical officer</td>
<td>345</td>
<td>3</td>
<td>681</td>
</tr>
<tr>
<td>Medical consultant</td>
<td>575</td>
<td>12</td>
<td>787</td>
</tr>
<tr>
<td>Midwife</td>
<td>202</td>
<td>10</td>
<td>360</td>
</tr>
<tr>
<td>Lawyer</td>
<td>380</td>
<td>5</td>
<td>689</td>
</tr>
<tr>
<td>Teacher</td>
<td>217</td>
<td>5</td>
<td>467</td>
</tr>
<tr>
<td>Police officer</td>
<td>209</td>
<td>5</td>
<td>285</td>
</tr>
</tbody>
</table>

Distribution of health workers

Of the health workers with a BSc, 90% of medical doctors and 100% of nurses work in the capital or other urban areas. Nurses with a diploma are more evenly distributed across the country, with 65% in urban areas and 35% in rural areas. However, typically most nurses do not remain in rural and remote areas beyond two years. This retention challenge results in high staff turnover. Only 10% of medical doctors work in rural areas, and none in remote areas.

Health workers in the private sector

Although health care in Criworkhea comprises mainly public institutions, there is an increasing presence of private health care institutions. The number of patients treated at the 125 private hospitals (4210 beds) has shown robust growth, reaching an estimated 4.7 million outpatient visits and 266,000 admissions in 2020. The number of beds in private hospitals varies as follows: 12% have fewer than 10 beds, 35% have 10–19 beds, 38% have 20–49 beds; 9% have 50–99 beds, and only 6% have 100 beds or more. It is estimated that 424 medical doctors are working full-time in the private sector.

Significant wage differences exist between the public and private sectors for medical doctors. The private sector offers a higher salary, but the public sector provides pension and tax benefits. Given that medical doctors and other health workers are permitted to work in dual practice, most
health workers in the public sector work full time and do after-hours care in the private sector to increase their base income. Dual practice allows medical doctors to have thriving practices in both the public and private sectors. The Ministry of Health estimates that in 2020, about 60% of publicly employed medical doctors also had a thriving practice in the private sector. The majority of private consultations needing inpatient care result in care at a public facility. A private consultation ranges from US$ 10–20 for a medical specialist and US$ 2–3 for a medical officer; however, inpatient private care ranges from US$ 100–500, making it a prohibitively expensive out-of-pocket cost for most.

In 2015, the number of nurses working in private hospitals was approximately 4500, most working full-time. Many of the nursing tasks in private hospitals are done by nurse assistants, who are trained within the private sector through training programmes, generally lasting six months. The training does not provide an externally recognized qualification; therefore, they can only work within the private sector. In addition, the number of partially qualified or unqualified practitioners working in pharmacies, laboratories, and directly in clinics is unknown. The use of unqualified or underqualified health workers raises critical issues for quality of care and patient safety, which need to be addressed.

**Employment in the health sector**

The growth in health and social work jobs is lagging behind in Criworkhea with respect to other sectors and population health needs, but the health sector offers a great opportunity to increase labour force participation for women and youth. Of the over 3.5 million people working in the service sector only 142 000 people work in health and social work. In 2021, jobs in the health and care sector comprised only 1.8% of all employment in Criworkhea. This is low compared to other sectors like education, with 4.1% of employment, and public administration and defence with 7.7% of total employment. Since 2018, only 13 802 new jobs were created in the health and social sector, while 42 069 new jobs have been created in the education sector and 38 854 new jobs in the public administration and defence sector. For comparison, Table 1 provides the macroeconomic situation for the country.

**Health worker education system**

The supply of health workers in Criworkhea is mainly generated from domestic public education programmes.

**Higher education**

In addition to domestic education, medical doctors can be trained internationally and enter the health system through a registration procedure. The country’s Medical Council regulates entry into the workforce for medical doctors, who must obtain registration with the Council to practise medicine legally in the country. Registration is granted to qualified foreign graduates of medical schools recognized by the Medical Council after passing the Examination for Registration to Practise Medicine and completing a year’s internship. The number of candidates completing the exam doubled from just over 100 in 2015 and 2016, to over 200 in 2018 and 2019, and doubled again to 400 in 2020 and 380 in 2021.
The Council grants registration to local graduates on satisfactory completion of a year’s internship. In 2015, 8265 applications were received by the public medical schools, of which 3790 were admitted and 1150 graduated in 2020. According to the Council, there are about six medical graduates per 100,000 population in Criworkhea.

The government fully funds public schools; therefore, there are no tuition fees. The government, through the University Grants Commission, holds the responsibility for funding and delivering medical education, planning and coordinating university education, allocating funds to higher educational institutions, maintaining academic standards, regulating schools’ administration and the admission of students. Currently nine approved universities conduct medical and health-related programmes: five of them are in the capital city, Belamoi, and the remaining four in other major cities. There is one private medical college: Mahama College. However, the medical degrees it confers are not recognized by the Criworkhea Medical Council. A decision to close this private medical school in 2021 has left the 1000 currently enrolled students in limbo.

Undergraduate medical education is five years, plus a one-year internship. Post-graduate medical education is through the Post Graduate Institute of Medicine, under the Faculty of Medicine, University of Belamoi. Trainees entering this stream do so through competitive screening exams. Once the post-graduate exams have been successfully completed and the degrees conferred, post-graduates must complete at least one year of foreign exposure at designated centres of excellence. Upon return to the country, the respective board of study will assess and approve them as board-certified specialists to be given appointments as consultants to work in Criworkhea.

Post-graduate education and the overseas experience are also financially supported by the government. Medical officers who undergo post-graduate foreign training sign a contractual agreement or bond to repay the fees if they do not return and provide a minimum of four years’ service in Criworkhea. Medical officers approved for post-graduate training are released from their duty stations without replacement.

Given the limited places in medical faculties, some of the 6000 applicants who do not get admitted each year seek alternative routes to study and practise medicine in the country. Table 4 sets out the capacity, applications, admissions and graduation numbers for seven categories of health worker.
As stated earlier, most nurses follow a three-year training programme leading to a nursing diploma. Currently, nurses can be trained in 18 nurse training schools with hospital-based placements in mostly urban locations under the Ministry of Health. There are no tuition fees and in addition, students are entitled to a monthly allowance. Nurses who obtain a BSc in Nursing can register for recruitment in the state public service.

**Private sector health education**

The private hospitals have created their own nurse training programmes (nursing assistant); however, these programmes and the nurses trained remain unrecognized by the government of Criworkhea, and data on their numbers are not available. Nurses who follow the private education pathway can therefore only be recruited to the private sector. Nevertheless, most private training institutions have obtained permission to operate from the Tertiary and Vocational Education Commission.

**International outflow of health workers**

In 2005 the number of Criworkhea-born doctors working in countries of the Organisation for Economic Co-operation and Development (OECD) was estimated to be 4668. By 2015, it reached 5784, an increase of 24%. However, the expatriation rate for doctors dropped from 31% in 2005 to 28% in 2015.

The Post Graduate Institute of Medicine has been sending over 200 medical officers for overseas training a year since 2012. Between 2010 and 2021, 2631 post-graduates went abroad, and 2146 returned to Criworkhea. Therefore about 18% of medical officers with post-graduate training were lost to international migration.

The number of Criworkhea-born nurses working in OECD countries was estimated to be 2032 in 2005. By 2015 this number had more than doubled to 5372.
Making HRH policy in the dark – coping with HRH data deficit

Learning objectives

• Develop technical and/or research questions related to HRH policy issues, drawing on themes, lessons and tools introduced in the module
• Select appropriate strategies and methodologies to obtain answers to the questions

Tasks and questions

Task 1 (asynchronous, 2 hours) – Read and reflect on the case narrative and one or two of the readings referenced in the footnotes. Your reflections on the readings should be guided by the four discussion points below. Choose those where, on the basis of your experience, you feel you can contribute to the group learning or where you want to engage with the group to optimize your own learning during Task 2.

1. About the state of the art on human resources information systems (HRIS):
   • What is your perception of the recent evolutions of HRIS?
   • What is the reality of HRIS in the African continent?
   • What is the experience with state-of-the-art HRIS solutions in your country compared with similar countries?
   • Is the HRIS part of the political agenda of the government and of the policy agenda of all relevant ministries?

2. Explore the leadership process for national HRIS in your country using the following questions:
   • What are the HRH data gaps in your country? What explains those data gaps? What are limitations resulting from those gaps?
   • Who and where are the leaders in your country that address the mindsets, interests, power, agency, existing technical capacity and financial leverage of national and international actors in explaining the HRIS situation observed? What constrains them to push for/adopt state-of-the-art solutions to correct the HRH data gap situation observed?

3. What specific recommendations would you consider within the HRIS solutions suggested by the consultants?

4. Reflecting on the epilogue, why do you think that certain recommendations were implemented and others not? That this is successful in some states but not others? How could a good leader have avoided such a stalemate six years ago? What can good leadership achieve now and how?

Task 2 (synchronous, 1 hour 30 minutes) – In small groups, discuss your reflections from Task 1 and contribute to a synthesis presentation of these discussions, focusing on:

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1 This case study is based on a mix of real experiences in Angola, Cabo Verde, Guinea-Bissau, Mozambique, Sao Tome and Principe and Zambia.
• reflections on discussion points 1–4;
• proposals to improve data relevance, completeness and accuracy for HRIS in participants’ countries.

**Task 3 (synchronous, 2 hours) – Plenary presentation and discussion of case studies**

**Suggest presentations are 10 minutes per group followed by 20 minutes whole class discussion**

Each group presents/discusses results from Task 2 with the class and the teacher/facilitator. Present your conclusions and promote further discussion around what you, as a leader, would propose in your country to improve data relevance, completeness and accuracy of the national HRIS. From the discussion, identify opportunities for cross-country collaboration and policy-transfer.

Following the group presentations, use the plenary discussion (30 minutes) to identify further issues to address and record them onto flip chart paper.

**Case narrative**

**Preamble**

Making policy without reliable data is a widespread reality in Africa.\(^1\) Country X is no exception.

In Country X, HRH strategies have been reactive to pressure from donors and/or crisis situations, either economic, e.g. after the collapse of the price of a barrel of oil, or related to epidemics such as Ebola virus disease, yellow fever and COVID-19. Hence, strategies remain fragmented, uncoordinated, inconsistent, and do not take into account health labour market dynamics and the relevant stakeholders from different ministries and social agents. In this context, decisions have to be made in the absence of data or with data that lack relevance, completeness, accuracy and concordance between different data records and registers. However there are strategies, tools and mechanisms to correct this situation.

**The country**

Power-sharing agreements have been widely used in Africa as paths out of civil war.\(^2\) Such is the case in Country X. The post-war government includes a Minister and a Vice-Minister in the Ministry of Health as representatives of different warring parties in a recently terminated civil war. The same arrangement exists in many of the other ministries. As part of the peace agreement there is a process of progressive decentralization of responsibilities to governors of the 20 provinces. One sector where this is happening is the health sector, including its workforce.

Country X is a relatively fragile state.\(^3\) As a major oil producer in sub-Saharan Africa, Country X is “resource cursed”, ailing from a “paradox of abundance”\(^4\) with negative impacts on the health sector and its workforce.

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It has suffered from successive epidemics over recent years: dengue, chikungunya, Ebola virus disease, malaria, yellow fever, Zika and Covid-19.

The challenges
With about 30 million inhabitants, there are 0.215 doctors and 0.408 nurses per 1000 inhabitants, making it a country with a severe shortage of health workers. There are no figures on any of the different 28 categories of allied health workers. About a quarter of doctors working in the country are expatriates, including a significant Cuban Medical Brigade.

Even so, paradoxically, the government has been unable to recruit into public service graduate doctors of the eight national medical faculties, resulting in a major strike of young doctors. Recently, the Nursing Council reported more than 10 000 nurses unemployed. In addition to the issue of unemployment, the Council identified the inadequacy of the career system and the proliferation of poor quality nursing schools. Other issues related to the practice of nursing include: non-payment of overtime; discrimination, professional disrespect and lack of promotion; insufficient food security for shift workers in the health units; and a lack of assistance with housing and transportation. These are major causes of industrial unrest and strikes by health workers.

Elections are approaching. With the collapse of the economy, the dependency on external funders increases with growing demands for explicit health sector strategies, including health workforce strategies.

The government decides to invest in a new national health workforce strategy (NHWFS). The previous strategy, focusing on the supply of health workers (pre-service training) was produced 13 years ago, before the start of the civil war. With the support of the World Bank an international consultant was recruited to assist a national consultant working with the HRH Department in the Ministry of Health.

Terms of reference for the international and national consultant

New national health workforce strategy
The objective of this technical assistance was to facilitate the process of preparing the NHWFS. This work was expected to be carried out in three phases, namely: (i) Support the Ministry of Health in the analysis of the HRH situation, addressing areas such as HRH availability, financing, distribution, productivity and management; (ii) recommend, in light of the conclusions and bibliography on HRH in Country X, a budgeted NHWFS; and (iii) within the framework of that strategy, in the medium term, advise the Ministry of Health on structural and institutional adjustments to strengthen the HRH management processes and mechanism in the sector.

The consultancy process:
The consultants met jointly with the Minister and Vice-Minister and obtained vague instructions about their work. Afterwards the international consultant met alone with the National HRH Director, affiliated with the party of the Vice-Minister, who advised against the completion of the strategy before the elections.

The work programme was approved. The consultants reviewed national documents and contacted partners and officials from different ministries. They also met union representatives and the presidents of the medical and nursing councils. A letter, signed by the Minister, was sent to all
20 provincial governors requesting HRH data and other relevant information: only four replied. Field trips to those four provinces were made. The major national hospitals were visited as well as some of the medical faculties and the School of Public Health.

The consultants found that, as part of the decentralization process, the responsibility for all HRH issues, except recruitment, placement and salary issues, had been transferred to the provinces. Hence the data available at the Ministry of Health referred only to the Ministry of Health and the national reference health care units that reported directly to the Minister or Vice-Minister. The Ministry of Health had no data pertaining to HRH placed in the provinces.

The quality of the data available in the facilities visited was variable. There were no national guidelines about keeping data on HRH, other than that necessary for administrative purposes such as annual leave. At the facilities in the provinces, they also found that many HRH, although placed at the facility, remained in the capital city. Absenteeism was rife, many times associated with dual practice commitments overlapping with working hours in the public facility.

Public sector HRH data were available from the Ministry of Finance as per the “payroll database”, which listed all public servants on the payroll of the Ministry of Health and of the National Health Service or training facilities: these data were deemed highly unreliable because of the presence of phantom workers on the payroll. They did not reflect the actual place of practice, as mentioned above, and did not include the significant number of health workers working for the security forces (the army, internal affairs [police] and justice [prisons]) as these data were considered confidential (as were the contractual arrangements with members of the Cuban Medical Brigade).

Data were also available from the professional councils. These data were also unreliable as they included health workers from all sectors since the beginning of the councils, i.e. the data were not corrected for workers who had died, migrated or retired. None of the available databases included foreign expatriates working in Country X.

The consultants were unable to obtain data from the ministries of health, education, or foreign affairs about the number of health workers graduating from the HRH training institutions in the country or studying abroad.

After three weeks, the consultants requested a meeting with the Minister and Vice-Minister of Health, and the National HRH Director to inform them of their difficulties. They were advised to work with the National HRH Director to change their terms of reference to make recommendations on improving the HRIS, which they did and submitted.
HRIS solutions considered
In the final mission debrief the consultants left a number of very clear technical recommendations. Among the many recommendations that might be considered, the consultants suggested:

- to conduct an HRH data gap analysis
- to carry out a service availability and readiness assessment (SARA)
- to conduct a labour force survey or census
- to adopt solutions like the national health workforce accounts system and the establishment of a human resources observatory.

Epilogue
Six years later, the Vice-Minister is now the Minister of Health. The new National HRH Director is a social scientist from the educational sector. Of all the recommendations made, the only one implemented was the establishment of the health workforce observatory: this was established in three provinces and functions well in one.
Lessons from the implementation of a service availability and readiness tool in a fragile health system

Learning objectives

- Develop technical and/or research questions related to HRH policy issues, drawing on themes, lessons and tools introduced in the module.
- Select appropriate strategies and methodologies to obtain answers to the questions.

Tasks and questions

Task 1 (asynchronous, 2 hours) – Read and reflect on the case narrative and one or two of the readings referenced in the footnotes. The latter is particularly recommended to students who are not familiar with availability and readiness tools. Your reflections on the readings should be guided by the following four discussion questions for the groupwork in Task 2. Choose the questions where, on the basis of your experience, you feel you can contribute to the group learning or where you want to engage with the group to optimize your own learning during Task 2.

- How can service assessment tools increase health systems’ effectiveness and efficiency; and to what extent have such tools been introduced in your country?
- Why is important to consider health workforce (HWF) in health service analysis; to what extent has HWF planning been reflected in policy-making in your country?
- How can tools like SARA (service availability and readiness assessment) contribute to improvements in workforce planning in contexts of scarce evidence?
- Considering the outcomes of the implementation of SARA in this case study (i.e. little impact on informed decision-making), and taking into account your experience, what strategies would be suitable to enhance the policy implication of technical tools for health planning?

Task 2 (synchronous, 1 hour 30 minutes) – In small groups, discuss your reflections from Task 1 and contribute to a synthesis presentation of these discussions, focusing on:

- reflections on questions 1–4;
- proposals to improve processes of data collection and use in political decision-making with regard to health planning more generally and the HWF more specifically.

Task 3 (synchronous, 2 hours) – Plenary presentation and discussion of case studies.

Suggest presentations are 10 minutes per group followed by 20 minutes whole class discussion

Each group presents/discusses results from Task 2 with the class and the teacher/facilitator. Present your conclusions and promote further discussion around what you, as a leader, would propose in your country to improve service-level data collection, analysis and use in decision-making to make changes in health planning more sustainable. From the discussion, highlight the extent to which different countries face similar or dissimilar constraints and opportunities, and the extent to which cross-country collaboration and policy-transfer might help to overcome cross-cutting issues.
Following the group presentations, use the plenary discussion (30 minutes) to identify further issues to address and record them onto flip chart paper.

Case narrative

Preamble

Rather than showcase specific aspects of the implementation of a SARA tool in a given country, this case study aims to raise awareness about complex decisions regarding data availability and collection, and key issues in the use of such tools, considering different traits and challenges of national health systems.

The SARA tool

Health systems strengthening is an ongoing effort in all countries. SARA is an assessment tool – perhaps the most acknowledged worldwide – created by the World Health Organization (WHO) to help countries to enhance the effectiveness and efficiency of health systems planning and management. Building on a set of service-level indicators, SARA can provide evidence that can assist in monitoring and accountability of health facilities and their managers at the middle and top levels of facilities. It informs decision-makers at the regional and national levels through the collection of standardized and comparable data. Comparisons within countries (regions/districts) and over time are both possible. In sum, SARA serves as a proxy to know which resources lack, for whom and where.¹

The set of service-level indicators relates to service availability, readiness, and service-specific readiness.² Service availability refers to the physical aspects of health care delivery (i.e. infrastructure, health workers, and service utilization). Service readiness refers to the overall capacity of health facilities to deliver health care (i.e. amenities, basic equipment, safety procedures, laboratory tests, medicines and commodities). Service-specific readiness refers to the ability of health facilities to deliver a specific health service in terms of guidelines, specific equipment, trained staff, diagnostic capacity, medicines and commodities.

SARA has been implemented with positive results across the globe in many national health systems, or in specific health services (e.g. infant and child care, maternal and newborn care, services for infectious diseases such as HIV, TB and malaria, and for noncommunicable diseases).

Key technical procedures

According to the MEASURE Evaluation project, funded by the United States Agency for International Development to strengthen health information systems in low-resource settings,⁴ SARA core indicators are collected by a standardized questionnaire completed through interviews of key informants (e.g. the person in charge or the most senior health worker) and observing the

facilities. Complementary, secondary sources of information can be used although some technical issues may arise.

To measure availability and readiness SARA aggregates existing tools. Two in particular are worth mentioning: the service availability mapping tool and the service provision assessment (SPA). New harmonized health facility assessment modules were launched in 2020.¹

**Key technical issues**

To provide reliable and comparable data on availability, SARA must be applied to all health care facilities, not just a sample; this depends on whether the range of analysis is the whole country, or a specific region, district, or health service. Moreover, all availability measures require data that link the numerator (e.g. number of facilities) to the denominator (population size). If other sources of information are used to complement the SARA questionnaire, metadata should be clearly assessed and only include data that do not generate methodological doubts.

As mentioned, SARA builds on pre-existing tools. One of these – SPA – has four aims: service availability, service readiness, quality of care, and user satisfaction.²

According to a recent study,³ standardized tools such as SPA lack reflection on how they are used in different empirical settings, and on the possible consequences of this on research and political decision-making. The authors devoted attention to the extent to which the specific component of quality of care is likely to be differently conceptualized and measured in SPA surveys across the world. Overall, their conclusion is that quality of care is operationalized in “extremely different ways”, which thus jeopardizes the core principle that tools like SPA and SARA allow to collect reliable, standardized and comparable data for sustainable and informed decision-making.

Their suggestions to strengthen and harmonize the measurement of care quality using SPA data include:

- incorporate patient-facing elements of infrastructure, e.g. availability of toilets, adequate waiting area, and auditory and visual privacy;
- enhance SARA indicators by adding quality dimensions such as storage quality and organization, capacity to repair equipment, employment quality (opportunities for promotion, job description), and hours and days of service/staff availability;
- include outcomes including patient-reported outcomes (“complaint score” of problems during visit, satisfaction with care, and would recommend to others) and appropriateness of clinical care.

Case studies

Case narrative: SARA implementation and outcomes

Country X is considered one of the poorest in the world, a fragile state with permanent political and social instability.

The reorganization of the hospital network was recommended in its national health strategy in order to concentrate and optimize resources and ensure a more effective response by the available health services. There was a proposal for an integrated approach to the provision of hospital services in the regions, where close to a third of the population is concentrated, as are a considerable proportion of health professionals, hospital beds and the entire offer of differentiated care.

This approach aimed to constitute a Hospital Complex as a way to concentrate resources and installed capacity in national reference hospitals, complementing them with a set of equipment that, by public or private initiative, was inaugurated without being foreseen in any strategy for the development of the health network.

The lack of current and reliable information on the health network limits the ability to plan its expansion, reconversion or restructuring. Thus, in order to contribute evidence to decision-making on the reform of the health map, a team of consultants decided to analyse the availability and readiness of the services of the health facilities that may be eligible for the new Hospital Complex.

SARA was chosen as a data collection and analysis tool. From a list of all units provided by the health authorities, 13 facilities were selected for the study (only those that had inpatient services available). As there was no version of the survey in the country’s official language, an original French version of the form was used. Due to the lack of devices to fill out the forms digitally (which would have allowed more agility and fewer errors in the collection, in addition to facilitating data processing), the information was recorded on paper by two teams of interviewers, during a visit to each of the 13 hospitals.

The interviewers had previously participated in training that included simulated completion of the form. Even so, gaps and omissions of responses were detected during the review and validation process, which could distort or invalidate the results. It was therefore necessary to hire, train and send another team to the field to collect more data.

Given the lack of local resources, the data had to be analysed by a team from a foreign university. From the outputs generated through the SARA Chartbook (version adapted to the local language), a descriptive analysis of the availability and readiness (general and specific) of the services of these units was made, paying attention to the differences and similarities between public and private facilities, i.e. for profit and those administered by religious organizations or nongovernmental organizations (NGOs).

Considering the unavailability of data on the population served by these units and on the demand for services, it was not possible to calculate the SARA indexes to characterize the general availability of services. However, it was possible to analyse some of the data used in the calculation of general availability, such as the number and type of beds, general condition of the...
equipment or existing human resources. This means that, despite the scarce information about this health system, there is a database with recent and relevant information that allows more targeted analyses to more specific topics.

In the case of human resources for health (HRH), it was possible to map 656 health professionals. Data on nurses, midwives and laboratory technicians were not obtained in one of the units. Public sector facilities employ 77% of these health workers, but the number of health workers working in more than one facility is unknown. The form only enables data collection of health workers employed part-time for doctors (about 21% of whom work in more than one place).

On the availability of specific services, it was possible to determine that all services considered essential by SARA are available in at least one of the units. The availability index varies between 15% (cervical cancer diagnosis services) and 85% (child health services, malaria services and sexually transmitted infection treatment services). The public sector is the only one that provides all 23 services considered. Units managed by NGOs provide 18 services (78%), while those managed by religious entities or private sector clinics (for-profit) provide 20 (87%) each. The readiness of these services to provide quality and safe care was also calculated, showing that in general NGO units have greater operational capacity than those in the public and private sectors. This analysis made it possible to gather elements to plan for a more effective reorganization of the offer of services.

Epilogue
The analysis of availability and readiness in Country X revealed similar conclusions to those already reported in different strategic documents and reports from international partners: lack of equipment, infrastructure and resources; predominance of the public sector; increasing importance of health facilities managed by NGOs and religious organizations and the flourishing of the private sector; as well as deficiencies in planning and regulation.

This scenario reinforces the strategy to create a Hospital Complex, bringing together different sectors in an effort to rearrange the offer of services, adapting them to the needs of the population and the objectives of the health strategy. In turn, this would promote an integrated and rational response that, although not necessarily consensual, would be pragmatic in situations of lack of resources.

A report was produced with the results of the study. The document and the recommendations were sent for approval by the Minister of Health. Three years have passed and still no decisions have been made.
The utilization of evidence in health workforce policy interventions – the example of imbalances in geographical distribution of physicians

Learning objectives

- Develop technical and/or research questions related to human resources for health (HRH) policy issues, drawing on themes, lessons and tools introduced in the module.
- Select appropriate strategies and methodologies to obtain answers to the questions.

Tasks and questions

Task 1 (asynchronous, 2 hours) – Read and reflect on the case narrative and one or two of the readings referenced in the footnotes. Your reflections on the readings should be guided by the seven discussion questions for the groupwork in Task 2. Choose the questions where, on the basis of your experience, you feel you can contribute to the group learning or where you want to engage with the group to optimize your own learning during Task 2.

1. How was the health workforce (HWF) problem in the case study identified?
   - Based on your experience about the leadership process in HRH policy formulation in your country, would you have similarly framed the possible causes of the problem?
2. Who were the most important actors/sectors in the case study? How would you characterize:
   - the type of actors engaged in the policy-making process?
   - their roles in the policy formulation?
   - their leadership style?
3. What facilitated the use of the evidence in this case?
   - What are the main problems for using evidence in your country?
   - What about evidence gaps in your country?
4. How would you characterize the use of evidence (data, HRH Observatory, research) in the HRH policy-making process in this case? Is it formalized?
5. How was evidence used in this case to prioritize alternative intervention strategies?
6. What changes can be used to boost the use of evidence in the political decision-making process in this case?
7. What were the mechanisms and approaches to promote the use of evidence?

Task 2 (synchronous, 1 hour 30 minutes) – In small groups, discuss your reflections from Task 1 and contribute to a synthesis presentation of these discussions, focusing on:

- reflections on questions 1–7;
- proposals to improve the process of utilization of evidence in HWF policy interventions in your countries.
**Task 3 (synchronous, 2 hours)** – Plenary presentation and discussion of case studies.

*Suggest presentations are 10 minutes per group followed by 20 minutes whole class discussion*

Each group presents/discusses results from Task 2 with the class and the teacher/facilitator. Present your conclusions on the relationship between health service availability and readiness analysis and HRH planning and promote further discussion around what you, as a leader, would propose in your country to mobilize evidence effectively in planning HWF interventions.

**Case narrative**

**Preamble**

Imbalances in the geographical distribution of qualified HRH in rural, underserved or poor areas are observed in almost all countries in the world,¹ and has been a “hot topic” for a long time. Research on HWF topics has developed in the last 10 years almost exponentially, and evidence on what works and what does not work to respond to this challenge is available. A relevant question is whether and how research results inform policy-making.²

The determinants of the use of evidence in the policy-making process include a lack of mechanisms for the use of evidence in the political process; the ability to select and evaluate the quality and applicability of the evidence; divergence of priorities between research and political agendas; the ability to produce high level quality research continuously in the country; and interaction and communication between policy-makers and researchers.³

The aim of this case is to enable discussion on the role of evidence in different stages of the political cycle (e.g. agenda-setting and policy formulation), as well as the importance of an organizational culture for the use of evidence, and existing instruments in place in the country.

**The case**

In April 2017, Wilson, the newly appointed Director of HRH in the Ministry of Health of Country X, came into the meeting room with his team.

We have a problem providing access to primary healthcare in some municipalities and we need to do something about it. I was called by the President, who explained that he is under pressure by his voters and the mayors are complaining about the lack of access to health services in underserved areas. We need to present a solid proposal to combat this lack of access to health workers in underserved areas. But first I want to understand the challenges faced to provide access to HRH in our country and the courses of action taken to address them. Then we can work with other relevant actors to get their perspectives on this problem.

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Gathering evidence
The technical advisers looked at each other, knowing that numerous previous governments had tried to carry out some sort of intervention to increase access to health workers in underserved (remote, rural or poor) areas. One of them mentioned:

*We could contact an international organization to help us to organize a seminar. We can set up an agenda calling the representatives of the network of observatories on HRH in the country to present both the results of research we are funding and evidence developed by other well-known researchers, as well as data from the National Health Workforce Accounts (NHWA) platform. We can also promote discussions with key stakeholders at the three levels of government – national, regional and district – so that we can frame the problem and its causes in order to identify strategies to formulate a national programme. We could also call for a tender and hire a consultancy with specialists in the area to produce a policy brief intended to present clear policy options and their applicability in the country.*

In parallel with the organization of the seminar, the group of technical advisers reviewed previous programmes carried out to address the problem in the country, and studies and evaluation on their impact, weaknesses and strengths. They managed to identify several strategies and corresponding investments that had been implemented by the government at national level to address the lack and uneven distribution of health professionals, since the late 1960s. Programmes of the 1990s and early 2000s demonstrated that isolated interventions tended not to spawn long-term sustainability, and that multiple interventions in different policy areas are needed to achieve it. The programmes were invariably short-lived, involved a limited number of health workers, and failed to change crucial issues in the training process. More recently, different programmes have strengthened the Ministry of Health’s institutional capacity to develop HRH interventions on imbalanced distribution of health workers and allowed greater agility in implementing the design strategy. This was essential for developing the conditions to design and scale up the implementation of a new programme.

During the seminar, it was clear that the participants (HRH technical advisers, researchers, HRH Director from the Ministry of Health, representatives of the Ministry of Education, international organization representatives) considered the causes of lack of access to health services to be mainly related to the lack of physicians and their uneven geographical distribution. Subsequent to the seminar, Wilson visited different countries to learn about successful experiences to address similar problems. Meanwhile, the technical advisers searched the literature for interventions implemented in other countries. Face-to-face meetings were also organized between Wilson and researchers who were developing studies commissioned and/or financed by the Ministry of Health, so that interim results could be presented and contribute to detailing the causes of the problem and help designing potential political options.

Outline of the problem and underlying causes
Problems around access to health workers in underserved areas led to the creation of a new intervention to recruit physicians to serve in remote areas of the country. The central argument was that the country had a doctor/inhabitants ratio below the international average, in addition
to suffering historically with an uneven distribution of doctors among the regions. Indeed, the country had a rate of 1.5 doctors per 1000 inhabitants, lower than other countries in the region – Country A (3.1), Country B (3.6), and Country C (4.3). Analysing the in-country situation, 70% of regions had a doctor/ inhabitants ratio below the national average, and the density of doctors varied from 52.0 to 506.0 per 1 000 inhabitants. Researchers concluded that there were insufficient doctors working in the National Health Service (NHS), an overconcentration of medical schools in some parts of the country, and production of doctors lower than the health system needs. According to other key actors, the causes of the problem go deeper:

- family health teams are lacking in the municipalities;
- municipalities have to contract health workers with their own resources to supply the population’s needs;
- the NHS has difficulties in recruiting doctors because of the low salaries in the public health sector;
- there is no public tender for doctors to enter the public sector and no prospect of career progression.

The media also described high levels of public dissatisfaction with the public health sector.

**Policy formulation**

After the assessment of published policy framework strategies (Box 1), the analysis of the problem, the underlying causes and possible solutions, the government was prepared to choose an intervention to increase the number of doctors in underserved areas.

**Box 1. Choosing the strategies to formulate a policy programme – framework of policies**

**Groups:** Policy responses need to take into account the reasons why doctors choose to locate in certain regions. Health workers may be: i) interested to work in underserved regions; ii) potentially available for service; or iii) not interested at all.

**Strategies:** The NHS has tried several solutions to the problem of maldistribution of health workers and poor access to health workers in remote/underserved areas, which can be grouped into three types of strategies:

i) those that focus on future doctors, increasing from graduation the number and qualification of those willing to work in the less attractive regions;

ii) those that use measures targeted to doctors already in activity, including financial and regulatory incentives to relocate professionals who live in certain concentrated regions and activities;

iii) those that adopt a “make do with less” approach, utilizing skills mix optimization such as providing alternatives involving other health workers combined with telemedicine technologies and distance assistance.
Wilson invited a few government technical advisers for an urgent meeting to share the outcome of a call from the President, who was under increasing pressure by his voters (with the election approaching), and the mayors’ complaints about the lack of doctors in the smallest municipalities were escalating. The President was very clear:

We need to present a solid proposal so that we can implement a programme to increase the supply and quality of doctors in primary health care, and have results by the end of this presidential term.

In view of the position of the President, and the results of the policy brief recently delivered by the consultant, a first version of an intervention had already been prepared by the HRH department with the following actions:

1. Review the number of places available in medical schools, prioritizing new vacancies, courses and/or medical schools in regions with a low ratio of doctors per inhabitant, and with a structure of health services able to offer a quality field of practice for students.
2. Enter into bilateral agreements with selected countries to contract foreign physicians.

Wilson and his team discussed and decided that the best strategy was to assess the different stakeholder viewpoints. They chose to have a mixed approach: carry out the above interventions, and implement a policy dialogue process. This involved the following actors with different approaches working collaboratively towards a common understanding: representatives of the ministries of health, education and finance, medical associations, trade unions, state/regional health representatives, private sector NGOs, donors, academia, international organizations, medical schools, and individual experts.

**Areas of action:**

- Education – interventions at different points throughout medical education may influence the later choice of practice location.
- Finance – countries can offer financial incentives, e.g. throughout the professional lifecycle of doctors, from scholarship with return-of-service obligation to the entry to medical school and clinical training.
- Regulation – countries may regulate which type of doctor is able to work where. Regulation can be anchored in entry to clinical training, e.g. in the form of return-of service agreements conditional on the choice of specialty.
- Service delivery reorientation – this may make the provision of service in otherwise unattractive areas less burdensome by improving working conditions and the life and job satisfaction of doctors practising there.

This process allowed an understanding of the different arguments:

- Medical associations presented evidence (based on commissioned studies) showing that the lack of incentives for doctors to work in underserved areas was the main problem, not the shortage of physicians. They also stated that the government needed to elaborate a career plan to attract and retain doctors in underserved areas.
- According to trade union representatives, the intervention was politically driven by presidential elections, and had merely electoral motivations.
- Based on data (using the NHWA platform) and different studies, members of the government pointed to a lack and uneven distribution of physicians in the country.

Forums for discussion were promoted as the mechanism for policy dialogue, each linked with the characteristics of the policy process in the country. The discussions in these forums lasted approximately four months, and different actors were engaged: civil society organizations, parliament representatives, researchers, and health managers working in different levels of the NHS.

Criticisms against the political options emerged in this dialogue, questioning the ability of foreign health workers to provide adequate assistance to the population, and the hiring conditions under the intervention. The mandatory diploma’s recognition of foreign trained doctors was not contemplated in the proposed intervention. The incentive to open new medical schools and changes in the authorization process for new schools were questioned.

**Epilogue**

The country had an organizational culture for the use of different types of evidence, so it could be included in the policy process with some instruments, especially the research agenda and with strategies like the HRH observatories and the NHWA. On the other hand, policy-makers could use evidence produced by renowned national academic institutes which gave them a sort of power based on the researcher’s impartiality. The opportunity to empower the citizens and other actors grounded by evidence to advocate for or against a strategy had been lost.

After the elections the government changed and the political option was at risk for the following reasons:

- diplomatic problems with countries with whom the bilateral agreements for hiring foreign physicians had been concluded;
- placing the problem on the political decision-making agenda was initially influenced by factors such as political and media pressure rather than an in-depth understanding about the causes of the problem;
- the actors who suffer the consequences of the implementation of the political options, e.g. physicians, were included only at the end of the formulation process, when options had already been chosen;
- the actors who suffer the problem – populations in underserved areas – had a limited voice in the process;
- the policy to recruit of foreign doctors allows the emergency adjustment of the delivery services in remote areas, but there are limits to its impact if not complemented with other measures to “make do with less”.