OVERCOMING THE HURDLE OF IMPLEMENTATION: PUTTING HUMAN RESOURCES FOR HEALTH TOOLS INTO ACTION

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ABSTRACT

The global human resources for health (HRH) challenge remains persistent. In 2006, the World Health Report identified 57 crisis countries, and, despite increased attention and investment in strengthening the workforce, those countries are still in crisis. While chronic HRH problems still exist, progress has been made in some countries where innovative programs have been implemented that show promise, or specific initiatives have been scaled up. Yet, these have not been substantive enough to move countries out of the "crisis" category. While many countries have HRH plans, this paper asserts that a major reason countries remain in crisis is the lack of sustained implementation to achieve concrete workforce strengthening results. This is true despite the fact that there have been major investments in a broad range of tools and resources aimed to support implementation of plans and initiatives. Given this picture, the paper states that it is critical for HRH leaders to take action to ensure that already available tools are disseminated, adapted and used to foster effective implementation at the country level. The paper highlights four such tools as examples that can be used to build implementation capacity, and acknowledges more like them. Having highlighted these tools, the paper concludes by offering recommendations as to how to support more results-oriented implementation. These recommendations are organized around three linked components: 1) providing sufficient *advocacy* to leadership at the national level to mobilize and commit them to implementation action, 2) assembling and managing the requisite *assets* (including the institutional arrangements, people and money) into a coherent and powerful whole, and 3) using *accountability* as a foundational tool to assess progress in implementation, track key indicators, celebrate achieving key milestones and identify problems when indicators are not achieved.

Key words: Human resources; Health personnel; Health policy (source: MeSH NLM).

The global human resources for health (HRH) challenge remains persistent. In 2006, the World Health Report identified 57 crisis countries, and, despite increased attention and investment in strengthening the workforce, those countries are still in crisis. The HRH problems that were described 5 years ago continue to be chronic problems – an absolute shortage of health workers, inequitable distribution, attraction and retention issues, poor work environment including faulty supervision, inadequate facilities, supplies and equipment, and so on. These problems have been well documented elsewhere, and it is not the purpose of this paper to elaborate on them.

Having noted that the chronic HRH problems still exist, it is also important to point out that progress has been made in some countries where innovative programs have been implemented that show promise, or specific initiatives have been scaled up. For example, Kenya – like most crisis countries – was faced with inadequate numbers of providers compounded by inequitable distribution. Especially in rural areas, this meant that clients were left without access to critical services like ART. Ironically,

with some cadres like nurses, qualified health workers were available to be hired, but the recruitment and hiring processes were so slow and cumbersome that it took one to two years to complete the hiring process. To address this issue, the Ministry of Health (MoH) and several related government ministries – with support from the USAID-funded Capacity Project and US President's Emergency Plan for AIDS Relief (PEPFAR) – designed an Emergency Hiring Plan. Through this program, which included a public-private partnership as well as several system improvements, "…830 health staff [were] hired, trained, and deployed in 219 public health facilities in approximately six months…" [1]

This was a major achievement, made all the more promising because the health workers were often placed in rural and hard to reach facilities. In addition to the numbers, there were other positive benefits of this program: "Workers…reported that they were treated fairly during hiring, were being paid on time and felt well prepared and confident in their ability to perform job tasks. Supervisors reported new hires were well prepared and added value to the facility." [2]. In Kenya,

others joined in the effort to support similar hiring plans, including the Clinton Foundation and the Global Fund to Fight AIDS, Tuberculosis and Malaria. It also stimulated interest from other countries as a promising practice (including Tanzania, which rolled out its own similar approach).

While other positive examples could be cited, they are also pilot programs or schemes that show promise (e.g., Malawi's Emergency Human Resources program), or initiatives that have been scaled up for one cadre (e.g., Ethiopia trained and placed 30,000 health extension workers between 2004-2009) but these have not been substantive enough yet to move a country out of the "crisis country" category. In other words, despite islands of promise, there are still no compelling, more comprehensive HRH success stories at the country level. Why is that?

For insight into that question, a recently published document provides some intriguing data. In December 2010, in preparation for the second Global Health Workforce Alliance (GHWA) Global Forum on HRH, an HRH tracking survey was published. This survey – albeit a desk survey relying on secondary sources – turned up some interesting results as it canvassed the 57 crisis countries in order to monitor progress in developing and implementing HRH policies. For example, it reports that "45 of the 57 countries have HRH plans," and that "40 of these 45 HRH plans are integrated in the national health plans." [3]

However, it then states that implementation could only be confirmed in 55% of these countries, and this was defined as "partial" implementation. The tracking survey then goes on to conclude:

> The major challenge lies with implementation. A more thorough understanding of the underlying reasons hampering implementation is critical. This is most likely due to insufficient commitment and inadequate capacity, which remains to be further documented.

This is exactly the same conclusion that we in the Capacity*Plus* project have come to based on 5 years of extensive experience in the HRH system strengthening field. There are indeed many countries with very good HRH strategic plans, some costed, some not, some involving a broad level of stakeholder input, some not. But, in most instances there is no or insufficient implementation. As a result, it is important for the HRH field to focus more resolutely in helping to support implementation work at all levels, to learn more about bottlenecks and to help build implementation capacity in sustainable ways.

As part of that process of building implementation capacity, it is extremely important to point out that since 2006, a variety of tools, resources and case examples have been produced by a broad range of HRH stakeholders. While there is always room for new resources to apply to unaddressed gaps, it is critical for HRH leaders to take every possible action to ensure that already available tools are disseminated, adapted and used to foster effective implementation at the country level. Significant investments have already been made, and the field needs to capitalize on these investments by using them in service of implementation. This paper highlights four such tools. These are good examples, there are many more like them, and they will all help to aid or build implementation capacity. Having highlighted these tools, some recommendations will be offered as to how to support more results-oriented implementation action using these and other tools.

THE HUMAN RESOURCES FOR HEALTH ACTION FRAMEWORK

Relatively early in the HRH "movement," if one might call it that, it was recognized that HRH challenges were complex, involved many different actors, organizations and sectors at the country level, and could not generally be addressed by a single player or by "one-off" interventions. This emerged as a strong theme from various Joint Learning Initiative meetings and was a key component of the World Health Report 2006. Given the growing realization of this complexity, a consultative group met in December 2005 with the goal of developing a shared, comprehensive framework that HRH leaders could use as a guide and resource for planning and implementing HRH initiatives.

From this meeting and subsequent consultations, the Human Resources for Health Action Framework (HAF) was developed. It resulted from a broad collaborative effort that was led by GHWA, WHO and USAID, and included people who represented different disciplines and sectors as well as global and country level partners. The intent of the HAF is to assist health managers to develop and implement comprehensive strategies to achieve an effective and sustainable health workforce.

The HAF went online in 2006 (http://www.capacityproject. org/framework). The introduction on the website describes the HAF as follows:

> The HRH Action Framework…includes six clickable Action Fields (HR Management Systems, Leadership, Partnership, Finance, Education and Policy) and four clickable Phases (Situational Analysis, Planning,

Implementation and Monitoring & Evaluation). To ensure a comprehensive approach to an HRH challenge, [each] Action Fields and Phases of the Action Cycle will need to be addressed. However, the Framework is constructed so that…any Action Field or Phase can be selected and drilled down to access relevant tools and guidelines, indicators and resources.

The HAF can be used to develop or assess the strength of existing HRH strategic plans, or to address gaps where they exist. For example, the Pan American Health Organization (PAHO), GHWA and the USAID-funded Capacity Project collaborated to use the HAF in Latin America to conduct regional workshops with HRH practitioners. The HRH practitioners then used the HAF as they developed country-specific strategic documents for their HRH departments. When asked for feedback about her experiences integrating the HAF into the workshops, a Technical Advisor at PAHO said, the HAF "provided a very crucial visual of this integration process, and many people need that. It's one thing to talk about theories and practices and approaches, but when you see it in that visual framework, it's so useful." (Allison Foster,Technical Advisor, PAHO, interview by Philip Hassett, January 2009).

In addition to the framework itself, users can access a rich and easily retrievable set of resources (currently 95 tools or resources are included). The HAF website is available in English, Spanish and French. In addition, the HAF has been disseminated by GHWA and WHO and global partners, and was published (minus the web links to resources) by Management Sciences for Health (MSH) in 2009 to provide access for users without easy Internet access [4].

Unlike the other resources described in this paper, we do have some basic data about usage patterns of the HAF website. According to Corinne Farrell, the Knowledge Services Manager for IntraHealth International and Capacity*Plus* who has been instrumental in helping to nurture and manage the website: "In the last six months, usage statistics have remained fairly steady across the English, Spanish and French versions of the HAF websites…however, given the increased attention human resources for health is receiving, we would have hoped that usage of the sites would be on an upward trend, but instead usage is merely holding steady."

Although the HAF is a meta-resource and has been in existence since 2006, and while there is anecdotal evidence of use at the country level, it appears that it is not being used as widely as it could be to aid in HRH

planning and implementation efforts. A key message about the HAF – and the other resources described below – is to do everything possible to get HRH leaders and practitioners at the country level to access the HAF, and to choose how to use it based on context and need – but to use it. Farrell puts it this way: "We know the HAF is useful when it's used if only people would USE it."

COMMUNITY HEALTH WORKERS

Community health workers (CHWs) have been an important part of the provision of primary health care for several decades. When CHW programs are well designed and supported, there is a good deal of evidence showing that they can add significantly to improving the health of the population, particularly in those rural and underserved settings lacking sufficient numbers of motivated and capable health professionals. The key phrase here is "when the CHW program is well designed and supported…" In 2009, GHWA, in collaboration with USAID, "…commissioned a global systematic review to address some unanswered questions on role of community health workers, and policies required to optimize the impact of related programs and strategies in the context of health workforce planning and management."

The study included an extensive literature review, and then integrated eight country case studies "…to evaluate the…impact and performance assessment of the practices of CHWs deployed at scale in 8 countries across the world, two being in Latin America (Brazil and Haiti), three in Africa (Ethiopia, Uganda and Mozambique), and three in South Asia (Pakistan, Bangladesh and Thailand)." The subsequent report – Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems – was launched in April 2010 and describes key aspects of CHW programs encompassing the typology of CHWs, selection, training, supervision, standards for evaluation and certification, deployment patterns, in-service training, performance, and impact assessment [5].

Since community health workers work at the edge of the system, there are questions around if, how, and when CHWs get paid, who supervises them, how their role is defined, and what their relationship is between formal and informal health systems. This report provides recommendations around these and other issues, and will be very useful to those HRH leaders at the country

level who are looking to design or re-energize CHW programs. There are two resources available, the first includes a global review of CHW interventions and eight country case studies, and a second, shorter version which synthesizes key messages.

IMPROVING RETENTION OF HEALTH WORKERS

Globally, approximately one half of the population lives in rural areas, but less than 38% of nurses and less than 25% of physicians work in these areas. While getting and keeping health workers in rural and remote areas is a challenge for all countries, the situation is worse in the 57 countries that have an absolute shortage of health workers. This maldistribution problem has been recognized in most of the HRH crisis countries, and there have been a number of different pilot retention schemes undertaken – some using direct monetary incentives like increased compensation in the form of rural hardship pay or providing stipends in exchange for certain periods of service in rural areas. Others used or combined these with non-monetary incentives like housing, schooling for children, longer leave times linked to length in rural areas, pay for transportation or providing a car, and so on. While some of these showed signs of promise, almost none have been brought to scale in the HRH crisis countries; in many cases, pilot programs either were not scalable or had some unintended consequences.

Beginning in 2009, WHO engaged a broad range of HRH experts in a highly consultative process aimed at examining available retention evidence in order to formulate retention guidance for country level application. The resulting guideline document was launched in September 2010, and proposed "…sixteen evidence-based recommendations on how to improve the recruitment and retention of health workers in underserved areas. It also offers a guide for policy makers to choose the most appropriate interventions, and to implement, monitor and evaluate their impact over time."[6]

Overall, the policy recommendations offer a comprehensive grounding in good general HR management practices for attracting, managing and retaining health workers in rural and hard to reach places. While these recommendations are general and replicable on a wide scale, the report stresses the country specific factors and context which must also be given due consideration. WHO is working with partners to promote application at the country level by supporting implementation in a small set of diverse countries. In addition, some development partners are

building on the WHO recommendations to design and test tools that will make it easier and more efficient to apply them at the country level. As one example, Capacity*Plus* is in the process of adapting the discrete choice experiment (DCE) methodology so that it can be used by HRH managers as a practical instrument to determine priority incentives to attract and retain health workers in rural posts. The project is also developing a related methodology to assess the costs of different bundles of interventions.

The retention policy recommendations – and the tools being developed to help in their application – provide an extremely useful foundation resource that can be used to address the still chronic problems of attracting and retaining health workers in rural and hard to reach places.

TASK SHIFTING

Task shifting has been much discussed as a possible intervention to help address directly the continuing shortage – and maldistribution – of health workers in many crisis countries. Task shifting is defined as follows:

> "…[The] rational redistribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health."[7]

In order to provide global leadership for countries wishing to engage in task shifting, WHO, the US President's Emergency Plan for AIDS Relief (PEPFAR) and UNAIDS collaborated to examine the evidence and create useful guidance. This initiative resulted in a valuable resource that was launched in December 2008, and includes a series of actionable recommendations organized around five categories: adopting task shifting as a public health initiative; creating an enabling regulatory environment; ensuring quality of care; ensuring sustainability; and organizing clinical care services. It also contains guiding principles for country adaptation and implementation, a table of evidence and the results of a WHO-commissioned study on task shifting.

This should be a very useful resource for countries that are looking to move their task shifting agenda forward. Yet it is unclear how much country level, formal work has gone on with task shifting since this resource was published (although it is important to note that task shifting often happens as a matter of

practice, especially in rural and hard to reach areas). It is also not clear how widely this resource has been disseminated, and how much it has actually been used. Moreover, it appears that task shifting is still problematic to many professional councils (especially physicians), and there is apprehension in some circles that task shifting will lead to inferior care and clinical errors. There is also a sense that task shifting is not defensible from an ethical standpoint because it assumes that poorer people will end up getting poorer medical service delivery. As a result, there are still ministries of health that are not acting or supporting task shifting, or they are sitting on the fence because it is unclear to them what to do.

However, in March 2010, a very useful article was published on the processes and impact of task shifting on ART in HRH and resource poor countries in sub-Saharan Africa. This article provides ample evidence to support task shifting, and its appropriate application. Here is one of the conclusions:

> Although formal cost effectiveness studies have not been done, the available evidence for task shifting in HIV care supports the conclusion that it is both effective and economical [77]. Non-physician health care workers are able, with careful training and supervision, to deliver equal and sometimes better results than doctors; similarly there is now considerable evidence regarding the possibility of shifting tasks from professionals or mid-level workers to lay or community health workers. Perhaps most importantly, task shifting seems to substantially expand access to HIV interventions, even in under-serviced areas [8].

The article is very important, as it suggests task shifting has made a positive impact. It also defines clearly the factors that are necessary for the "appropriate application of task shifting" and concludes by stressing that it must be undertaken "...within broader health system goals of building access, equity and responsiveness; and where task shifting involves the mobilization of community health workers, to questions of community participation and accountability."

Taken together, the task shifting guidelines provide operational recommendations about how to plan and implement it effectively and the article puts forth the evidence that task shifting works when applied appropriately. These are practical and evidence based resources, certainly ready for use and adaptation at the country level to help implement desired task shifting goals that match particular contexts.

RECOMMENDATIONS TO PROPEL IMPLEMENTATION ACTION

These are excellent tools, and there are many others that have been produced. With the possible exception of the HAF website, which has a limited window on usage through web statistics, it is not clear how – or how extensively – the resources are being used at the country level. The key question is why they are not being used. Based on extensive Capacity*Plus* experience as well as existing evidence, the answer combines three components – 1) insufficient *advocacy* to leadership at the national level to mobilize and commit them to action on the issue, 2) lack of the requisite *assets* (including the institutional arrangements, people and money) being assembled into a coherent whole, and 3) little *accountability* for lack of progress in implementation compounded by the failure to track key indicators.

We offer the following key recommendations accordingly:

ADVOCACY

1. Global and country partners should work together *to advocate national leadership at the highest level to support policy decisions and provide resources for implementation*. One specific advocacy message should be aimed at creating support to disseminate, enable, and support the use of available tools to address specific implementation goals. As one such example, the Ministries of Health in Laos and Uganda are working with WHO and Capacity*Plus* to apply the WHO policy recommendations on retention and to pilot and build capacity to use the DCE and costing tools described earlier. These kinds of partnership efforts – whether among partners within countries or between global and country level partners – will help to move into practice the range of tools available. This will help them become more accessible, and through the process, build implementation capacity to apply them to HRH plans in need of implementation or use them to address critical HRH gaps.

2. On a more general level, energetic implementation work must rest on the principle of country ownership. As such, HRH leaders and development partners at the country level need to *advocate for and support actively the work to build sustainable implementation capacity*. To do this, leaders must allocate sufficient resources to those who lead and staff implementation work. For example, from a very practical perspective, leaders can look at specific slots or "spaces" within the HR management system to build implementation capacity. These

slots or spaces could be found at the central level within HRH units, or at provincial or local level positions with HR responsibility. Once identified, these key HRH staff can be provided with support to build their capacity to use and adapt appropriate resources or tools. Donors can help in this process by funding results-oriented coaching or knowledge to build capacity. Or, perhaps more importantly, by funding a certain number of positions that would be aimed at implementation. An alternative recommendation is to consider having a small Implementation Unit that reports to the Minister and is charged with catalyzing and supporting implementation of priority initiatives related to the HRH strategic plan. This unit could be staffed with expert implementers who also have capacity building skills.

ASSETS

3. As it is clear that the health workforce dynamics and challenges are complex and require cross-sectoral and inter-organizational cooperation, HRH leaders need to make certain there is at least one key cross-cutting stakeholder leadership group in existence, and that an important part of its purpose is *to organize assets to support implementation* – and work together to streamline the institutional arrangements to reduce bottlenecks as they are experienced. It is critical that this leadership group includes non-state actors in the process, including both the private for-profit and private not-for-profit sectors. There are many templates out there for groups like this, and many groups already exist at the country level (although they do not always focus on implementation). WHO supports Observatories at the regional and country level, GHWA has a clear Country Coordination and Facilitation framework that it has disseminated broadly, and there are HRH Stakeholder Leadership Guidelines about to be published [9]. All are based on the principle of country ownership; any can be used or adapted to support implementation.

4. HRH leadership should *create a positive "implementation environment"* by taking actions that will create incentives and help to get the most out of the resources at their disposal. These include actions like the following: 1) make implementation of plans and initiatives a specific part of the job expectation for all HRH leaders and staff; 2) publicize the launch of particular implementation initiatives in much the same way an HRH strategic plan gets launched; 3) use the implementation benchmarks described to increase accountability, yet acknowledge when these

benchmarks are reached by having a public ceremony where individuals or teams who played key roles are honored.

ACCOUNTABILITY

5. *To increase accountability and make it a positive force to push and track implementation work*, HRH leaders need to focus more effort on implementation monitoring and evaluation (M&E). The GHWA Tracking Survey noted that M&E was often lacking, and that the lack of data and measurement contributed to implementation challenges. There are at least two ways M&E support could contribute to implementation: first, as part of operational planning, clear and important benchmarks with timelines could be agreed on and published. These benchmarks could then be monitored to ensure accountability, and the fact that stakeholders know this in advance would help drive implementation (as well as providing valuable data for possible adjustments as needed). Second, work could be done to track the use of tools as they are applied in the implementation process. As tools and resources become more accessible to HRH country level leaders and development partners, they can ensure they are used to support implementation work. Those who are leading implementation efforts could in turn document success stories (and problems) to be disseminated to inform action in other countries. This knowledge sharing effort could be led by GHWA, with help from all its partners.

In sum, HRH leaders at the country level can work towards achieving concrete workforce strengthening results by increasing the effectiveness of advocacy, assets and accountability to step up implementation.

Conflicts of Interest

None

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