A Review of the Human Resource Content of PRSP and HIPC documentation in 6 selected African Countries

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Executive Summary

- The HIPC/PRSP process is intended to be a major instrument for achieving improved service delivery for poor people Crucially, improved service delivery depends on having the right professional, technical and other human resources in the right place at the right time.

- This review examined for 6 African countries, the country based poverty reduction strategy paper (PRSP) documentation and the associated World Bank/IMF HIPC documentation for human resources for health content. These documents were supplemented with other relevant country documents such as health strategies

- The review consisted of a desk study in two parts: elaboration of country chronological stories using all available documents (41 documents); and a statistical analysis of a sub-set of the available documents (26 documents) for each country based on the pre-defined set of questions with respect to human resources in the field of health care.

- The results suggest that:

  a) In most country based PRSP documentation reviewed, and included in the analysis, there is a recognition of the human resource constraints to achieving the change and policy implementation

  b) Despite this recognition, very few country-based PRSP documents indicate how the human resource constraints can be addressed

  c) Less HIPC documents than country based PRSP documents refer to the human resource constraints

  d) Hardly any HIPC documents refer to how the human resource constraints can be addressed

  e) Health objectives contained in PRSP documents are most commonly disease specific, well thought out in terms of the expected outcome, and often with an associated cost, but the human resource implications of achieving the objective are largely ignored.

- This picture is perhaps not surprising for number of reasons.

  i) The management capacity at country level may generally be poor, and whilst being able to able to recognise that problems exist, is less clear about how these problems might be addressed. Or in some instances, local managers do know what should be done but lack the support and environment to do it.

  ii) Furthermore the PRSP source book whilst encouraging the identification of human resources constraints, offers no guidance about how the problems might be addressed.

iii) Country ownership of the PRSP process is seen as paramount. Therefore authors of for example Joint Staff Assessment of Progress Reports may be reluctant to run the risk of offering HR guidance to countries and thus undermining country ownership.

iv) Indeed perhaps the relationships between the Bank/IMF and countries are ambiguous, and require constant negotiation, and frequently involve conflicting objectives such as rapid movement of money versus detailed planning for policy implementation. This situation may militate against taking opportunities to provide supportive encouragement through the review for example progress reports might be given or accepted by countries.

v) Crucially, even if a more active role were established, Bank staff at country-level probably do not have either the time, or necessarily the expertise to offer the sort of support which might be most useful.

- Notwithstanding these factors, it is difficult not to draw the conclusion that, in the absence of any other process that would pick up the issue of implementation, the PRSP process has a weakness in respect of human resources for health. Although not specifically studied, it is suspected that this weakness extends beyond the health sector. It would appear, therefore, debit relief is being often achieved without realistic plans about how policies that will make use of the debit relief for their implementation can in fact be implemented from a human resource perspective.

- There has to be a limit to the extent to which the HIPC/PRSP process can effectively operate both from the country-side and from the Bank/IMF side, without realistically addressing what is the probably the most important implementation issue to achieving poverty reduction. Those governments that genuinely are committed to improving the services for poor people deserve encouragement and support that will actually help them develop capacity in human resource planning, implementation and management so that polices can stand a chance of becoming reality.

- The Health, Nutrition and Population section of the Bank Guidance on the preparation of PRSPs, the PRSP Source Book, raises the question 'Are human resources and material resources available' this is not followed up by how identified problems might be addressed.

- With regard to civil service reform, the picture that emerges is that rarely does civil service reform seem to have macro-sectoral linkages. The impression of the authors is that from this analysis and beyond, that in many instances civil service reform is linked only to efforts to reduce budgets and numbers of staff. Given the majority of costs are on staff, efficiency has to focus on staff. Whilst the reallocation and deployment of staff can improve efficiency, the reality is often that the rights skills are not available to make reallocation or redeployment a realistic possibility. This leaves reducing staff numbers as one of the main ways of becoming more efficient.

- Whilst reducing staff numbers to become more efficient (i.e. providing the same services with less people) is not wholly contradictory with strengthened service delivery through the improved effective use of human resources, it certainly sits uneasily with the need to increase staffing levels because of the effects of HIV/AIDS or migration for example.

- Civil service reform should be seen as implementing tool for countries to achieve change and not an end in itself dominated by a drive towards efficiency. An efficient service that delivers little or no effective services for the poor wastes most of the money, whilst an inefficient service that does deliver effective services to the poor only wastes some of the money.

Acknowledgments

We am grateful to colleagues within the DFID Health Systems Resource Centre and Ed Elmendorf and other World Bank colleagues, for the encouragement advice and support they gave to us in the conducting this study and drafting the report.

Introduction

Developing countries have committed to achieving the Millennium Development Goals. They will need to make the most effective use of all available resources to achieve the MDGs – this includes human resources. Many countries are improving their short and medium term financial planning and budgetary processes. Few, if any, are giving human resource planning a similar focus. Improving service delivery to their citizens, particularly the poor will depend on improvements in education and health services but these cannot be achieved without the right skills and expertise to deliver the services.

The HIPC/PRSP process is a major instrument for achieving improved service delivery for poor people. Crucially improved service delivery depends on having the right professional, technical and other human resources in the right place at the right time.

This review which is desk based review has looked at PRSP/HIPC documentation and related documentation and seeks to shed light on whether these documents adequately reflect the growing importance of human resource planning, implementation, and management in achieving real reform. The terms of reference for this work are attached at Annex A.

For the reader who would like to know more about the PRSP/HIPC process and documentation, the World Bank document 'Development in the HIPC/PRSP Context: progress in Africa Region during 2000 provides a useful background document and also addresses the issue of Human Development.[1]

[1] Development in the HIPC/PRSP context: progress in the Africa region during 2000, Tan, J.; Soucat, A. ; Mingat, A.; Africa Region Human Development Department, World Bank , 2001

Methodology

The review was led by David Johnson, Health Systems Specialist, DFID Health Systems Resource Centre, with the support of two research assistants- Hannah Sutton (February 2003 to April 2003) and Svetla Tzolova (May 2003 to July 2003).

When difficulties about acquiring documentation were encountered, it was decided to add Uganda to the list of countries, so documentation from the following countries was reviewed:

Kenya
Ghana
Malawi
Mauritania
Tanzania
Uganda

The review consisted of a desk study (document review). The review comprised two parts:

1. Elaboration of country chronological stories using all available documents
2. A statistical analysis of a sub-set of the available documents for each country based on the pre-defined set of questions with respect to human resources in the field of health care.

Country stories

The country stories were complied from a total of 41 documents as follows:

Country	Country based PRSP documents (i.e. Interim PRSPs, PRSPs, and PRSP progress reports)	HIPC documentation (i.e. Joint Staff Assessments of PRSPs and PRSP Progress Reports, decision point documents, and completion point documents)	Other documents	Total
Ghana	3	3	1	7
Kenya	1	1	1	3
Malawi	2	2	0	4
Mauritania	2	4	1	7
Tanzania	4	4	4	12
Uganda	3	4	1	8
Total	15	18	8	41

Full details of the documents used in the country analysis are given at the start of each section of the country stories. Documents in French received from Mauritania were translated before being added to the analysis.

Statistical analysis

Discussion with Ed Elmendorf of the WB, who was undertaking a complementary study, confirmed the difficulties of the recording information about the content of documentation. He also advised at the outset on the documentation to be examined (suggesting for example that there was little point in examining country assessment papers because these are focussed on the macroeconomic situation in the country and would be unlikely to throw much light on the human resources issues).

A sub-set of the available documentation was entered into the statistical analysis. The list of documents included is given in the section Statistical Analysis. This analysis used only country PRSP or HIPC related documentation, and excluded for example an Interim PRSP when the full PRSP was available in order to avoid duplicating results.

The documents were reviewed for the specific statistical analysis of human resource content of the documentation.

The framework for the statistical analysis was structured using the answers to the following questions:

- Does the document refer to HR problems in health or offer HR solutions for health?
- Does the document go further by describing how such improvements can be implemented?
- Within the health objectives, how many include a human resources component?
- If any, is it clear how the human resources component is going to be achieved?

Here we are specifically talking about human resource issues rather than human development.

Documents mentioning civil service reform:

- Is it likely to help HR problems in health?
- Is there evidence from other documentation that the changes are linked to the needs of HR in the health sector?

Quality Assurance

The questions above used to conduct the statistical analysis are subjective in nature. Each research assistant with the study leader developed an understanding about the nature of the questions and the scoring to be used. The sequential support from the two research assistants provided an opportunity to conduct the statistical analysis twice, thus providing a degree of quality assurance. Nevertheless the statistical analysis remains essentially a subjective assessment of the HR content of the documentation and needs to be treated in this light. Whilst it was expected that more objective criteria might be developed during the study that would have provided a more scientific basis for the analysis, this proved elusive. The country stories contained in the report would benefit from further work at country level, to verify the information more thoroughly so that the stories truly reflect the experience and activity at country level.

Summary Country Stories

Ghana

The overall vision of the Government of Ghana expressed in several documents is to transform economy and society in order to improve the quality of life of its population. The stated objectives with regard to poverty reduction are related to improved health level and productivity of the population as well as increased investments in social services.

The Ghana Interim PRSP under the section Ghana's Development Strategy and Priorities - Strategic Policy Framework sets the main objectives of the strategy include attaining: a healthier and more productive population. Principal elements of the strategy to achieve these objectives include: increasing investment in human resources through improving the quality of and access to health. Specialist outreach programs have been introduced to facilitate the use of available specialists. A key element of the strategy is increasing investment in human recourses through improving the quality of and access to health. Although there is a special section on strengthening the capacity of the state to promote better governance in general, the HRD in health field is not emphasised.

The Ghana Poverty Reduction Strategy 2003-2005 - An agenda for growth and Prosperity published in February 2003, puts more attention on HRD. It addresses policies and areas for intervention in response to medium-term growth and poverty reduction under thematic areas, one of which is Human Resource Development and provision of basic services. For achieving human resources development an increase in the proportion of government expenditure dedicated to the social sector is foreseen.

The detailed Ghana country story is given in Annex B.

Kenya

The Government of Kenya shows commitment to reforming the entire health sector. In line with these intentions several important documents have been elaborated. The five-year national Health Sector Policy Framework and Strategic Plan explains the fundamentals of health sector reform strategy actions. The interim PRSP proposed that personnel should be redistributed to rural areas, but there was no exploration of this policy. One of the changes put forward in civil service reform was a cut back in the overall size of the civil service and increase some wages so as to retain a smaller workforce, the object being to establish overall government savings. This strategy implies that the cut backs will be greater than the increased retention of staff. This would appear at least on the information available to contradict the human resources needs stated in the health sector documents.

The detailed Kenya country story is given in Annex C.

Malawi

In the recent years, Government of Malawi and international community expressed willingness to make poverty reduction the top development priority, which is clearly expressed in the different documents (country and international). Improving health is a part of the overall strategy for poverty reduction. The Malawi documentation acknowledges all the major difficulties facing human resources. The documents attempt to the address the issues in some areas but leave many issues unsolved. There is a clear commitment to train more staff; this proposal was prioritised in two of the set objectives, but it was unclear how such objectives would be achieved. The recognised problems of attrition due to the migration and HIV/AIDS are not addressed in these documents although it is known that another Government document does address this issue. Strategies to improve job satisfaction were given under civil service reform; develop career paths and performance based bonuses but there is no evidence that from any of these or the health sector documents that the proposals in civil service reform are linked to the health sector.

The detailed Malawi country story is given in Annex D.

Mauritania

Since 1985 Mauritania has been implementing comprehensive program of economic stabilization and structural reforms, and registered considerable progress in this regard. Social policy development has been strongly emphasised and prioritised. Of all the countries studied, Mauritania showed the greatest awareness of and determination to address human resource constraints it faces in implementing its poverty reduction strategy. The Poverty Reduction Strategy Paper (December 13, 2000) is built upon four main themes that are mutually supporting and that converge towards the attainment of the desired objectives. One of the major themes is aimed at developing human resources and access to essential infrastructures. This theme is the one that, over the long term, will have the most perceptible effect on poverty, through its impact on productivity and improved living conditions for the poor. Access to health, in particular, reduces the vulnerability of the poor considerably.

The detailed Mauritania country story is given in Annex E.

Tanzania

Tanzania has put enormous efforts to implement changes and to fight with poverty in the recent years. Although the poverty reduction initiatives are well documented, the documents show a vague, minimal effort to address human resources for health. In the Poverty Reduction Strategy Paper the focus along with other efforts is on improving human capabilities, survival and social well-being. Initiatives with respect to this aim are directed toward: personnel training; promoting HIV/AIDS and public health awareness, including peer education in schools. Under specific poverty reduction interventions, catalysing communities and other stakeholders is listed, performed by self-help schemes (health centres), however this could not be clearly related with HR capacity. One document proposes to train more personnel, another document proposes an increase the budgetary allocation in human resources for health development. Neither of the

statements were put in the context of known problems or given methods of implementation. The one health objective that included a human resources component, from a total of eight, was the rate of attended births- a direct millennium development goal. No explanation was given for how this might be achieved. Changes proposed under civil service reform were not linked to the health sector.

The detailed Tanzania country story is given in Annex F.

Uganda

Uganda's strategy to eradicate poverty has its roots in the following Government initiatives: 1997 Poverty Eradication Action plan which serves as national planning framework to guide medium term sector plans, district plans and budget process and the "Vision 2025" where the long term national aspirations are described. The Uganda documentation acknowledges specific human resources problems but do not address the problems in any detail. Quantity of health workers was stated as a problem and a commitment was made to train more workers in one of the objectives, but with no explanation of how this was to be achieved. The documents stated that HIV/AIDS and emigration were preventing staffing norms from being met, but there was no attempt to resolve the issues. The Poverty Reduction Strategy Paper stresses that improving the health of the Ugandan population is a priority objective of the Government of Uganda. The Health Sector Strategy sets targets of reducing child mortality. Human resource factor in health sector is not discussed in the paper.

The detailed Uganda country story is given in Annex G.

Results of the statistical analysis

In total a sub-set of 26 documents were included in the statistical analysis. The details of the documents considered per country are shown in the tale below.

Table A – Details of all the documents included in the statistical analysis

Type of document	Ghana	Kenya	Malawi	Mauritania	Tanzania	Uganda	Total
PRSP	1		1	1	1	1	5
Interim PRSP		1					1
PRSP or Interim PRSP progress report				1	1	1	3
PRSP or Interim PRSP progress report (2)						1	1
Joint staff assessment of PRSP or interim PRSP	1	1	1	1	1		5
Joint staff assessment of PRSP progress report				1	1	1	3
Joint staff assessment of PRSP progress report (2)						1	1
HIPC decision point document	1		1	1	1	1	5
HIPC completion point document				1	1		2
Total	3	2	3	6	6	6	26

Out of the 26 documents included, 17 (65%) refer to HR problems in health or offer HR solutions for health. However, only 3 of the 17 actually make clear how the HR component is going to be achieved. (See table B)

It is striking that when the analysis looks separately at the country and HIPC documents, 9 out of 10 of the country documents refer to HR problems in health or offer HR solutions for health, as compared with only 8 out 16 HIPC documents.

Of the 9 PRSP country documents where a reference to HR problems in health or offer HR solutions for health was made, only two of the documents offer a description of how the HR component is to be achieved. (See table C).

In this respect, it might be expected that the HIPC documents such as Joint Staff Assessments might have identified this lack of clarity about how the HR component is to be achieved but only 1 document out of all the HIPC documents offers any comment in this way. (See table D)

Looking at the issue of health objectives, the picture is much the same. 15 of the documents overall refer to at least one objective with an HR component, but 9 (out of 10) of these are country documents and 6 (out of 16) are HIPC documents (See table B). In 4 of the country PRSP documents there is some clarity about how the HR component is going to be achieved (table C) whereas only 2 HIPC documents have this clarity (table D).

Table B - Statistical analysis for all documents (cell entries are the number of documents for which the answer to the question was yes)

Question	Ghana	Kenya	Malawi	Mauritania	Tanzania	Uganda	Total
Does the document refer to HR problems in health or offer HR solutions for health?	2	2	2	5	2	4	17
Does the document go further by describing how such improvements can be implemented?	0	0	1	1	0	1	3
Within the health objectives, how many include a human resources component?	2	0	2	3	2	6	15
If any, is it clear how the human resources component is going to be achieved?	0	0	2	3	0	1	6
Documents mentioning civil service reform	3	2	3	5	6	6	25
Documents where civil service reform, is linked to strengthening HR management	3	2	1	2	2	2	12
Is it likely to help HR problems in health?	0	0	1	2	2	1	6
Is there evidence from other documentation that the changes are linked to the needs of HR in the health sector?	3	0	0	2	0	1	6

Table C - Statistical analysis for country PRSP documents (cell entries are the number of documents for which the answer to the question was yes)

Question	Ghana	Kenya	Malawi	Mauritania	Tanzania	Uganda	Total
Does the document refer to HR problems in health or offer HR solutions for health?	1	1	1	2	2	2	9
Does the document go further by describing how such improvements can be implemented?	0	0	0	1	0	1	2
Within the health objectives, how many include a human resources component?	1	0	1	2	2	3	9
If any, is it clear how the human resources component is going to be achieved?	0	0	1	2	0	1	4
Documents mentioning civil service reform	1	1	1	2	2	3	10
Documents where civil service reform, is linked to strengthening HR management	1	1	1	1	1	2	7
Is it likely to help HR problems in health?	0	0	1	1	1	1	4
Is there evidence from other documentation that the changes are linked to the needs of HR in the health sector?	1	0	0	1	0	1	3

25 of the 26 documents refer to civil service reform, and in 12 of these documents, civil service reform is linked to strengthening HR management. However, in only 6 documents are the changes linked to the needs of HR in the health sector.

Table D - Statistical analysis for HIPC documents (cell entries are the number of documents for which the answer to the question was yes)

Question	Ghana	Kenya	Malawi	Mauritania	Tanzania	Uganda	Total
Does the document refer to HR problems in health or offer HR solutions for health?	1	1	1	3	0	2	8
Does the document go further by describing how such improvements can be implemented?	0	0	1	0	0	0	1
Within the health objectives, how many include a human resources component?	1	0	1	1	0	3	6
If any, is it clear how the human resources component is going to be achieved?	0	0	1	1	0	0	2
Documents mentioning civil service reform	2	1	2	3	4	3	15
Documents where civil service reform, is linked to strengthening HR management	2	1	0	1	1	0	5
Is it likely to help HR problems in health?	0	0	0	1	1	0	2
Is there evidence from other documentation that the changes are linked to the needs of HR in the health sector?	2	0	0	1	0	0	3

Do the Country Documents Acknowledge Human Resources for Health?

Ideally acknowledgment of human resources for health issues would involve addressing all the known problems, prioritising these problems, and creating an appropriate human resources development plan with a shown commitment to implement the solutions and include human resources aspects in most of the set health objectives.

The level of acknowledgement varied considerably between countries, though no country achieved complete realisation. Most commonly the importance of human resources was understated. Frequently the documents would state a human resources issue or policy with no further explanation or reasoning; unconvincing that the issue had been founded by known sector needs, properly understood or that the country was both committed to addressing the issue and understood how this could be done. However there was evidence in places that considerable efforts had been made to improve human resources for health. Both I-PRSPs were weaker in addressing human resources for health than the full PRSPs.

Do the World Bank and IMF documents push Human Resources Issues?

Of the sixteen WB and IMF documents, there were two incidences where human resources for health issues were given active encouragement; the Mauritania decision point document stated that budgetary allocation for salaries should increase, the decision point document Malawi prioritised human resources by incorporating the issues

in the ‘completion point triggers’. However, each of these points followed a strong recognition of the issue from the government paper, and these points were the exception rather than the norm. Most frequently the WB and IMF avoided discussing the human resources for health matters brought forward in the government documents despite constant iteration that proposals for health improvements were failing. A JSA for Tanzania put such failings down to insufficient budgetary allocation. The Ghana and Kenya JSA viewed human resources as a limiting factor, and rather than addressing the problem, stated that health interventions should be prioritised accordingly. Where the WB and IMF documents did acknowledge human resources for health, it was simply to state what the proposal was, or to recognise that the human resources objectives were not being met. The documents did not suggest ways of strengthening such policies.

Was Human Resources included In the Targeted Health Objectives?

The health objectives were most commonly disease specific strategies such as decreasing the number of deaths caused by HIV/AIDS. The objectives were well thought out in terms of calculating the numbers of reduction; how the end product would look and even the costing of achieving these objectives were considered in most cases, but the process of how to get there - the human resource element was largely ignored. Of the few objectives given that do include human resources; over half were to improve the ‘rate of birth attendance’. This is perhaps not surprising since increasing the number of skilled personnel to attend births is a very specific MDG, and the only one with a specific HR target. It is unlikely that this particular issue is the most important human resources aspect that should be prioritised to this extent over other human resources issues, thus indicating that countries are being pulled towards aiming for particular targets rather than actually looking at the real needs of the health system and making efforts to improve the system accordingly.

The role of Civil Service Reform in Human Resources For Health

In general, civil service reform in the HIPC documents concentrated on structural changes, ways of altering the system, i.e. decentralising management, increasing community participation, making the system more democratic and transparent. Overall the dynamics of the system were explained without considering the staff at the heart of the changes. On the rare occasion where civil service reform did address human resources directly, it was to do with the over all size of the workforce, incentives and salaries. These things were not dealt with at the level of the health sector.

This highlights difficulties in attempting to improve human resources for health. As the changes proposed are cross-sector, there is no clear guarantee that the changes will be included in strategies to improve human resources at the level of the health sector. For example, the Tanzanian decision point document proposed that civil service reform would bring about improvements in the level and structure of salaries, but in the health section, it explicitly stated that the budgetary allocation for salaries would not increase- this is backed up by the ministry documentation. Even if health was included in this statement, improving salaries for the whole civil service is so watered down, with every sector wanting its share, that there would be little real impact for the health sector.

Having to go up to the level of civil service reform to improve salaries and incentives gives makes addressing the problems a lot more complex for Ministries of Health. In general it seems that civil service reform is not linked well to addressing the health

sectors human resources issues. Mauritania was the only country where civil service reform was successfully linked to the needs of the health system and increased spending on salaries and incentives. The drivers for civil service reform come from all areas of the government, not just the health sector. For example, there may be a requirement to reduce government spending and improve efficiency but which overlooks the needs of the health sector to increase sector spending to improve service delivery to poor people as highlighted in the case of Kenya where civil service reform involved cut backs in the size of the staff in the health system.

Discussion and conclusions

This review is contains a degree of subjective analysis of PRSP/HIPC documents from a sample African countries Nevertheless, the country stories and the statistical analysis do paint a clear picture.

1. In most country based PRSP documentation reviewed, and included in the analysis, there is a recognition of the human resource constraints to achieving the change and policy implementation

2. Despite this recognition, very few country-based PRSP documents indicate how the human resource constraints can be addressed

3. Less HIPC documents than country based PRSP documents refer to the human resource constraints

4. Hardly any HIPC documents refer to how the human resource constraints can be addressed

5. Health objectives contained in PRSP documents are most commonly disease specific, well thought out in terms of the expected outcome, and often with an associated cost, but the human resource implications of achieving the objective are largely ignored.

This picture is perhaps not surprising for number of reasons.

- The management capacity at country level may generally be poor, and whilst being able to able to recognise that problems exist, is less clear about how these problems might be addressed.

- Furthermore the PRSP source book whilst encouraging the identification of human resources constraints, offers no guidance about how the problems might be addressed.

- Country ownership of the PRSP process is paramount. Therefore authors of for example Joint Staff Assessment of Progress Reports may be reluctant to run the risk of offering HR guidance to countries and thus undermining country ownership.

- Indeed perhaps the relationships between the Bank/IMF and countries are ambiguous, and require constant negotiation, and frequently involve conflicting objectives such as rapid movement of money versus detailed planning for policy implementation. This situation may militate against taking opportunities to provide supportive encouragement through the review for example progress reports might be given or accepted by countries.

- Crucially, even if a more active role were established, Bank staff at country-level probably do not have either the time, or necessarily the expertise to offer the sort of support which might be most useful.

Notwithstanding these factors, it is difficult not to draw the conclusion that, in the absence of any other process that would pick up the issue of implementation, the PRSP process has a weakness in respect of human resources for health. Although not specifically studied, it is suspected that this weakness may extend beyond the health sector.

This is not to say that such a human resource implementation plan does not exist, but it is rarely the case that the HIPC/PRSP confirms that such a realistic plan exists and it is these documents that trigger the debit relief. So put another way it would appear as if debit relief is being often achieved without realistic plans about how policies that will use the debit relief for their implementation can in fact be implemented from a HR perspective.

Whilst placing some HR conditionality within the HIPC/PRSP processes would add to the managerial burden placed on Governments, there has to be a limit to the extent to which the process can effectively operate both from the country side and from the Bank/IMF side without realistically addressing what is the probably the most important implementation issue to achieving poverty reduction. Those governments that genuinely are committed to improving the services for poor people deserve encouragement and support that will actually help them develop capacity in human resource planning, implementation and management so that polices can stand a chance of becoming reality.

Furthermore whilst the Health, Nutrition and Population section of the Bank Guidance on the preparation of PRSPs, the PRSP Source Book, raises the question 'Are human resources and material resources available' this is not followed up by how identified problems might be addressed. The meticulous efforts of the World Bank to avoid any weakening of Government ownership is laudable, but perhaps needs to be balanced by real help and support to Governments to achieve their desired objectives and utilise debit relief effectively – debt can only be relived once. Perhaps the Source Book is not the best vehicle for providing help and such support but support and help is needed.

With regard to civil service reform, the picture that emerges is that rarely does civil service reform seem to have macro-sector linkages. The impression of the authors is that from this analysis and beyond, that in many instances civil service reform is linked only to efforts to reduce budgets and numbers of staff. The World Bank document Development in the HIPC/PRSP context'[2]: progress in the Africa region during 2000, Tan, J.; Soucat, A.; Mingat, A.; Africa Region Human Development Department, World Bank, 2001 refers for the need to focus on efficiency. Given the majority of costs are on staff, efficiency has to focus on staff. Whilst the reallocation and deployment of staff can improve efficiency, the reality is often that the rights skills are not available to make reallocation or redeployment a realistic possibility. This leaves reducing staff numbers as one of the main ways of becoming more efficient. Whilst reducing staff numbers to become more efficient is not wholly contradictory with strengthened service delivery through the improved effective use of human resources, it certainly sits uneasily with the need to increase staffing levels because of the effects of HIV/AIDS or migration for example.

[2] Development in the HIPC/PRSP context: progress in the Africa region during 2000, Tan, J.; Soucat, A. ; Mingat, A.; Africa Region Human Development Department, World Bank , 2001

Furthermore, the evidence would suggest despite the support of World Bank to civil service reforms (CSRs) for the last two decades it has been found that World Bank-supported CSRs were largely ineffective in achieving sustainable results in downsizing, capacity building, and institutional reform. [3]

Civil service reform should be seen as implementing tool for countries to achieve change and not an end in itself dominated by a drive towards efficiency. An efficient service that delivers little or no effective services for the poor wastes most of the money, whilst an inefficient service that does deliver effective services to the poor only wastes some of the money.

[3] Civil Service Reform: A review of World Bank Assistance, WB Operations Evaluation Department, 1999

Annex A Terms of Reference

Terms of reference for Study into the human resource management content of PER, PRSPs, HIPC, SWAPs, MTEFs and Health Sector Strategies

Introduction

Human resources account for a substantial amount of any health sector expenditure. Although service delivery is reliant on its budget and supplies, the labour intensity of a health system means that problems in human resources can be the most limiting factor in achieving successful outcomes. Therefore, tackling the issues in human resources must be a fundamental process in achieving the Millennium Development Goals and improving the huge public health crisis faced by many LMI countries.

Most countries are reforming their health systems in some way, be it decentralisation, expanding the private sector or implementing essential service packages. This creates opportunities for human resources but also brings new challenges. With every change new skills and competencies must be learned. For the reforms to be successful the impact on human resources must be accounted for.

This study

The aim of this study is:

For specified countries, review the following documentation:

Public expenditure reviews
Poverty reduction strategy papers and progress reports of PRSPs
HIPC documents including health sector measures to reach the floating point under the initiative
Country assessment papers
Health Sector Reviews
Sector Wide Strategies in health
Health Sector Strategy
Medium Term Expenditure frameworks for health or that encompass health

The review of this documentation will analyse the human resource management content of each and the consistency with which human resources is handled between the various documents. At the end of the study it is intended to be able to assess how well human resources is covered in these selected countries in the major change programmes embarked upon by government.

Analysis of the documents

In order to make these assessments the following categorisation will be used.

The content of human resource management will be recorded as:
Full civil service reform
Major change in human resource management
Specific categories of human resource deployment /employment e.g. nurses
Human resource management absent

As well recording level of human resource content, assessment will also be made of whether the document indicates how it is expected that the desired change in human resources will be achieved.

Countries to be studied

It not possible to study many countries in this study given the resources available and the likely time it will take to gather the relevant documentation. The choice of countries has been guided by those countries where it is known that documentation exists. It is felt nevertheless that the results will provide a pointer as to whether the issue of human resource management is being addressed by governments when they are planning and implementing major change programmes affecting their health systems.

The countries chosen are:
Malawi
Ghana
Kenya
Tanzania
Mauritania

Specific task to be undertaken

The following specific tasks will be undertaken:

Gather the relevant documentation
Analyse the content of the documentation including the consistency with which human resources is handled between the documents
Present the analysis in the form of a spreadsheet with supporting text, and provide a discussion of the findings.
Compare the findings with health advisor view in country.

Expected Outputs

The expected outputs from this study are as follows:
For the selected countries, assessment of the HR content of key policy documentation
Comparison of the analysis of the written evidence with the views of health advisors in selected countries
Contribution to the debate about how the key policy instruments might be adjusted to better reflect the HR dimensions of implementing policy

The outputs from this study will contribute to two outputs in the overall TORs for the HR work programme:
Output 1 - HR policy debate is strengthened using knowledge of good practice and evidence of effectiveness.

Output 2 - The profile HR work in aid instruments raised

Timescale

The work will be undertaken from February and completed by the beginning of April 2003.

Annex B Ghana detailed country story

The following documents have been reviewed:

1. Interim Poverty Reduction Strategy Paper 2000-2002 (June, 2000)
2. Memorandum of the president of the international development association and the international finance corporation to the executive directors on a country assistance strategy of the WB Group for Republic of Ghana (June 29, 2000)
3. Poverty reduction strategy, progress report 2002
4. Joint Staff Assessment of the PRSP Preparation Status Report (February 4, 2002)
5. Enhanced Heavily Indebted Poor Countries (HIPC) Initiative Decision Point Document (February 4, 2002)
6. Ghana Poverty Reduction Strategy 2003-2005 - An agenda for growth and Prosperity (February 19, 2003)
7. Joint Staff Assessment of the Poverty Reduction Strategy Paper (March 4, 2003)

The **Interim Poverty Reduction Strategy Paper 2000-2002** (June, 2000) sets government strategic policy framework and aims toward poverty reduction. A principal element of the strategy is increasing investment in human recourses through improving the quality of and access to health. In order government to achieve the poverty reduction objectives of "Vision 2020" a principal of wages and economic growth has to be considered by redirecting resources saved by cuts in interest payments to social sector expenditure in health. The poverty reduction agenda for 2000-2002 considers improving coverage of and access to primary healthcare facilities.

According to the document, for achieving its goals, the government of Ghana has protected the increase in expenditures for health. The reforms are designed to address problems and challenges such as limited access to services, inadequate service quality, inefficiency and wastages, inadequate funding of health services and inefficient resource allocation. Although there is a special section on strengthening the capacity of the state to promote better governance in general, the HRD in health field is not emphasised.

The main attention is directed toward improving primary health care services and related set of objectives, strategies and measures. The only word about HRD is with respect to more efficient use of resources to improve geographical access to secondary and tertiary health services. The document does not elaborate further on the HRD.

The **Memorandum (June 29, 2000)** discusses among issues of economic growth, investment and portfolio management, also decentralization and civil service reform. Improving health of the population is an ultimate objectives stated in the country assistance strategy. The document stresses that the Government of Ghana is encouraged to elaborate issues of decentralization, however need for a major effort in capacity building has to be considered. According to the document more consistent and effective strategy to promote decentralization needs to be developed, which focuses on the efficient delivery of key social services.

The Memorandum points out that a Second Health Project (WB) is planned for continues sector-wide support to health services. The fight against HIV/AIDS is of high importance,

as well as involvement of private sector.

Increase in government and total public financing of health and increase of expenditure as percent of domestic primary expenditure and maintain a reasonable balance between capital and recurrent expenditures is planned. Several strategic actions are planned, incl. Increase in funding to district services, under served areas and for the poor are also foreseen, however it is not clear how these changes would reflect on HRD.

Strengthening of HR in the area other than health is planned, however, in the field of health care HR development is not discussed in details. Capacity weakness is perceived as a major challenge in Ghana and the country assistance strategy matrix refers to capacity building actions in the public sector in general. Special Comprehensive Development Framework matrix for capacity building is attached to this memorandum where stakeholders involved in improving HR skills are listed, incl. health care.

The **Poverty Reduction Strategy Progress Report (2002)** stresses that in the preparation of the strategy one of the core teams established to constitute the focus of analysis and recommendations was on HRD and Basic Services in general. The document does not refer to the progress in health filed.

The **Joint Staff Assessment of the PRSP Preparation Status Report (February 4, 2002)** acknowledges that the social sector policies focus is on providing equitable access to health services and improving resource allocation.

The **Enhanced Heavily Indebted Poor Countries (HIPC) Initiative Decision Point Document (February 4, 2002)** shortly assesses the health sector situation in Ghana in comparison with other African countries in terms of health spending, outcome indicators and health infrastructure. The role of private sector in health care is recognised but the issue on human resources in health care is not raised. According to the document a pillar in the PRS with regard to the governance and institutional reform is the enhance capacity of the civil society as well as equitable HRD in terms of access to and quality of health care.

The objectives of health sector listed in the document reflect issues on equity, efficiency in service delivery and access to care. Regarding human recourse in health the paper foresees the redistribution of health workers toward poorest regions. The changes put forward in civil service reform to decentralise personnel management may have repercussions for human resources in health but this proposal is not strategically linked to a health strategy.

The **Ghana Poverty Reduction Strategy 2003-2005 - An agenda for growth and Prosperity (February 19, 2003)** addresses policies and areas for intervention in response to medium-term growth and poverty reduction under thematic areas, one of which is Human Resource Development and provision of basic services. For achieving human resources development an increase in the proportion of government expenditure dedicated to the social sector is foreseen.

The section of the GPRS on Human Resource Development and Basic Services stresses that significant gaps exist in access to and utilisation of basic services by the poor, particularly with regards to health, HIV/AIDS control, etc. Underlying constraints in the provision of quality health care are efficiency and financing gaps. These include

limited decentralisation, inadequate motivation of professional staff, ineffective supervision and monitoring, and weak links between facilities and communities. Financing constraints are reflected in weaknesses in the implementation of the user-fee exemption policy, yet-to-be established links between the exemption policy and the proposed national health insurance scheme, concentration of considerable resources at the regional level and limited success with partnership with other government agencies and the private sector.

Due to significant progress made on the sector wide approach to health care, the GPRS will highlight three priority interventions that need to be planned for in the (next) 2002-2006 Programme of Work of the Ministry of Health (titled "Partnerships for Health – Bridging the Inequalities Gap"):

- Bridging equity gaps in access to quality health services
- Ensuring sustainable financing arrangements that protect the poor
- Enhancing efficiency in service delivery

The GPRS focuses on standardising the quality of basic healthcare to ensure that wherever one is in the country, one has access to good quality health care. Strategies that ensure availability of health workers will be developed, especially in deprived regions, including provision of financial incentives, accommodation, opportunities for career development and expanding enrolment in training institutions in deprived regions. A key issue to be addressed within the planned period is the migration of health workers. To further enhance efficiency in service delivery, human resource management will be decentralised to the regional level. Staff and resources will be provided to expand community-based health service delivery and collaboration with informal providers will be strengthened.

A financial framework is attached to the document, specifying the break down of needed resources.

The **Joint Staff Assessment of the Poverty Reduction Strategy Paper** (March 4, 2003) points out that the GPRS addresses fundamental factors for HRD such as the incentives to retain experts in the public services and reform of the management of public services. It evaluates the strategy for the health sector and to combat HIV/AIDS as comprehensive and coherent.

Annex C Kenya detailed country story

The following documents have been reviewed:

1. The National Health Sector Strategic Plan: 1999-2004 (July 1999)
2. Interim Poverty Reduction Strategy Paper 2000-2003 (April 2000)
3. Assessment of the Interim Poverty Reduction Strategy Paper (July 12, 2000)

In the **National Health Sector Strategic Plan: 1999-2004** HRD is discussed in a special chapter where the strategic objectives and main activities are described in details. The expected outcomes as well as the budgetary requirements for HRD are listed. Development of policy network is stated as necessary action.

The **Interim Poverty Reduction Strategy Paper 2000-2003 (April 2000)** for health sub-sector represents a major milestone by linking the objectives contained in the Kenya Health Policy Framework Paper (1994) and the National Health Sector Strategic Plan (1999-2004). According to the Interim Poverty Reduction Strategy Paper the most striking feature of the 3-year implementation plan is the proposed real shifts of human resources from curative to preventive/promotive/rural health services sub-votes, for which budget allocation is also foreseen. However, the HRD for the new emerging tasks and obligations is not discussed.

The stated government immediate priority is to reduce poverty in general. The emerging issue is to improve health by improving provision of and access to basic services. Another important aspect discussed in the paper is the improvement of governance in broad sense as well as HRD. However, the particular aspects and steps for HRD in health sector are not elaborated.

Job creation and promotion of a productivity, as well as improvement in the provision of skills and knowledge for the workforce is foreseen. Public Service Reform Plans foresee capacity building and training. Some measures aiming at changing incentive mechanisms are also considered, i.e. increase remuneration for public employees over the medium term with resources made available by the planned reduction in the number of public employees. The commitment of these actions is not necessarily linked with the health sector.

The **Assessment of the Interim Poverty Reduction Strategy Paper (July 12, 2000)** points out that the poverty analysis in PRSP identifies a number of reasons for poverty situation, including poor governance in general. According to assessment report, the interim PRSP presents broad outline for reducing poverty, incl. improving of governance by adoption and implementation of a code of ethics for all public servants and improving management. The government issues however seem to be very general and do not offer more detailed view on intended policy measures. The assessment report recognises health sector strategies for poverty reduction listed in PRSP, i.e. HRD. Although it is recognized as an objective HRD in health care is not elaborated in details. The medium term strategies are directed toward policy changes and budgetary allocations for priority areas and institutional reform.

The assessment report states that in the health sector, the government has laid out a

plan to shift public support from centralized hospital care for centralized primary health care. The document does not discuss the advantages and problems that could be associated with such a strategy. Human recourses constraints are mentioned as a problem, however it is not clear from the document how this aim would be overcome in terms of availability and capacity.

The assessment report recognises the government's medium-term strategy on a significant reduction in the size of the civil service. One of the changes put forward in civil service reform has been a cut back in the overall size of the civil service and increase some wages so as to retain the reduced workforce in order to establish overall government savings. This strategy implies that the cut backs will be greater than the increased retention of staff. This clearly contradicts with the human resources needs stated in the health sector documents. This document does not expand on HR any further than listing the findings in PRSP interim. The assessment report points out the necessity and actions taken for assuring effective cooperation and coordination between agencies to make the best use government's limited human resources. The conclusion in the assessment report refers to the key challenges in fulfilling objectives when implementing PRSP, which lay in the financial and human resource constraints.

Annex D Malawi detailed country story

1. Interim poverty Reduction and Growth Strategy Paper – A Road Map (August, 2000).
2. Decision Point Document for the Enhanced Heavily Indebted Poor Countries Initiative (December 7, 2000)
3. Malawi Poverty Reduction Strategy Paper (April 2002)
4. Joint Staff Assessment of the Poverty Reduction Strategy Paper (August 23, 2002)

Government of Malawi has prepared the **Road Map of Interim poverty Reduction and Growth Strategy Paper (August, 2000)** outlining the steps to be taken in developing a comprehensive PRSP. The paper points out continued efforts of the country achieve reduction in poverty. Inadequate human capacity at all levels, as well as poor incentive structures within the civil service is seen as deficiency of poverty alleviation actions. Decentralisation of health care management is a foreseen initiative in the health sector, however the paper does not make clear how this would be realized in practice. The document states that the government has recently developed a policy for resource development in light of critical human recourse constraints in the health sector. The document IPSP matrix lists under the health sector objectives and policies, reduction of staff shortage by implementing management and incentive reforms. This action has no specific timetable but it is defined as “on going”.

Decision Point Document for the Enhanced Heavily Indebted Poor Countries Initiative (December 7, 2000) states clearly that the Malawi’s National Health Plan indicates that the critical factor behind poor health outcomes is the serious shortage of medical personnel, particularly in rural areas. The severity of the problem manifests itself in vacancy rates ranging from 33% to as much as 80% in some positions, resulting in extremely high ratios of population to medical personnel. A complex set of factors is listed to account for the staffing shortage, including low salaries, attrition to more lucrative jobs, sickness or death mainly from HIV/AIDS, and the training institutions’ limited capacity to produce fresh graduates. According to the Decision Point Document, the Government has put together a long-term HRD Plan, which addresses the issue. In this context there is commitment for raising the output of medical personnel in 3 areas where vacancy rates are the highest. The target for progress towards a reduction of the human resources is through recruitment, training and deployment of at least 200 nurse technicians, 50 new medical assistants and 20 radiography technicians per annum, as completion point triggers.

Malawi Poverty Reduction Strategy Paper (April 2002) makes a sectoral analysis of poverty which shows that social, human capital and income indicators are very poor in the country. The MPRS is built around four pillars. These pillars are the main strategic components grouping the various activities and policies into a coherent framework for poverty reduction. One of the pillars is to enhance human capital development.

The MPRS recognises that human capital is key to poverty reduction in Malawi. To ensure that human capital of the whole population is developed to fully participate in the socio-economic development of the country will be achieved through the design and implementation an Essential Healthcare Package (EHP). The overall objective of the

health sector is to improve the health status of Malawians by improving access to, quality and equity of health services. The key strategies under the EHP are to recruit, train and adequately remunerate nurses and other health workers, to promote the construction of health facilities, especially through the construction of rural health centres. These delivery components will be supported by ongoing reforms to health services, focussing resources on preventative and primary healthcare, and decentralising management and administrative responsibilities.

The first component of the EHP is to promote clinical human resource development. Human resources are an absolutely critical delivery input of the EHP implementation. This will involve ensuring that clinical teaching and training institutions are fully utilised and expanding the training of various clinical cadres like nurses, medical assistants, clinical officers, and technical support services (such as radiographers, orthopaedic technicians and pharmacists). Government will also review the remuneration and career structures for medical staff in order to address problems of attrition through “brain drain”.

A strategy to develop financial and managerial resources so as to strengthen planning, budgeting and transport management, particularly at a district level is also foreseen. This will involve training and retraining financial managers/accountants, administrators, senior nurses and matrons. According to the document the financing and management of essential healthcare services will also be strengthened through the development of a Sector Wide Approach (SWAp) in the health sector. Essential Healthcare Targets till 2005 are foreseen, e.g. number of HSAs trained to achieve 7,000, number of nurses trained – 470, number of technical staff trained -825, number of physicians trained – 60, etc.

Decentralisation of the health sector, within the context of the broader devolution to the local government through district assemblies, is planned to create the setting in which the EHP is to be delivered. One common objective of decentralisation is to take the planning of health services closer to the people they are intended to serve. If local involvement is to be meaningful, there should be flexibility for district managers, in consultation with health staff and community members, to “weight” resource allocation to the various components of the EHP according to local needs.

Based on the statements in the **Joint Staff Poverty Reduction Strategy Paper (August 23, 2002)** the PRSP of Malawi is considered as well-developed and sound strategy. The successful implementation with respect to HRD, however, require further elaboration of a clear capacity building program to redress the impact of HIV/AIDS in particular. The assessment document points out that the health sector PRSP appears to be more focused on the delivery of health services, with less emphasis placed on a multi-sectoral approach. The recommendation of the report is directed toward more emphasis on service provision by local community groups and other proven delivery agents during implementation of PRSP. There is no further discussion on HRD.

Annex E Mauritania detailed country story

The following documents have been reviewed:

1. Decision Point Document under the Enhanced Heavily Indebted Poor Countries (HIPC) Initiative (January 14, 2000)
2. Poverty Reduction Strategy Paper (December 13, 2000)
3. Joint staff Assessment of the poverty reduction strategy paper (January 12, 2001)
4. Medium-Term Expenditure Framework (2002-04) for improving Efficiency and equity of public health expenditure (June 20, 2001)
5. Poverty Reduction Strategy Paper, implementation report (March 2002)
6. Joint staff assessment of the PRSP, Annual Progress report (April 29, 2002)
7. Completion Point Document Under the Enhanced Heavily Indebted Poor Countries (HIPC) Initiative (May, 10, 2002)

The **Decision Point Document under the Enhanced Heavily Indebted Poor Countries (HIPC) Initiative (January 14, 2000)** recognises the social development and poverty reduction, which has been an integral part of the government's economic program. It points out that despite fiscal constraints (in the period 1992-1998) the government increased spending in social sector and managed to improve the quality and effectiveness of its social expenditure program.

The decision point document reviews the actions taken by the government since 1991 in the field of health, population and nutrition. The adopted Health Sector Policy and Health Sector Development Program (1991, and the amended version in 1998) set an objective for decentralization on the decision-making process. Although there is recognition in necessity of comprehensive development in the filed of health sector, initially there has been no specific objective related to human resources development.

The report reveals the government plans to strengthen its administrative capacity and raise the quality of government decision-making by reorganizing the civil service and improving transparency. The ongoing civil service reform envisages performance-based evaluation and merit-based recruitment. In the Action Plan for the fight against poverty launched in 1998 (for the period 1999-2002) one of the main lines is specifically stated to be achievement in human development by increasing the share of budgetary resources in health sector, with attention to efficiency considerations. The decision paper points out that the idea to devolve delivery of public service to local authorities should be accompanied with actions to put in place capacity building measures to enable local authorities to implement these programs.

The **Poverty Reduction Strategy Paper (December 13, 2000)** is built upon four main themes that are mutually supporting and that converge towards the attainment of the desired objectives. One of the major themes is aimed at developing human resources and access to essential infrastructures. This theme is the one that, over the long term, will have the most perceptible effect on poverty, through its impact on productivity and improved living conditions for the poor. Access to health, in particular, reduces the vulnerability of the poor considerably.

In the diagnostic part of the document, the weak access to health services and low life expectancy is explained partly by the poor fit between personnel qualifications and assignments, which is linked to problems of training, pay and motivation as well as to the stagnation in public health expenditures. At the primary level, the quality of health care is still poor, while the second tier is not yet able to assume its role of taking referrals due, among other things, to the lack of personnel in certain essential specialties. The result is overcrowding at the National Hospital Center, whose facilities are vastly over-extended. It is stressed that despite efforts over the past few years at training and at achieving a significant increase in the numbers of medical personnel, this personnel remains too few in number and poorly distributed. In addition, health staff is insufficiently motivated.

The focus of the activities designed to improve the health of the population and especially of the poor are clear and directed toward boosting the coverage and quality of health care and the utilization of health facilities by taking steps to increase the availability of human resources in rural areas by training and redeploying qualified staff and creating incentives (decentralization of recruitment, providing contracts and financial and nonfinancial incentives to health personnel in rural areas and ensuring the availability of doctors trained in basic surgical techniques).

The **Joint Staff Assessment of the Poverty Reduction Strategy Paper (January 12, 2001)** paper stresses that the major obstacles to poverty reduction have been identified in the PRSP, i.e. low labour productivity and lack of human capital. The analysis of the experts presented in this report, points out the development of human resources as one of the main pillars of Mauritania's poverty reduction strategy. The report considers the need for deeper analysis of obstacles that affect performance in health sector, however there is no further elaboration on the Human Recourse Development issues.

The **Medium-Term Expenditure Framework (2002-04) for Improving Efficiency and Equity of Public Health Expenditure (June 20, 2001)** points out that Mauritania's health budget has grown regularly over the past 10 years expressed in current terms. Significant increase in the health expenditure at the administrative and tertiary levels, with relative levelling off at the primary level is reported as well. This trend is pointed out to be particularly acute with respect to wages: the number of personnel has not increased for primary and secondary services, whereas the number of employees has skyrocketed at the tertiary level. It is stated that the main lines of the expenditures program has been developed according to the guidelines to fund human resources to boost the sector's ability to implement and absorb funds.

The listed actions to be taken have been designed to improve the availability of human recourses – recruitment and training of specialized medical personnel and payment of bonuses for work in disadvantaged areas. Availability of human resources is listed as key determinant. The issue is discussed in the context of "steps" or dimensions of performance - if a health service is accessible but not properly staffed the issue of whether it is properly stocked is irrelevant, i.e. there is no point in making progress on one step if the system fails on previous steps. Increasing availability of human recourses up to 100%, particularly in rural areas is one of the most important steps in strategies for increasing coverage for poor.

The lack of human resources constitutes an "additional broken step" in the delivery of packages for priority interventions: primary preventive services, community, family- and

facility-based health care and therefore improvement of availability of human resources is stated as an essential area of intervention. The intervention objectives are linked with program budget. The document gives detail description of objectives for improving ability of HR by listing aims, recognising types of personnel, involvement of female personnel in rural areas (to improve use of health services by women), types of operating and investment costs, as well as dependency of the program from the key reforms.

Special attention in the paper is devoted to the program aimed at building the sector's institutional capacity. To ensure that the foreseen program expenditures are reflected in performance, one of the reform initiatives of the Ministry of Health deliberately listed in the expenditure framework report, is to take actions in reforming personnel training, management and performance incentives to create zone-specific contracts and skills-based bonuses in outlying areas to encourage health personnel to practice in the countryside.

The medium-term expenditure framework for health (1999-2004) substantially increases the funds for human resources and also significant increase in funds for institutional capacity building. A special section on program budgets comprehensively discusses the actions for improving availability of human recourses: objectives, type of personnel, funding requirement for operating and investment costs, and conditions for success. Attention is paid also on the management abilities of the institutions to implement changes.

The **Poverty Reduction Strategy Paper Implementation Report (March 2002)** points out the four main objectives of PRSP (2001) for the period 2001-2015, two of which are HRD, expansion of basic social services, emphasis on institutional development and good governance. Significant progress is recognized in these areas. The document reports completion of training of particular/defined number of health specialists (doctors and auxiliary staff)[4], introduction of area- and technical- skill-related bonuses designed to attract and keep qualified medical personnel to rural areas, as well as establishment of Medium-Term Expenditure Framework (MTEF) as basis in preparing sector budget.

The report also points out the progress made in strengthening civil service capabilities and decentralization. Some gaps are recognized in relation to scheduling, monitoring and evaluation, data collection and analysis. However, the document stresses that the establishment of a training program for local representatives and local government personnel has been achieved. Basically, the document considers the PRSP as still relevant, in terms of strategic outlook and priority action plan, but according to the authors of the implementation report some of the targets for 2004 in for health care sector need to be revised.

Human Resources Development in health is not listed in the outlook of priority measures for 2002-2004. However, there are some capacity building actions foreseen, i.e. programming, monitoring of evaluation of economic policies and improvement of absorptive capacity. It is stressed that the weakness of capacities in general is the primary constraint to implementing PRSP and the efforts of Government to alleviate the problem have been directed toward establishment of National Capacity Building Program.

[4] Continuation of training program is foreseen for 2004.

According to statements in **Joint Staff Assessment of the PRSP Annual Progress Report (April 29, 2002)** the first year implementation of the PRSP has been perceived as successful and well documented in the implementation progress report. Besides repeating the conclusions of previous implementation progress report, this annual report suggests some more improvements such as need for developing poverty and social impact analysis. One significant achievement, stressed in this document is the preparation of MTEF, which enabled the government of Mauritania to shift the priority of public sector toward social sectors. The established incentives for staff to work in poor remote areas is again recognized as an important issue, however document points out that the ambitious health program is fraught with significant risks: weak managerial capacity of the Ministry of Health.

The **Completion Point Document Under the Enhanced Heavily Indebted Poor Countries (HIPC) Initiative (May 10, 2002)** does not discuss further achievements and possible problems of PRSP in health sector and particularly in terms of HR development, but lists once more the issues that has been pointed out in the JSA (progress and annual) reports.

Annex F Tanzania detailed country story

The following documents have been reviewed:

1. Interim Poverty Reduction Strategy Paper (PRSP- March, 14/2000)
2. Decision Point document Under the Enhanced Heavily Indebted Poor Countries (HIPC) Initiative (March 20, 2000)
3. Poverty Reduction Strategy Paper (October 01, 2000)
4. Poverty Reduction Strategy Paper - Joint Staff Assessment (November 2, 2000)
5. Poverty Reduction Strategy Paper - Progress Report – 2000/1 (August 14, 2001)
6. Poverty Reduction Strategy Paper – Progress Report, Joint Staff Assessment, (November 1, 2001)
7. Completion Point Document for the Enhanced Heavily Indebted Poor Countries (HIPC) Initiative (November 8, 2001)
8. Poverty Reduction Strategy Paper, draft Progress report (2001/02)
9. Tanzania Joint Health Technical Review, (February, 2002)
10. Joint Health Review (March 2002)
11. Health Sector PER update FY 2003 (February, 13, 2003)
12. Human Resource for Health: Requirement And Availability In The Context Of Scaling-Up Priority Interventions In Low- Income Countries (January 2003)

In **the Interim Poverty Reduction strategy paper (PRSP- March 13, 2000)** there are no clear HRD or capacity building strategic objectives. The only indication is that some steps have been taken is in the civil service policy performance timetable, where it says that “reallocated surplus staff at hospitals and local authorities” (scheduled for April 1999). The civil service reform policy matrix does refer to establishment of efficient and motivated civil service and improvement of quality and effectiveness of delivery of public services and strengthening of leadership and management.

In the **Decision Point document Under the Enhanced Heavily Indebted Poor Countries (HIPC) Initiative (20 March, 2000)** changes in structure and level of civil services wages and establishment of quasi-autonomous executive agencies are seen as some of the steps to of complete the reform of the public service. Along with devolution process, an objective is also established to build management capacity among local authorities. However, the document does not give a clear HR strategy in the health sector. It envisages the gradual introduction of changes linked with block grants for health sector (along with other priority sectors) supervised by regional authorities and training in financial management. Improving management and delivery mechanisms are deliberately listed as objectives of health sector policy.

In the **Poverty reduction strategy paper (October 01, 2000)** specific concerns about the poor level of health education are expressed. Under the strategy for poverty reduction, the focus along with other efforts is on improving human capabilities, survival and social well-being. Initiatives with respect to this aim are directed toward: personnel training; promoting HIV/AIDS and public health awareness, including peer education in schools. Under specific poverty reduction interventions, catalysing communities and other stakeholders is listed, performed by self-help schemes (health centres), however this could not be clearly related with HR capacity. Under the monitoring and evaluation section, incentives and disincentives are seen as part of the field of funding, access to

training and other elements in institutional capacity building. It is pointed out that significant investment in capacity building is necessary, as it is importants and needed at all levels.

The **Poverty reduction strategy paper - joint staff assessment (November 02, 2000)** does not point out any issues on Human Resources Development. Under the section risks, there are remarks that "commitment to implementing the PRSP remains largely untested at the local level, and institutional weakness and lack of capacity may delay the development of the remaining elements of the poverty reduction program, or its implementation".

The **Poverty reduction strategy paper - Progress report – 2000/1 (August 14, 2001)** focuses on initiatives for strengthening growth e.g. enhanced budgetary support for health as a priority area. As to the implementation, it is pointed out that new guidelines have been developed and distributed, and training of trainers has been completed.

With regard to institutional and organizational reforms, the report notes various capacity building initiatives, incl. TASAF (Tanzanian Social Action Fund) for fostering broad participation and ownership of key poverty-reducing interventions. According to the document, the budget 2001/2 has provided resources for continued civil service reform and other initiatives for strengthening the effectiveness of the public sector (incl. accountability for recourses aimed at assisting the poor). Generally, one could observe the intention to implement civil service reform, however progress in HR development is not explicit. The Master plan outlines a program of work for the next 3 years and provides detailed costing of activities and outlines capacity building efforts that will be needed. In the budget (table 5 – financing of primary health, 2001-2 – 2003-4 (July-June)) under point 10, human resources development is foreseen.

Within interventions in the area of HIV/AIDS, emphasis is placed on introduction of HIV/AIDS education in schools, and actions on public education programs, but there is no information on the human resource capacity in general and particularly in the newly established agency (TACAIDS). Under Local government reform section training in financial management has been undertaken on in-house basis, as part of capacity building, but there is no clear link with HR in health care in particular.

HRD is not mentioned in the **Poverty reduction strategy paper – progress report, joint staff assessment, (November 1, 2001)**. There is slight increase in public spending on health per capita, however this finding is not correlated with HR development strategy. The issues on HIV/AIDS are discussed in this document with respect to public awareness campaign and behaviour change. Establishment of Tanzanian council on AIDS is foreseen, however there is no discussion on human capacity in this new agency.

Completion Point Document for the Enhanced Heavily Indebted Poor Countries (HIPC) Initiative (November 08, 2001) does not discuss HR issues.

The Poverty Reduction Strategy Paper, draft Progress report (2001/02) introduces a special section on development of human capital (as cross sectional issue). A highlight in the 2002/03 budget is the increased share for health sector. Under the financial framework for Primary Health care 2002/03-2004/05 there is slight increase in the budget funds for HRD.

According to the document the health sector reform has been synchronised with the local government reform, and it is perceived as a progress. The absence of sufficient capacity building is seen as a challenge. “Capacity building, particularly at sub-national level is another major challenge that needs to be addressed in order to implement fully the Health Sector Reform (HSR) activities.” Another challenge regarding HSR pointed out in the document is the necessity of more advocacy at all levels of administration, governance, leadership and implementation.

The lack of trained personnel especially at dispensaries and health centres levels is specifically mentioned. Despite of the fact that HR problems have been highlighted, further steps related to HR development in health are not elaborated in the plan. Within the section on human development there is no explicit attention toward development of HR in health care.

Some of the country specific documents discuss HRD in more detail. The **Tanzania Joint Health Technical Review, (February 2002)** devotes a special chapter on human resources where the implementation and lessons from HRH plan (1996-2001) are described. The conclusion drawn is that the HRH plan is weak as many activities are not feasible for implementation within the time frame and some steps for improvement are indicated. The document reports on strategies and approaches for developing a new long term implementation plan to address issues as well as Local Government Reform needs and requirements in terms of HRD. It is pointed out that despite of the understanding the problem, the expected HRH plan 2002 – 2007 is not yet developed. The problems of HRD for Health Information System are discussed in special sub-section. The document also makes link between current situation, previous studies and further actions which could be feasible for improving HRD. The recommendations are clearly listed at the end of sections.

The **Joint Health Review (March 2002)** reviews areas described in the Health Sector Technical Review and has a separate section on milestones to facilitate improved performance in the health sector for 2002/03. The paper criticise the Health Sector Technical Review for not giving clear guidelines on how to address the issue of HRH distribution and management with the line of health sector and local government reforms. The concluding part points out responsible bodies for improving health reform process. Regarding development of the long term human resource plan, the following actions are listed to be performed: HRH data base development, absorption of graduates into public/private health institutions, HR attrition due to HIV/AIDS, mobility of HR in the health sector and SADC countries. The responsible body for execution of these tasks is the Ministry of Health.

The **Health Sector PER update FY 2003 (February 13, 2003)** as vital component of government planning and budgeting process reveals the funds allocated for HRD in accordance with the objectives of PRSP. The separate budget line for HR development/capacity building could be considered as a progress.

The **Technical Review of health service delivery at district level (debriefing note, 17 February 2003)** recognises the HR problems on local level – availability of skilled resources (quality and quantity) and the lack of incentives both on Government and District level to use staff efficiently. Although considerable training activities have been initiated in the recent years, the technical review team couldn’t assess the

appropriateness and effectiveness of these training efforts. A special paragraph discuses the motivation and rewarding of staff and particularly the problem of lack of structure performance based reward system for health care staff. Recommendations are directed toward service delivery the success of which requires skilled and motivated human resources. Several recommendations are directed toward investment in the main recourse of the health sector – human capital with regard to workload norms, performance based incentives, decentralisation of authority toward districts, analysis of skills and manpower and training needs at local level.

One of the most recent case study for Tanzania with regard to human resources - **"Human Resource for Health: Requirement and Availability in the Context of Scaling-Up Priority Interventions In Low- Income Countries"** has been published in January 2003. The document discusses in detail the HR availability and requirements. The detailed and comprehensive conclusions describe the necessity of improved staff management for improving productivity.

Annex G Uganda detailed country story

The following documents have been reviewed:

1. Initiative for Heavily Indebted Poor Countries Second Decision Point Document (January 24, 2000)
2. Poverty Reduction Strategy Paper - Uganda's poverty eradication action plan summary and main objectives (March 24, 2000)
3. Initiative for Heavily Indebted Poor Countries Second Completion Point Document (April 4, 2000)
4. Poverty Reduction Strategy Paper (PRSP), Progress Report (March 2, 2001)
5. Poverty Reduction Strategy Paper Progress Report, Joint Staff Assessment (March 9, 2001)
6. Ministry of Health - Health Sector Strategic Plan 2000/01-2004/05
7. Poverty Reduction Strategy Paper, Progress Report 2002 (March 2002)
8. Poverty Reduction Strategy Paper, Annual Progress Report, Joint Staff Assessment (August 26, 2002)

Under the section "Characteristics of Poverty", the **Initiative for heavily Indebted Poor Countries Second Decision Point Document (January 24, 2000)** points out in the health sector the recent sharp increase in the expenditures has had little impact on key output indicators. The household survey has reported that the population expresses the view that the health care staff is corrupt of hostile and limited access to health facilities is reported to be a problem. Therefore, one of the main goals of Uganda's poverty reduction strategy, according to this document is achieving universal access to primary health care. Furthermore, despite the increase outlays in the health sector, only about 34% of health centre's staff positions were filled in 1998/99. For achieving its goals the government initiated a process of decentralisation as well as development of health sector-wide policy framework.

The document doesn't identify explicit objective related to HRD under the health sector program. It stresses on strengthening of the decentralisation process and limited effectiveness of public expenditures, particularly in the area of health (e.g. delivery of services, staffing levels).

The **Poverty Reduction Strategy Paper - Uganda's poverty eradication action plan summary and main objectives (March 24, 2000)** stresses that improving the health of the Ugandan population is a priority objective of the Government of Uganda. The Health Sector Strategy sets targets of reducing child mortality. Human resource factor in health sector is not discussed in the paper.

The **Initiative for Heavily Indebted Poor Countries Second Completion Point Document (April 4, 2000)** mainly focus is on Economic performance and there is no discussion on social issues and HRD in particular.

In the **Poverty Reduction Strategy Paper (PRSP), Progress Report (March 2, 2001)** the major pillars of Poverty Eradication Action plan are listed. Under the "Directly increasing the quality of life of the poor" framework the objective of the Government is to improve quality of life by better health. The document however states that the health

outcomes have been mixed and that the interim target for training staff has not been met in 1999/2000. The section “Good governance and security” describes the approaches toward efficient delivery of public services – e.g. decentralisation and human resource management. The key challenge facing the decentralisation efforts is to improve the capacities and incentives of local governments so as to promote more effective planning, management and implementation.

Effective human resource management is recognised as critical for service delivery. The number of contracts are listed: a) shortage of qualified applications; b) limited capacity at the district level to undertake routine human recourse management functions caused by inadequate resources; c) substantial delays in getting new staff onto the government payroll once they are appointed. It is pointed out that in 2001 in order to address these problems, the government has prepared an action plan to streamline the recruitment process and expedite access to government payroll.

Under the chapter “Improving the quality of life of the poor” the document overviews the health status of Ugandans, health care system and health policy milestones. When discussing quality of health services the document refers to the availability of qualified personnel as the most important aspects of quality. Although the Percentage of health centres with minimum staffing norms as an interim target has been specified in the PEAP/PRSP, the target has not been achieved. The problems Ministry of health faced in recruiting staff are listed: small number of applications, the capacity of districts to advertise and interview candidates, difficulty of identifying the overall wage bill and getting new health sector staff onto the government payroll. In addressing the problems, the document stresses the initiative of the government to train and upgrade skills of staff (nursing assistants). The view of the way forward expressed in the paper is large expansion of resources for health, recruiting health workers within available resources and training of the health staff.

The **Poverty Reduction Strategy Paper Progress Report (Joint Staff Assessment March 9, 2001)** discusses the introduction of output and outcome measures in the budget framework and points out that since 1999/2000 the Government has been incorporating staffing plans and related wage bill issues in sector expenditure programs. The document stresses that in 2000 only 40% of health units had trained staff, a lower level than the PRSP/PEAP target of 55%. There is no further elaboration of HRD is the document.

In the Ministry of Health’s Health Sector Strategic Plan 2000/01-2004/05 the human resources element is listed as an output of the Integrated support systems strengthened and operational program. The report states that the human recourse for health remain inadequate (recruitment and training). Wages are also inadequate and irregular. The document requires particular attention to be paid on the training, recruitment, rational deployment, motivation and retention of qualified staff. Furthermore, almost each of the particular disease management programs described in the document refers to necessity for training of the health staff and capacity building in general.

There is a special section in the document on HRD, which points out objectives, norms, and the implementation strategy. HRD and Management Program summarised in a logframe table, overviews in details the output, indicators, means of verification and key assumptions of the action plans and activities toward HRD. The interaction of different actors is also stressed as vital in the capacity building process.

The **Poverty Reduction Strategy Paper, Progress Report 2002 (March 2002)** reviews the changes in PRSP indicators. Regarding health care pillar it points out the % of approved positions filled by a trained health workers for the period 2000-2004 as outcome and target. A separate section discusses pay reform and payroll management, as well as capacity building and decentralisation in general. There is no further elaboration for health sector. Under the government future actions training and deploying more personal with midwifery skills is foreseen.

Poverty Reduction Strategy Paper, Annual Progress Report, Joint Staff Assessment (August 26, 2002) recognises the efforts of the government to implement effectively the PEAP human development strategy, however there is no detailed elaboration of the issue.

The Uganda documentation acknowledges specific human resources problems: quantity of health workers, recruitment and training, however it does nor elaborate the issue in sufficient details.