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## HUMAN RESOURCE CHALLENGES IN FAITH-BASED ORGANIZATIONS



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# THE AFRICA CHRISTIAN HEALTH ASSOCIATIONS PLATFORM

## Showcasing the contribution of CHAs

*Under the umbrella of the Platform the CHAs have a stronger voice to advocate at regional and international level.*

The Africa Christian Health Associations Platform (ACHAP) is a networking forum for Christian Health Associations (CHAs) and Networks from Sub-Saharan Africa established in 2007 with support from World Council of Churches. ACHAP's core functions are coordinated by a Secretariat which is hosted at the Christian Health Association of Kenya (CHAK) in Nairobi, Kenya.

The Platform's core mandate is to facilitate networking, communication and experience-sharing among the CHAs. Under the umbrella of the Platform the CHAs have a stronger voice to advocate at regional and international level. Advocacy is aimed at strengthening of health systems in CHAs, establishing partnerships to achieve sustainable quality health care in Africa, and ensuring acknowledgment of the crucial role played by CHAs in health service delivery in sub-Saharan Africa countries.

conference held in Bagamoyo, Tanzania in 2007. The Platform's governance structure, mandate and core functions were affirmed in 2009 at the fourth CHAs biennial conference.

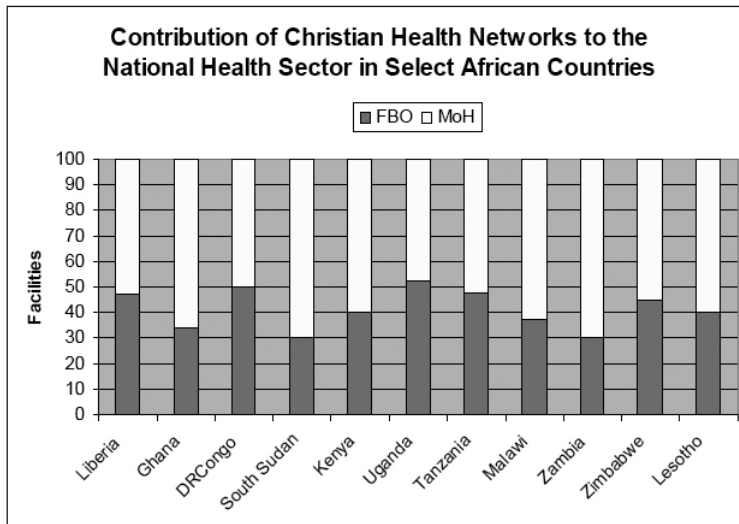
Membership to ACHAP is open to Christian Health Associations and Christian Health Networks from Africa while associate membership is open to collaborating and development partners. Members pay an annual subscription fee of US\$200.

### ACHAP's mandate

The Platform's Secretariat maintains an updated Directory of CHAs in Africa. The Secretariat has assisted in coordinating exchange visits among CHAs from different countries. ACHAP also facilitates the translation of important health-related documents and publications into both English and French and disseminates them to member CHAs in Anglophone and Francophone countries in Africa. In addition, the Secretariat produces a quarterly e-bulletin known as the *Africa CHAs Update*, as well as a monthly e-publication on Human Resources for Health (HRH) that is produced in collaboration with IMA WorldHealth.

ACHAP's website ([www.africachap.org](http://www.africachap.org)) is a rich database of information regarding CHAs health systems and partnership policy documents which are useful reference resources on sub-Saharan CHAs and their partners.

Human Resources for Health (HRH) is a priority area of focus for ACHAP as it is a critical component required for strengthening health systems. IMA WorldHealth, with funding from USAID through the Capacity plus project, has seconded an HRH specialist to the ACHAP Secretariat. The HRH specialist, Doris Mwarey, provides technical support to CHAs to assist them address HRH issues



Source: "The relationship between CHAs and ICCO & CORDAID in attaining community empowerment in health: Synthesis report of a multi-country study on perceptions and expectations; by Cordaid & ICCO (April, 2010)

### How it began

CHAs from across Africa began gathering together for the purpose of networking in 2001 and held these conferences every two years. The decision to establish ACHAP was made at the third biennial

Cover illustration: Elly Wamari  
The human resource crisis in Africa contributes to high disease burden, high mortality rates and low life expectancies on the continent

in their institutions. This technical support is helping ACHAP members to develop policies for HRH, and to motivate, retain and improve the performance of health workers in these institutions.

The ACHAP Secretariat is responsible for convening the biennial conferences. Together with the current host organization, CHAK, the Secretariat mobilized resources for and coordinated the fourth biennial conference in Kampala, Uganda in 2009. The Platform is now preparing for the fifth biennial conference which will take place in Accra, Ghana in February 2011. The theme of the fifth CHAs biennial conference is "Improving women's and children's health in Africa; FBOs response towards achievement of MDG targets".

At the fifth biennial conference ACHAP will review progress and assess the status of faith-based organizations' contribution to Millennium Development Goals four and five which focus on maternal and child health. The CHAs will also identify priority focus areas, develop a strategy for the next two years, and discuss further institutional strengthening of ACHAP including adopting a communication strategy for the Platform.

### Recognition and advocacy

ACHAP has received growing recognition from various organizations globally. Consequently, the Platform has had representation in various international fora. These include: the 62<sup>nd</sup> World Health Assembly held in May 2009; the World Bank Faith and Development forum held in Accra, Ghana in September 2009; GAVI partners' forum held in Hanoi, Vietnam in November 2009; the UNAIDS stakeholders meeting held in Bangkok, Thailand in April 2010; the UNFPA consultation on faith, gender and women's health held in New York in June 2010, and the 2<sup>nd</sup> Global Forum on HRH by Global Health Workforce Alliance held in Bangkok in January 2011. These fora have provided ACHAP with opportunities for advocacy, networking and building of partnerships.

To enhance its advocacy efforts, ACHAP has become taken up membership in two international networks: the Christian



The fourth biennial CHAs conference in Kampala, Uganda

Connections for International Health (CCIH) and Medicus Mundi International.

Amongst its notable achievements are, the Global Initiative for Faith, Health and Development (GIFHD) strategic framework which was presented to the White House in November 2010, has recognized the role of ACHAP in networking, partnerships, capacity building and advocacy for health systems strengthening. In addition ACHAP and member CHAs have participated in various research studies which have sought to identify the role and contribution of CHAs in health service delivery.

### Partners

ACHAP's growth and development is a result of successful partnerships. Partners who support ACHAP include: the World Council of Churches (WCC), Global Fund, IMA World Health (with funding from USAID through the Capacity Project), the World Health Organization, the Global Health Workforce Alliance (GHWA), ICCO, Cordaid, Miserior and Difaem.

The Platform continues to seek more partners to collaborate with in the course of its work in Africa.

**Dr Samuel Mwenda** is the General Secretary of the Christian Health Association of Kenya (CHAK) which hosts the ACHAP Secretariat. He is also the Coordinator of ACHAP. Further information about ACHAP can be found at [www.africachap.org](http://www.africachap.org)

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# FORMULATING POLICY FOR HUMAN RESOURCES IN HEALTH

*At its forty-eighth session held in 1998, the World Health Organization (WHO) Regional Committee for Africa adopted a regional strategy for the development of Human Resources for Health (HRH). Acceleration of the implementation of this document was adopted at the Committee's session in 2002 and concrete steps were taken to advocate for a comprehensive approach to develop and implement in WHO member states in Africa.*

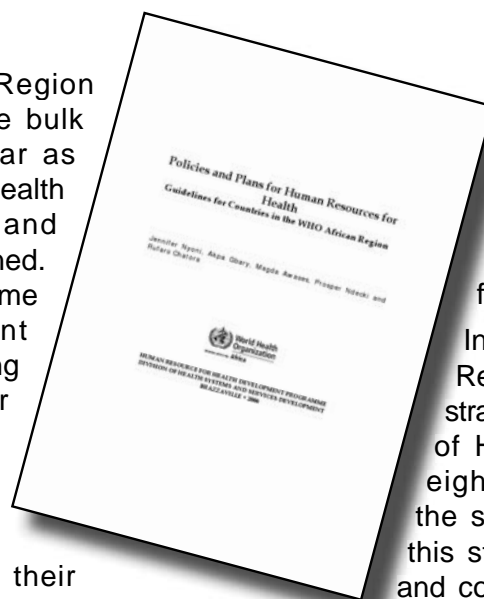
*The region faces extreme pressure in important areas such as producing the required number of key health cadres, utilizing them and managing them in such a way that they remain motivated to serve in their home countries.*

**T**he WHO African Region seems to have the bulk of the problems as far as human resources for health (HRH) development and management is concerned. The region faces extreme pressure in important areas such as producing the required number of key health cadres, utilizing them and managing them in such a way that they remain motivated to serve in their home countries. High staff turnover of skilled health personnel through migration and brain drain is the order of the day in many African states.

Some of the pull factors that encourage migration of health workers from their countries include: the desire for better remuneration, better working conditions, opportunities for postgraduate education and training, good educational institutions for their children, and better standards of living.

The push factors are the absence of most or all of the aforementioned pull factors in their home countries. However, while all this is generally known by most governments, an up-to-date, comprehensive HRH situation is rarely known and documented in these countries.

While most of the challenges faced by these developing countries are due to limited resources, inefficient management systems have also contributed to the human resource crisis. To reverse the trend, available resources must be used



judiciously to make accurate assessment of the HRH situation, to develop policy and to draw up comprehensive plans for implementation.

In 1984 the WHO African Region adopted a regional strategy for the development of HRH during the forty-eighth session. However the slow implementation of this strategy raised concern and consequently at the fifty-second session of the Regional

Committee in 2002, a document to accelerate the implementation of the strategy was endorsed. The acceleration document placed greater emphasis on the need for:

- Consistent implementation of policies and strategies;
- Relevant education and training;
- Resolution of management issues relating to brain drain;
- Retention of professional personnel, among others, at country level.

The aim of the WHO Regional Strategy is to support member countries to assess their HRH situation and develop national policies and plans in a comprehensive and consistent way.

The Strategy provides a set of guidelines on how to develop HRH policies and plans within a national context. Although the guidelines are not the only way to develop policies and plans, they offer good

suggestions on how to a country may go about the process. The preparation of these guidelines was informed by various country and regional experiences.

Interactions with WHO member countries in Africa to encourage and support the adoption of a holistic approach are ongoing.

### **Developing Country Strategies**

A national HRH policy expresses a government's commitment to the HRH goals and guides action in the health sector. Such a policy describes the HRH priorities that a country wants to achieve as it responds to its national health needs. It identifies the main strategies for attaining those priorities and provides a framework for the coordination and implementation of human resource activities. It also provides a framework within which human resource activities can be coordinated and implemented; it encompasses the country's vision for short, medium and long-term HRH development.

The target groups for a country's HRH strategy include human resource managers in the Ministry of Health and other related ministries such as education, planning and finance; managers of health facilities; and civil or public service agencies dealing with HRH issues.

Using the Regional Strategy guidelines countries developing national HRH guidelines should consider the following:

#### **① Objectives and content**

The overarching objective of an HRH policy is to ensure availability of health workers in sufficient quantity and quality at professional and technical levels, at the right place at the right time, and who are well-motivated to perform their functions.

The specific objectives of an HRH policy are shaped by the country-specific situation, and should be consistent with the broader national health objectives. Determinants include the national health policy, the prevailing health system context, and the national development policy. HRH is central to the achievement of the overall national health objectives because these depend on the availability of required personnel competencies in appropriate

numbers where health services are offered. This is the starting point, and such information should be obtained through an situation analysis.

#### **② Financing**

Many African countries do not have HRH policies or strategies due to lack of financial support. Sporadic and piecemeal support, mostly directed to training activities is common. However, this token support is usually only given to quell a particular crisis, such as work stoppages by discontent health workers.

African countries need for long-term investment from partners to finance HRH. In order to attract the investment partners, African governments must put specific mechanisms in place, such as having a human resource development component within the design of the national health development program. By developing and approving HRH plans and strategies, a government can demonstrate its commitment to achieving health targets, and this can convince development partners to invest in HRH.

#### **③ Setting up a Multidisciplinary Committee**

This should be spearheaded by a senior authority (from the health sector or any other sector depending on how health workers are developed and managed in that country). The Committee's chairperson should provide policy direction and be able to take on-the-spot decisions during deliberations of the Committee.

#### **④ Conducting a situation analysis**

This establishes the status of HRH, identifies the challenges that need to be addressed, and highlights the issues that require policy direction.

#### **⑤ Making preparatory steps**

It is important that the senior most level of management at the Ministry of Health is committed to the achievement of the HRH policy. Ideally, the Human Resource department at the Ministry should take the lead in the process. Equally important is the selection of the focal point for the process (possibly the most senior staff in the HR department) and the full-time

*The overarching objective of an HRH policy is to ensure availability of health workers in sufficient quantity and quality at professional and technical levels, at the right place at the right time, and who are well-motivated to perform their functions.*

team that will be part of the development process.

### ⑥ Developing terms of reference and other relevant documentation

Developing the terms of reference for the Multidisciplinary Committee (whose composition should include representation from outside the HR department and Ministry of Health, for example from the Ministry of Education or the Public Service Commission), and sending out letters of invitation endorsed by the most senior member of the Ministry of Health, should be done well ahead of time. This allows for proper representation by relevant stakeholders.

All relevant documents (such as the HR policy, HR situation, poverty reduction strategy papers, national health plans, medium-term expenditure framework, expired HR plans, etc.) should be collected and copies made available to the committee members.

### ⑦ Developing the initial draft

At its first session, the Committee should adopt guiding terms of reference and a work plan before embarking on the drafting process. The Committee's work should include compiling and analyzing information obtained from the relevant documents. This should be followed up by interviews with key informants and focus group discussions with key stakeholders.

The first draft of the Policy should be submitted to the pre-agreed authority in the health ministry, or other sector agency, before holding broader consultations with stakeholders and partners.

Revisions incorporating comments and suggestions from different authorities and partners should be made at this stage. The Committee should incorporate comments from stakeholders before submitting the final draft for review by the supervising authority at the Ministry of Health.

### ⑧ Costing of the final draft

At this stage a health economist or a financial expert should cost of the plan for implementing the policy. Costing the plan at an earlier could mean double work as revisions before the final draft may affect

the financial implications.

### ⑨ Final editing and printing

A well-edited and printed policy document should be prepared for dissemination and an official launch of the plan should be organized. The final policy document should be disseminated to all relevant stakeholders to ensure effective implementation and as a reference document for the preparation of operational plans at facility, institution and agency levels. Every opportunity should be taken to raise funds by preparing an implementation framework for the plan.

### ⑩ Developing an annual plan

Since an HR strategic plan normally covers at least five years, it is recommended that countries also develop annual plans to make implementation feasible and to address resource implications.

### ⑪ Monitoring and evaluation

A multidisciplinary coordination committee to monitor the implementation of the policy should be established. The terms of reference of the committee and the frequency of its sessions should also be decided. This process should include extracting the monitoring and evaluation indicators that are part of the policy.

The process for developing HRH Strategic plan and policy is as important as the plan and policy themselves. This is because the implementation of the plan and policy transcends the HR department and Ministry of Health. All relevant and key stakeholders need to have a sense of ownership and the necessary levels of commitment to the HR plan and the HR policy because after their approval for implementation, all those involved in HRH development will be required to use these documents as the reference points.

**Nestor Lar** works is the Regional Coordinator of CHAN Medi-Pharm Ltd, a subsidiary and the drug supply and distribution arm of the Christian Health Association of Nigeria (CHAN).

**Mike Omotosho**, formerly Head of Programs and Advocacy at CHAN MediPharm Ltd currently holds the position of Managing Director at SHI-Logistics, Nigeria.

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*It is important that the senior most level of management at the Ministry of Health is committed to the achievement of the HRH policy*

# HUMAN RESOURCE CRISIS IN CHRISTIAN HEALTH ASSOCIATIONS

*The human resource crisis is not new to many African countries. Every year, thousands of health professionals head overseas looking for better employment opportunities.*

Looking back into the last two decades, only a few health workers were migrating away from sub-Saharan countries, but the number of emigrants began to increase in the 1990s, rising even further as political, economic, and social conditions in Africa deteriorated. In the last few years, the brain drain has escalated in magnitude to levels that have serious implications on the economic growth of developing countries. Zimbabwe, once one of the most educated and skilled nations in Africa, now runs the risk of being turned into a society of expatriates because of the unprecedented exodus of professionals fleeing the country.

Skilled worker migration has had a negative effect on the quality of health care offered in many African health institutions. The migration of health professionals from developing countries has worsened already depleted health care resources and widened the gap in health inequities. Skilled emigration also affects other sectors of the economy, thus creating gaps across sectors. In Zimbabwe, the health and teaching professions are the most affected while accountants constitute about 16.9% of the total number of Zimbabweans in the Diaspora.

The key factors associated with skilled worker migration include difficult working conditions characterized by heavy workloads, lack of equipment, poor salaries and diminished opportunities for advancement. These conditions contribute to demotivation and poor performance of staff, ultimately causing some of them to leave.

Other reasons contributing to skilled worker emigration are personal ones. These include social security, medical, pension benefits, insecurity or the threat of violence in some countries, and the desire to provide good education and a viable future for children.

## Internal and external triggers

There are two dimensions to the brain drain phenomenon: those that are internally provoked by situations in the country, and those that are externally accelerated by international demands outside the country.

Within the country, brain drain takes the form of health professionals migrating from the public sector to the private sector to seek better conditions of service and better remuneration. The private sector is used as a stepping stone for “greener pastures” and an opportunity to enhance one’s curriculum vitae so as to command improved salary packages later on.

Brain drain out of the country is mainly triggered by the lure of attractive income and benefits packages that are offered by countries with economic and political stability, such as in the United Kingdom, the United States of America, Canada, Australia, South Africa.

## Impact on church health facilities

In Zimbabwe, church health institutions attribute the migration of health workers to factors such as lack of opportunities for professional advancement and the unavailability of social amenities such as shopping facilities, schools, banks, good accommodation and transportation in rural and remote work stations. These conditions make church health institutions unattractive to work in.

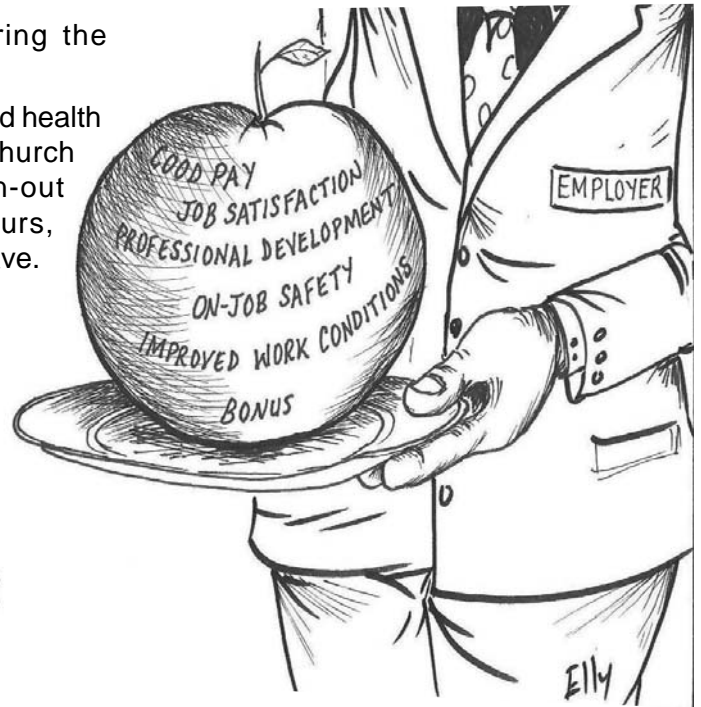
There are also challenges linked to performance of work, such as lack of injections and thermometers and other diagnostic equipment. This makes it difficult for health professionals to conduct their duties efficiently, consequently affecting their morale. In some instances, health workers feel that their safety is not adequately catered for, exposing them to risks of contracting HIV and other

*The key factors associated with human resource migration include poor remuneration, bad working conditions adverse political and economic climate, and intellectual and professional discrimination.*

communicable diseases during the course of their work.

The shortage of suitably qualified health professionals in public and church hospitals leads to staff burn-out because of long working hours, prompting many of them to leave.

*Through brain drain, governments lose highly skilled professionals who leave their public sector positions for better paid jobs in the private sector.*



As a result, these institutions end up with unqualified staff filling up critical positions that fall vacant, a situation that puts patients at risk.

Both urban and rural health institutions face serious staff shortages, although rural areas are more adversely affected; in urban areas, patients at least have the option of accessing services from private health institutions. The private institutions offer better services to patients albeit at a higher cost. The private health sector also provides an escape route for the disgruntled health professionals working in the public sector.

Most poor people prefer to seek services at church health institutions where services are offered for free or at a subsidized cost. Consequently, the church health institutions are overburdened by the demand for services which increases the workload on their staff, in turn causing some of the staff to look for better working conditions.

The public health facilities also lose highly skilled professionals who leave their public sector positions in favor of better paid jobs in the private sector. Some of these professionals take up consultancy work with international partners and NGOs to earn higher salaries. Skilled migration affects the national health systems negatively by reducing the number of qualified health professionals within public facilities – not only of doctors and nurses,

but also pharmacists, scientists, engineers, radiographers and administrators.

### Stopping the exodus

Not much has been done to address the migration of skilled personnel, such as medical specialists and consultants. Existing policy responses have not had a significant effect on the retention and attraction of health professionals. It is therefore critical for policy makers to design attractive employment packages for institutions plagued by brain drain.

Efforts should be made to attract skilled staff, taking into account the cost of training tertiary level professionals as well as the prevailing salary scales in the private sector. Some of these strategies could include:

- ❶ Introducing or reviewing of social security schemes, medical benefits and retirement packages.
- ❷ Developing policies that focus on all cadres of professional health workers, including those who provide paramedic and ancillary services, rather than focusing on only doctors and nurses.
- ❸ Managing health institutions as business organizations in line with the demands in health and trends in medical technology. (There is nothing like free health services, someone somewhere is paying for it).

④ Moving away from the concept that migrating health workers can be easily replaced by training more workers. This is a waste of resources; many managers in public health institutions mistakenly think that the government has a bottomless pit of resources.

### Way forward

There are possible solutions for addressing brain drain in African countries. These include:

- Demanding compensation from departing professionals;
- Bonding or delaying their departure through compulsory services which could be viewed as an extreme;
- Regular review of workers salaries in the public health sector taking account the various skills mix in the delivery of health services;
- Permitting health professionals in the public sector to do some private practice;
- Providing a conducive working environment that allows for growth with adequate funding, facilities and a vibrant intellectual community.

Christian Health Associations should consider allowing sections of the hospitals to provide private specialist services. The income generated from these services can be ploughed back into the hospitals to support their upkeep, top up of specialist salaries, and purchase commodities.

In rural areas where the remote location means no good schools, the provision of educational benefits to health workers' children can be an incentive for staff retention. In the case of Zimbabwe, another strategy would be to provide skills training for medical aides and nurse assistants whose qualifications are not recognized outside the country.

A regional human resource policy is needed to curb the ongoing migration of health professionals. A regional policy would complement country human resource policies (if any), and can be aimed at retaining existing personnel and re-attracting emigrant staff.

### Terminology on International Mobility of Skilled Workers

**Mobility of Highly Skilled Persons:** Refers to the movement of "tertiary" educated persons, primarily those with at least 4 years of education following primary and secondary education (12 years). Mobility refers to any type of international movement from one-time target to recurrent to permanent patterns.

**Brain Drain:** A "brain drain" can occur if emigration of tertiary educated persons for permanent or long-stays abroad reaches significant levels and is not offset by the "feedback" effects of remittances, technology transfer, investments, or trade. Brain drain reduces economic growth through unrecompensed investments in education and depletion of a source country's human capital assets.

**Optimal Brain Drain:** Some economists argue that developing countries benefit from just the right amount of skilled emigration (not too much, but not too little). The possibility of working abroad for higher wages creates an incentive for natives to pursue education; that may increase domestic educational levels and economic growth.

**Brain Waste:** When developing country labor markets cannot fully employ native-born workers then there is a "brain waste" and emigration poses little economic threat. This might be the case if, for example, there are few jobs for mathematicians. Likewise, emigrants may find themselves underemployed in receiving countries, as when scientists can only qualify as cab drivers.

**Brain Circulation:** Lively return migration of the native born, or "brain circulation," re-supplies the highly educated population in the sending country and, to the degree that returned migrants are more productive, boosts source country productivity.

**Brain Exchange:** A given source country may exchange highly skilled migrants with one or many foreign countries. A "brain exchange" occurs when the loss of native-born workers is offset by an equivalent inflow of highly skilled foreign workers.

**Brain Globalization:** Trade sometimes follows in the wake of skilled mobility; in fact, some level of tertiary migration appears to be integral to trade. Multinational corporations and the forces of globalization necessarily require international mobility.

**Brain Export:** In a few cases, developing countries choose to educate and export their highly skilled workers, either in bilateral contract programs or in free-agent emigration. The strategy is to improve the national balance sheet through return of earnings and the return of more-experienced workers, or through remittances, technology transfer, and investment.

**Source:** Lowell B.L. & Findlay A.M. (2001). *Migration of Highly Skilled Persons from Developing Countries: Impact and Policy Responses*. A synthesis report. Prepared for International Labor Office (ILO), Geneva. ([www.ilo.org/public/english/protection/migrant/download/imp/imp44.pdf](http://www.ilo.org/public/english/protection/migrant/download/imp/imp44.pdf))

For low income countries, poverty is a fundamental problem, and there are not enough resources to attract and retain highly skilled staff. There should be dialogue between them and receiving countries to negotiate on compensation for the training and the investment costs associated with migrating workers. Since developing countries spend a significant portion of their limited resources training a professional who in the end emigrates and does not serve the country that trained him or her in the first place.

**Vuyelwa Chitimbire** is the Executive Director, Zimbabwe Association of Church Related Hospitals (ZACH).

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# HEALTH WORKER RETENTION AND MIGRATION IN AFRICA

## Implications for Sustaining Health Systems

*Human Resources for Health (HRH) in African countries are characterized by absolute shortages of health workers, poor work environments, and a maldistribution of health workers between urban and rural facilities, and often between private and public sectors.*

There are various causes for the HRH crisis in sub-Saharan countries, including low training capacity, restrictive macro-economic environment that places caps on health worker employment and pay, lack of motivation among the health workers, high attrition of health workers and the high demand for health workers in developed countries. This scenario is particularly challenging in post-conflict countries such as Southern Sudan, Liberia and Sierra Leone where the infrastructure and social fabric of communities have been destroyed.

While pay is a necessary incentive, it is often not the deciding factor and additional strategies are needed to motivate health workers and keep them from migrating.

### Responses to the Crisis

Responses to the crisis have included initiatives at global level, including the establishment of the Global Health Workforce Alliance (GHWA) to provide a common platform to address the crisis, the development and adoption of the Global Code of Practice on International Recruitment of Health Professionals by the World Health Assembly in May 2010, and the World Health Organization (WHO) policy recommendations for increasing access to health workers in remote and rural areas through improved retention.

These global initiatives complement and build on those championed within the continent by regional organizations such as the Southern African Development Community (SADC) and the East Central and Southern Africa Health Community (ECSA HC), which have both developed HRH strategies.

At country level, a wide range of financial and non-financial measures have been applied to attract and retain health workers and to stem the tide of skilled worker

migration. There is much literature on the use of non-financial incentives within African countries but most authors note that these have not been evaluated for impact. It can be argued that in situations of very low wages, financial incentives are key and can have dramatic and immediate results, either slowing down the exodus of skilled workers from the health sector or attracting them to the system. However, while pay is a necessary incentive, it is often not the deciding factor for employee flight and additional strategies are needed to motivate health workers and keep them from migrating.

Evidence points to the effectiveness of strategies such as: improving job satisfaction and providing opportunities for career progression, enhancing working conditions and the quality of supervision, addressing on-the-job safety and security concerns, redressing the unavailability of good schools for children in rural areas, and improving the structure and management of the payroll. If applied in complementarity these strategies can contribute to attracting, motivating and retaining health workers within the public sector, especially in rural regions where staffing problems are most acute.

### WHO guidelines

WHO has developed retention guidelines which propose four distinct categories of interventions to attract and retain health workers: education strategies, regulatory measures, financial incentives and personal and professional support. Of the four categories, the strongest evidence is for the education measures, such as targeted recruitment of students

from rural areas and locating training sites outside major cities. This means incentives for retention need to be applied in the context of training programs that enhance possibilities for retention. The right candidates should be recruited for training, and the approaches used during training should encourage its students to practice in locations where they originate from. Opportunities for continuing professional development should also be made available to health workers already in working in the health system.

The management of incentive schemes varies across the countries. Some are embedded in HRH policies while others are program specific. These strategies work best when they are tailored to the local context. A holistic, integrated approach where a package of incentives is offered seems to be more effective than a “single issue” approach to the problem.

### Managing migration

Health worker migration threatens to undermine the ability of many African countries to meet development targets such as the Millennium Development Goals (MDGs). Health worker migration affects the functioning of health systems, which become increasingly unable to deliver good quality services because of a shortage of professional staff. Among the responses documented are:

- Providing incentives to skilled professionals to encourage them to stay, for example improved pay and educational opportunities;
- Creating barriers to flight through initiatives such as bonding or compulsory service;
- Recouping financial investment losses from those who leave;
- Using substitutes;
- Engaging the diaspora by encouraging return of talent (brain circulation) where alumni return to their home country to teach, contribute equipment, or provide clinical service;
- Appealing to receiving countries for compensation.

Managing migration is a complex issue that goes beyond national policies and requires the efforts of the global community. Most health workers prefer to stay and work in their home countries, and the push factors often lie beyond the health sector in the wider political and economic conditions. Therefore, while retention incentives and training can address some of the factors, the debate has shifted to measuring the effects of migration to mitigate its impacts, and to link the costs of this to negotiations with countries receiving health workers.

There is no one-size-fit-all solution to the HRH problems in Africa, and no set of answers will adequately address every problem. From the lessons highlighted above, there are ingredients for country solutions, based on prevailing circumstances.

### What is needed now?

❶ **For retention:** In addition to the WHO retention guidelines which spell out specific approaches for remote and rural areas from a global perspective, African countries need to consider:

- **Retention packages** that are applied across the whole health sector, and are based on a needs assessment and intersectoral and stakeholder input. These packages should be costed and supported by an HRH monitoring system and there should be sufficient institutional capacity to manage the incentives.
- **Health worker policies** with clear and comprehensive frameworks that aim to build cohesive and functional health teams, respect health workers rights and responsibilities towards patient and community rights.
- **Financial incentives** as immediate measures to address extremely low real wages. They should be prepared to negotiate for these incentives even outside the normal budgetary processes.
- **Regular reviews of retention strategies**, and giving feedback to all stakeholders on the the progress and impact of any interventions undertaken.

Health worker migration affects the functioning of health systems, which become increasingly unable to deliver good quality services because of a shortage of professional staff.

*Measures to retain and attract health personnel must move from statements of policy intention to operationalized plans and programs...*

- Strengthened monitoring and evaluation systems to allow the analysis of primary data on different dimensions of migration and retention and to assess the effectiveness of the incentive schemes.

## ② On migration:

Many of the measures for managing retention equally support the management of internal migration. However, for outward migration there is a need to build the capacity to support policies, enhance the enforcement of ethical codes, and negotiate bilateral agreements. Enactment of codes of practice on ethical recruitment such as the recent WHO Code should not be seen as an end in themselves, but as windows of opportunity to improve the monitoring and exchange of information on practices across countries.

## Conclusion

The shortage of health professionals affects virtually all countries in Africa, though the magnitude, causes and characteristics of the shortage vary across the countries. In some instances, these shortages are compounded by macro-economic constraints that limit a health system's capacity to employ and pay health workers. For example, they may result in low training capacity in some countries, or cause maldistribution of health workers between rural and urban areas, and between public and private sectors.

Various measures are being implemented within the countries, but there is little evidence of evaluating their effectiveness and sustainability. Clearly, however, countries need to manage health worker migration in ways that address the drivers of migration. Specifically, there should be strategies to motivate health workers to stay and work in their home countries.



Mothers and infants waiting at a clinic in the Democratic Republic of Congo

Dr Ngoma Kinnaudi-Santé Rurale (SANRU)

Measures to retain and attract health personnel need to move from statements of policy intention to operationalized plans and programs that are backed by resources, management personnel, skills, and an information system that can generate evidence on their impact. There should also be a sound monitoring, evaluation and reporting mechanism.

While international migration of health professionals is a concern for most African countries, a few countries like Egypt which have an 'over-production' of certain professional cadres such as doctors, could provide a solution for the shortage of doctors. There has not been a coherent approach to respond to health worker migration, but the adoption of the WHO Global Code of Practice on International Recruitment of Health Professionals provides an opportunity for concerted action.

Reproduced from a presentation made at the First Consultation of the African Platform on Human Resources for Health in 11-13 October 2010 in Nairobi, Kenya. <http://www.hrh-observatory.afro.who.int/en/home/101-platform-first-consultation.html>

# NEW ECONOMIC MODELS FOR FAITH-BASED HEALTH CARE

*A mother of five gets home to find that her youngest child has a fever. What should she do? Living on the outskirts of an African town, she has the option of catching a bus to the nearest government hospital to seek a diagnosis. She fears that her child may have malaria. Malaria is a common ailment where she lives, in fact this is the fifth time in as many months that one of her children has developed a fever. Each time it has happened she has taken the sick child to hospital for diagnosis and treatment. The cost of these hospital visits has taken a toll on the family's meagre finances. She now has to make a difficult decision: either to put food on the table for the whole family for the next few days, or use the money available to take the sick child to hospital.*

*Although she knows that not all fevers are malarial and that some fevers can clear up on their own after a day or two, the only way she can be sure about the cause of the fever is to take her child to hospital. Usually she is very cautious with her children's health and always takes them to hospital when they show signs of illness. This time, however, she is hesitant because there is no money to spare.*

*She once heard on a radio health programme that the government supports free malaria treatment at all public hospitals, but whenever she takes her children to the hospital for treatment the malaria medicines are always out of stock. She is usually directed to go and buy the medicines at the nearby market. And when she returns to the clinic to get instructions on how to administer the medicine, she has to part with more money to attract the nurse's attention.*

*Can she afford to go through this routine again? What if there is another incident of illness in her family in the coming month? Will she have to keep incurring debt to protect the health of her children?*

**T**here is one key fact upon which everyone agrees— out of pocket fees for health care keeps people in poverty and in poor health. Despite the best efforts of global and bilateral donors, the struggle to rid communities of this financial burden continues unabated. While many governments proclaim the ideal of universal health care provided free at the point of delivery, few developing countries have achieved the goal.

Church health facilities face the same dilemma. More than ever they have to charge for every element of the services they provide, such as registration, consultations, tests and medicines. Consequently, when a sick person goes to a church health facility for treatment, they do not know how much it will cost to see their recovery through. They take a risk; a financial risk.

Governments and donors are trying to remove this risk by pumping money into health systems. Nevertheless, a vast majority of people in low-income countries face hard choices at times of illness. Should they risk using their meagre resources on paying for treatment, or

should they wait a bit in the hope that the symptoms will clear up on their own?

## **Sharing the financial Risk**

This situation can change. Large sums of public money are not necessarily the solution to this challenge. Instead, risk can be shared and spread across members of communities rather than being borne by individual households.

## **Community support schemes**

The Rwandan government has recognized this and formed community based health insurance schemes called 'Mutuelles'. Each village pools together the contributions from every household to fund the villagers' treatment at local clinics. Thus the risk to the individual is reduced and the flow of resources into the health system is increased. The scheme is coordinated at district level to ensure that the target of universal coverage is achieved. So far the *Mutuelles* have reached in excess of 80% of the population. At present, this program relies heavily on external donors, but it has the potential to attain a greater degree of self-sustainability.

*...when a sick person goes to a church health facility for treatment, they do not know how much it will cost to see their recovery through. They take a risk; a financial risk.*



Dr Ngoma Kimandu/Santé Rurale (SANRU)

An infant receives treatment from healthworkers at a church hospital in DRC

*Rather than focusing on treatment, some experts argue that adopting a stronger primary health care strategy would go a long way in reducing the financial risks to household budgets.*

However, the story of public insurance programs presents mixed results. Another country in sub-Saharan Africa which has introduced national health insurance plans that promise to be affordable for all is Ghana. The scheme in Ghana has a coverage of about 50-60 percent.

In Tanzania a district-based insurance scheme reached only a small minority of the population and its future is uncertain. In South Africa, the Minister of Health has been campaigning hard to introduce a universal insurance scheme in the country, but he faces significant opposition from a wide range of stakeholders.

The fundamental question facing the future of insurance in developing countries is one of capacity. Can national governments introduce and maintain such substantial systems? Will the bureaucratic weaknesses and embedded corruptions of so many countries limit their ability to manage universal health programs?

### **Risk management for church health services**

Church health facilities are caught up in the web of funding uncertainty. External donors to support the work of these facilities are becoming increasingly hard to come by, therefore out-of-pocket fees

have become the mainstay of most church health services. Even when church health facilities are incorporated in national insurance schemes, there are still risks. In Ghana, for example, church hospitals and clinics under the umbrella of Christian Health Association of Ghana (CHAG) entered into an agreement with the government to provide health services to the public under the national insurance scheme. However, this arrangement did not work out so well because payments to church health facilities were often delayed by several months, adversely affecting their cash flow systems. The lesson learned here is that although collaboration with government is useful and important for sustaining church health services it is not a panacea for financial management.

Some experts argue that adopting a stronger primary health care strategy would go a long way in reducing the financial risks to household budgets. For instance, the use of malarial bednets, clean water and provision of basic health education can significantly reduce episodes of illness amongst low income families. While preventive interventions are very cost-effective, they still have to be paid for, and usually from public funds.

Some churches have sought assistance from external donors to get the resources required to provide primary health care. However, the economics of primary health care, though inexpensive, still require the sharing of resources every bit as much as health insurance programs.

### **The microinsurance strategy**

Microinsurance has emerged as an innovation aimed at providing health insurance protection to low income communities in exchange for regular premiums payment that is proportionate to the livelihood and cost of the risk involved. This approach places emphasis on prevention and education as the first and best interventions.

The Anglican Health Network (AHN) believes that the health microinsurance concept may provide its members with an opportunity to risk pool their health

expenditure where mainstream insurance markets are too expensive. This is not the first time that church health systems are experimenting with health microinsurance. From time to time, membership schemes have been offered to local communities by a church hospitals. Members usually pay an annual subscription in exchange for health services offered throughout the year without need for further payment, or for a modest fee each time they go for a consultation.

Higher up the scale, Microcare offered an insured policy in Uganda that brought premiums down to a relatively affordable level. However, like so many hospital membership schemes it failed to manage its costs and its membership.

Drawing from these lessons, AHN has established two pilot programs: one in Dar es Salaam, Tanzania and the other in Kerala, India. In partnership with the leading microinsurance organization, MicroEnsure, AHN is putting in practice two different approaches to developing microinsurance.

The pilot in India is based around a large teaching hospital in Kerala. With the assistance from government subsidies to support the payment of premiums for individuals classed 'below poverty line', the scheme has managed to draw in 40,000 people in its first seven months of operation. Inevitably it has drawn in people who were already sick putting excess pressure on the insurer. The challenge will be to persuade the wider community that it is worth sharing the financial risk amongst the healthy as well as the sick. A more comprehensive recruitment campaign is now underway.

The pilot project in Dar es Salaam, Tanzania approaches the strategy from a different angle. It starts by targetting individuals within the parish community and seeks to pool together their contributions, while commissioning several health service providers to provide treatment. Marketing of the scheme is done at churches on Sundays. The challenge will be to gain people's confidence so that they are willing to pay their hard-earned income to an industry that is held in low regard by many Tanzanians because of repeated failures.

As AHN continues to develop these micro-finance programs it has a clear understanding that primary health care is key to reducing the burden on the insurer. AHN is seeking to draw from the experiences of community health workers and parish nurses to establish a complementary relationship between primary health care and curative care. It is in the interests of insurers to embrace primary health care so that the risk to their capital is minimized.

### **The future needs new solutions**

Church health systems cannot rely on a fee based economic system to plan effectively. Not only is it unsustainable, but it also creates a poverty inducing regime. Churches need to find a careful balance between public and private financing models in order to relieve the poor of financial risk and sustain provision of health services into the future.

Microinsurance provides an opportunity to develop a more equitable business model. In the face of systemic uncertainty in public health systems. It offers an independent approach of financing church health services. Collaboration with governments through with ministries of health remains crucial to achieving national health outcomes, however, the financial uncertainties of public partnership need to be addressed and a wholesale shift in church health service business plans is required.

**Rev Paul Holley** is the coordinator of the Anglican Health Network (AHN), a formal network of the Anglican Communion that is mandated to renew the health mission of the Church. Further information about their programs can be found on the website: [www.anglicanhealth.org](http://www.anglicanhealth.org)

*Church health systems cannot rely on a fee based economic system to plan effectively. Not only is it unsustainable, but it also creates a inducing regime.*

# LOCAL DOCTORS SHUN WORKING AT RURAL CHURCH HOSPITAL

*There is an ongoing debate about the role of expatriate medical personnel in the development of health projects. This raises some questions: Do hospitals in developing countries need overseas professionals in order to sustain services, or is the presence of these expatriates counterproductive for hospitals striving for greater sustainability? Do local doctors get discouraged from working at hospitals when expatriate doctors work there, or does the presence of expatriate doctors attract indigenous ones?*

**M**any international donors recognize the importance of investing in human resources for health by financing training of health personnel. There are many people in industrialized countries who are willing to donate money to rural hospitals in resource-poor countries. However, some are only willing to do so if expatriate doctors are working there. On the other hand, others criticize health projects that depend on outside funding for their sustainability.

Braun Memorial Hospital (BMH) is a good example for discussion on the role of expatriate doctors in rural hospitals. BMH is one of two large hospitals run by the Lutheran Health Services (LHS) of the Evangelical Lutheran Church in Papua New Guinea (ELC-PNG). Despite various efforts by German partner churches to encourage local doctors to work at BMH, none have so far been attracted to do so.

The situation of BMH is typical of many hospitals established by mission agencies. These hospitals have several key stakeholders; BMH's stakeholders include the ELC-PNG, partner churches, government authorities and the local people. The question is whether these stakeholders ever share their agendas with each other, and whether they understand each other's priorities.

## **The staff situation at BMH**

Besides the government, established mainstream churches like the Lutheran, Anglican and Catholic churches, have been the main health care providers. Churches fill the gap, particularly in far-flung and remote areas of the country where the government does not have health facilities.

## **About Papua New Guinea (PNG)**

*PNG's per capita income should classify it as a middle-income country. However, the country's wealth is unevenly distributed, and for much of the population the quality of life and social indicators are no better than those in low-income countries. An estimated 40 per cent of the population lives on less than one dollar per day, up from 25 per cent in 1996. The health status has declined in the past decade as well. Infant mortality rate is at 87 per 1000 in rural PNG and of particular concern is the increase on prevalence rates of communicable diseases like tuberculosis and malaria and HIV.*

*Since the 1980s, along with a worsening economic situation, the accessibility and performance of health facilities have deteriorated especially in rural settings. Health facilities have been poorly maintained and serviced, and health workers have poor access to resources. One reason for this deterioration is that the national health budget has been increasingly concentrated in urban areas even though 85 per cent of the population live in rural areas. Another reason is that skilled personnel are not willing to live and work in remote rural areas.*

BMH, a former "missionary hospital" falls under this category. The hospital is located in Morobe province and serves a population of approximately 100,000 people.

BMH was established to provide healthcare to the under-served rural population and it is still doing this today. Most of the hospital's patients come from the local community, but about 30 percent come from outside the hospital's catchment area. BMH has earned a reputation of providing excellent surgical services which attract patients from far-off places, including the provincial capital Lae, where the government referral hospital is situated.

People from Lae who can afford to pay for health care prefer to travel to BMH for treatment because they consider the services there better than those provided at the government hospital.

BMH has 53 indigenous staff members who have worked at the hospital for many years. Their commitment to the Christian mission of healing is demonstrated by the fact that they have stayed on at the Hospital in spite of various challenges with salaries. LHS is responsible for local staff recruitment, but salaries are paid from government subsidies, which tend to be received irregularly.



Patients in the ward at Braun Memorial Hospital

Dr med Jochen Bitzer/DI/FAEM - German Institute for Medical Mission

### Where are the local doctors

Until recently the hospital was entirely dependent on expatriate doctors sent by partner churches overseas. Over the last few decades, there have been between one and three expatriate doctors at the Hospital. Indigenous doctors have only ever worked at the hospital on short-term temporary basis.

The lack of local doctors at the hospital has been a concern to the overseas partner churches for many years. LHS together with partner churches have tried different approaches to attract local doctors to work at the hospital, including paying incentives to medical students and offering them contracts to work at BMH for an extended period of time.

Many young doctors are in training willing to serve their compulsory three-months "rural block" in remote rural health facilities such as BMH. This is regardless of the fact that the hospital is recognized by the Faculty of Medicine of the University of Papua New Guinea as a training hospital. The small number of medical students who have worked at the hospital acknowledge the high quality services and the conducive working environment at BMH. Yet, not a

single of one those who have served their rural block at BMH has ever returned to work at the hospital.

The lack of local doctors in rural hospitals like BMH is compounded by the fact that the University of Papua New Guinea does not train enough medical doctors. The small pool of medical student who graduate usually opt to work either in the private sector or emigrate to neighboring countries such as Fiji and Samoa. In 2004, there were only 275 doctors registered in PNG. Compared to other countries in Oceania like Fiji, Micronesia, Solomon Islands or Vanuatu the density of doctors is lowest in PNG with an average five doctors per 100,000 population.

Apart from shunning health facilities in rural locals, indigenous doctors in PNG are also reluctant to serve in church hospitals for various reasons. One of the main reasons is money – doctors get higher salaries at government facilities than in church facilities. Furthermore, most church hospitals are in the rural areas and they would prefer to live in urban centers where they can supplement their salary by engaging private practice to earn additional money. Another reason is the lack of career advancement prospects as well as a lack of social amenities such as schools for their children in the far flung remote locations.

Many young doctors are not willing to serve their compulsory three-months "rural block" in a remote rural health facilities such as BMH, even though the Hospital is recognized by the Faculty of Medicine of the University of Papua New Guinea as a training hospital.



Due its remote rural location medicines and medical supplies are delivered by air to BMH

*...expatriate doctors not only fill posts that might otherwise remain vacant, but they also encourage an influx of donations and financial support from overseas directly connected to their presence at the hospital.*

### **Local or expatriate; does it matter?**

Although expatriate doctors are not necessarily better skilled than indigenous doctors the local population reportedly value the expatriate doctors more highly and believe that they provide better quality services. It is true that expatriate doctors are, in most cases, highly motivated and qualified. The fact that the BMH has earned itself such a good reputation, because of the work of expatriate doctors, is important to the staff and encourages patients. For the LHS, expatriate doctors not only fill posts that might otherwise remain vacant, but they also encourage an influx of donations and financial support from overseas directly connected to their presence at the hospital. Furthermore, LHS does not need to pay for the expatriate doctors' salaries.

An obvious disadvantage is that the recruitment of expatriates is done by overseas partners and does not involve the Church in PNG. These partners raise funds from churches in their home countries, and they look for suitable candidates whom they send to PNG.

Another disadvantage is that expatriates usually only serve at the Hospital for a few years. Different expatriates have different interests, and during their stay they initiate different projects at the hospital or in the community. Some of these projects are

sustainable, but many expatriate-driven projects have had a short life span, dying out shortly after the expatriate leaves the country. An example of a successful and sustainable activity is where villagers were trained to treat simple diseases and to recognize and refer complications. On the whole, the advantages of having expatriate doctors work at BMH outweigh the disadvantages. These doctors help to provide vital health services to the people in Morobe province and set standard for quality services in a rural setting.

**Dr. Med Sigrid Leszke** is the Primary Health Care Program Supervisor and temporary Administrator at Braun Memorial Hospital, Papua New Guinea.

# LOCAL VERSUS EXPATRIATE; WHOSE INITIATIVE IS IT?

## Examining the Case of BMH in Papua New Guinea

*In this article we explore the question of whether sustainability has a real meaning in the provision of health care at Braun Memorial Hospital (BMH) in Papua New Guinea. Is sustainability connected to the ongoing support that the hospital receives in terms of expatriate medical personnel? We also examine the more difficult question of whether secondment of overseas professionals is detrimental to the sustainability of this hospital, or whether sustainability is basically maintained by the presence of expatriate doctors. Another question is whether or not BMH can be said to be sustainable.*

**A** group of researchers on health management describe a sustainable society as one "...that can persist over generations, one that is far-seeing enough, flexible enough, and wise enough not to undermine either its physical or its social systems of support. In order to be socially sustainable, the combination of population, capital, and technology in the society would have to be configured so that the material living standard is adequate and secure for everyone to meet this condition of social sustainability. Specifically, all people having their basic needs met for water, food, shelter, clothing, health care, and education and yet not putting too much strain on the environment."

We would call the Braun Memorial Hospital (BMH) sustainable if there were enough financial resources to ensure a regular supply of medical equipment and drugs, maintain the buildings, pay the salaries and meet all other needs like logistic procurement and hiring of health professionals. .

During the last few decades the Lutheran Health Services (LHS) in Papua New Guinea, which runs BMH, has reached a sustainable condition for the hospital. Financial and personnel support received from overseas partner churches have been an integral part of the system and have contributed to the existing sustainability. Consequently, we could say that the current sustainability includes support from partner churches and secondment of overseas doctors.

However, when we from the partner churches talk about reaching sustainability, we often mean sustainability without our support. This understanding of sustainability is shaped by our cultural background and knowledge. We do not really know whether the LHS and the Evangelical Lutheran Church in Papua New Guinea (ELC-PNG) whom we support want to reach sustainability for their health services or what they mean by it.

### Goals of the key players

What are the goals of the key players regarding the secondment of medical professionals from overseas? If the partner churches stopped sending expatriate doctors, which of their goals would still be relevant? What are the main issues of consideration for key players like the LHS? Within PNG, do the decision makers at LHS and those at ELC-PNG share the same goals?

Different opinions and questions might arise. Sending overseas doctors to BMH may give the impression that 'white doctors' are able to get things right, which sends wrong signals to the LHS and to the local population. In that case should South-to-South secondment be considered as an alternative or would it also have exactly the same implications?

Also debatable is the issue of whether sending more expatriate doctors will have a positive effect on recruitment of indigenous staff. Experiences from other LHS facilities show that even when

*Sending overseas doctors to BMH may give the impression that 'white doctors' are able to get things right, which sends wrong signals to the LHS and to the local population.*



An expatriate missionary doctor and a local nurse at BMH

overseas partners do not send expatriate staff, indigenous doctors are still not attracted to work there.

Another important issue to consider is whether personnel secondment results in the side effect of gaining additional support such as medical equipment and drugs. Would partners continue

to give this support if they did not have an expatriate on the spot to supervise distribution of resources?

Who carries the responsibility of finding indigenous doctors who are willing to work at BMH? What are the pre-requisites, besides an 'acceptable' regular salary, to attract an indigenous doctor to work in a rural setting? Acceptable salaries for doctors are higher than those in most other professions; would the bishop of the ELC-PNG allow a local doctor to earn more money than he does? These questions must be answered in a collaborative and transparent process.

As a matter of fact, the LHS continues to request for expatriate personnel, but so far has not requested financial support to attract and subsidize salaries of local doctors. We could assume that both partners (LHS and overseas partners) would like to continue with the secondment of medical doctors, because it enriches their partnership. LHS probably also appreciates the "side effects" of having expatriate doctors working at their hospitals, such as earning the hospital a good reputation.

### **Towards a common understanding**

Sustainability of health services is as important in rural areas as in any other setting; but is sustainability the be-all and end-all for health services?

Although many expatriate driven projects have not been sustainable, many people have been reached and helped through them. In a recent interview the manager of a large hospital in a poor Asian country argued that "...a person only has one life, so the important thing is to save lives now.

The concept of sustainability has no real meaning in the context of health services". In the case of BMH, thousands of patients have been treated and many lives have been saved, and this will remain true even if the hospital was to close down.

Sustainability is an important goal for projects, but we should consider whether sustainability of health services is fixed within national boundaries. Looking at the long-existing relationship between the ELC-PNG and its supporting churches overseas, this partnership can very well ensure the sustainability of the health services provided both partners are committed to it. Another important point is that the sending of expatriate personnel maintains the understanding between these partners.

We cannot usefully discuss the issue without considering the goals and long-term agenda of PNG's Ministry of Health and the local district health departments, and the collaboration between them and the ELC-PNG. We should also not forget the local communities that are served. They have a right to receive basic health care and should be consulted about what their needs are and how these can be met. Such a process could help the partners to move a step further along the road to a common understanding.

### **Conclusion**

In 2006, DIFAEM, together with LHS conducted an evaluation on the secondment of medical professionals. As a result, an intensified dialogue started and one local doctor is now working at BMH on a two-year contract.

DIFAEM continues to support LHS and overseas partners with technical expertise. In 2010, a consultant from DIFAEM facilitated LHS strategic planning process. Human resource development is an important part of the strategic plan 2011-2020 and approaches to human resource capacity building at various levels are hoped to attract and retain local staff to work in remote places.

**Dr. Med Sigrid Leszke** is the Primary Health Care Program Supervisor and temporary Administrator at Braun Memorial Hospital, Papua New Guinea.

*"...a person only has one life, so the important thing is to save lives now. The concept of sustainability has no real meaning in the context of health services".*

# THE CHALLENGE OF RETAINING HEALTH WORKERS IN LESOTHO

*Health care services in Lesotho's are delivered primarily by the government and the Christian Health Association of Lesotho (CHAL). CHAL provides about one-third of the health care to the country and works in urban areas as well as rural communities and distant outposts. The country's health care system suffers from chronic personnel shortages, especially in remote and rural areas. Access to health services is difficult for many people because of the country's mountainous terrain, poor road system, and high transportation costs. To increase access to health services, especially for the rural population, the Lesotho government initiated a program in 2000 to decentralize the healthcare system. This effort, however, has been thwarted by limited funding and human resource shortages.*

**T**he Christian Health Association of Lesotho (CHAL) has schools of nursing that offer diplomas in general nursing and midwifery. The training curriculum is comprehensive and is reviewed every five years. Nurse educators work across the clinical area administering clinical practice as well as teaching students.

Like many faith-based training institutions, the challenges faced by CHAL include: shortage of qualified teaching staff, inadequate space for classrooms and libraries, shortage of tutors and clinical instructors, and limited funds. There is heavy reliance on missionary doctors and tutors. It has been noted that presently, these doctors and tutors are not as committed to service as the missionary doctors of the past. The benefits of being an expatriate seem to outweigh the spirit of dedication, devotion and commitment.

## Where do trained nurses go?

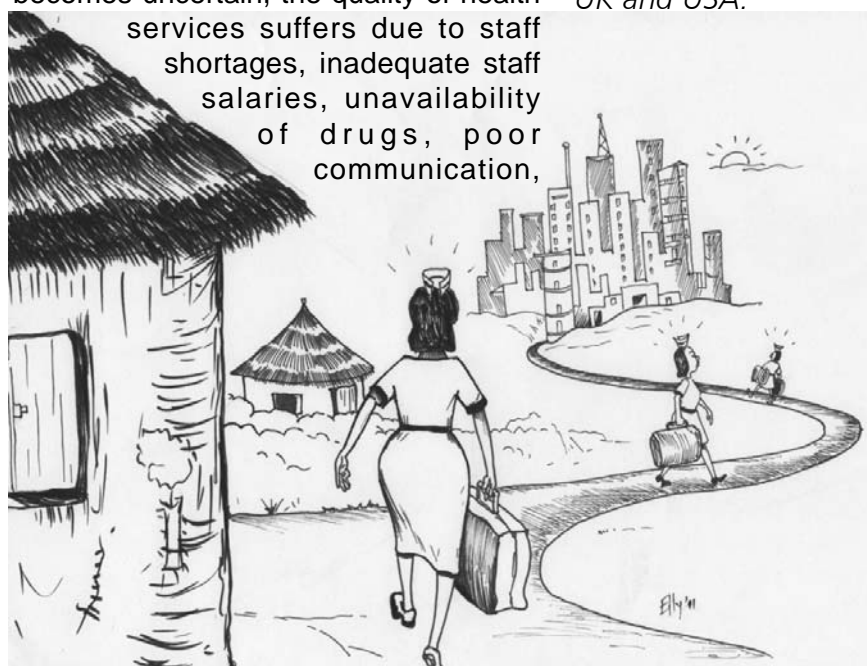
The biggest employers of CHAL's nursing graduates are the Ministry of Health, CHAL and Non-Governmental Organizations. This is a major challenge for church health facilities since many newly qualified nurses use CHAL as a stepping stone to get registered for service in South Africa and other overseas countries.

There is a high attrition of health personnel, especially nurses, to neighboring countries such as South Africa and Botswana as well as further afield to countries like the UK and USA. Often these newly qualified nurses have to take up posts in understaffed

rural regions and therefore get limited orientation to their jobs, local diseases, treatment protocols, culture, or language. This increases the burden on the other nursing staff at these facilities, who have to translate and provide on-the-job orientation to the new staff. The situation often leads to professional conflict and personnel stress within the institution. There has also been a lack of continuity as would-be migrant health workers usually come for short periods of time before they leave for 'greener pastures'. This means that follow-up of patients under their care is compromised.

Many CHAL facilities are struggling to survive financially and some of them face bankruptcy. As their financial status becomes uncertain, the quality of health services suffers due to staff shortages, inadequate staff salaries, unavailability of drugs, poor communication,

*There is a high attrition of health personnel, especially nurses, to neighboring countries such as South Africa and Botswana as well as further afield to countries like the UK and USA.*



lack of utilities and essential equipment and poor facility maintenance. These deteriorating conditions lead to a poor working environment and lower staff morale.

**Efforts to address the shortfall**

To address the health care worker issues, the Government of Lesotho and CHAL have developed partnership programs. In March 2003, CHAL began receiving government funding through the Ministry of Health and Social Welfare’s (MoHSW) supplementary emergency funding facility. Four years later, in 2007, a Memorandum of Understanding (MOU) was signed between the government and CHAL to eliminate the salary discrepancies between health care professionals working in public facilities and those working in church facilities. The aim of the agreement is to lessen medical personnel flight from faith-based health facilities to government facilities where the pay is better.

However, the implementation of this agreement has been problematic because portions of the agreement are unclear to both parties. This has increased uncertainties instead of clarifying the relationship. In the MoU the MoHSW facilitates the subvention to CHAL on behalf of the government. However, there are often delays in the disbursement of the subvention and payments for expenses incurred by CHAL health facilities.

Another challenge in the CHAL relationship is that there remains significant discrepancies between the terms of remuneration and benefits for CHAL health workers and those of government health workers. This is despite the fact that the MoU states that terms and benefits should be applied uniformly. For example: while government staff are pensionable health workers in CHAL affiliated institutions are not, government employees get allowances while those in CHAL institutions do not, government employees may operate private practices while CHAL health staff are prohibited from doing so.

These discrepancies in staff remuneration and benefits continue to contribute to the

migration of health workers from CHAL institutions to government facilities, private practice, NGOs, or externally to other countries.

CHAL has been working to improve employee conditions at its affiliated health institutions by improving its relationship with the government and with other partners. The Association has established a human resources (HR) office responsible for guiding the development of HR policies and guidelines at the national and facility levels of the CHAL. This office works closely with the HR officers based in the church facilities. The CHAL HR officer represents the Association on the National Human Resources Board.

In addition, CHAL and its affiliated facilities have participated in international workshops focusing on HR. CHAL is also taking advantage of the learning opportunities to ensure that the knowledge does not stay at national level, but is implemented at the lower levels, with the ultimate goal of benefitting even the lowest level health care facilities.

Although CHAL has made significant strides in improving its HR issues, there is still much to be done, at the national level as well as at facility level. Nationally, CHAL continues to advocate to the government and MoHSW to maintain equitable numbers of government and CHAL health care workers on MoHSW-led training courses. CHAL is also working with its affiliated facilities to develop annual strategic plans.

**Baptista Ramashamole** serves as the Senior Economic Planner for the Christian Health Association of Lesotho.

...discrepancies in staff remuneration and benefits contribute to the migration of health workers from CHAL institutions to government facilities, private practice, Non-Governmental organizations, or externally to other countries.

# READY TO REBUILD

## Sudanese Doctors Return Home

*In Southern Sudan, the combined effects of poverty, underdevelopment and decades of war have produced one of the most challenging health situations in the world. "Malaria kills thousands of adults and children every month, HIV prevalence is rising and maternal mortality is the highest in the world," says William Kiarie, a Capacity Project team member in Southern Sudan.*

The 2005 peace treaty between the government of Sudan and the Sudan People's Liberation Army created a window of opportunity for rebuilding the southern Sudan's severely damaged health sector. The need was urgent: there were only 50 doctors to serve 10 million people, and even the capital city only had a couple of poorly equipped hospitals with limited electricity and water.

The Capacity Project provided technical assistance to the Ministry of Health to strengthen its ability to plan for and manage Southern Sudan's health workforce. The effort to rebuild the health sector got a boost when 15 Sudanese-born doctors returned to the country ready to help. William Kiarie a member of the Capacity Project team explains, "An increase of 15 doctors would be small in most countries, including African countries, but for Southern Sudan this is highly significant." The Capacity Project provided logistical support to this program initiated by Samaritan's Purse, Canada and the University of Calgary Faculty of Medicine.

The doctors were part of a group of 600 young people transported out of Sudan in 1986 so they could obtain education and someday return to Southern Sudan to help rebuild their country.

The doctors arrived in Juba in October 2006 to an enthusiastic welcome, including a private meeting with the President of Southern Sudan and formal state dinners. Returning home for the first time in 20 years was an emotional experience for them. After spending three weeks in Juba reconnecting with family and their country, the doctors were flown to Kenya for a one-year clinical training experience. Capacity Project's partner, Interchurch Medical Assistance (IMA), played a primary role

in coordinating clinical training for the doctors. Presbyterian Disaster Assistance, Church Ecumenical Action in Sudan and Christian Health Association of Sudan were also involved in the program.

Daniel Madit Thon Duop, one of the returning doctors, contacted Samaritan's Purse, which worked with the University of Calgary Medical School to develop a one-year refresher course in Canada that prepared him and 14 others to return home.

"There will be many challenges," affirms Dr. Thon Duop. "But our objective is to help our people." He is especially concerned about assisting Sudanese children. "I want to help them have the childhood that I did not have," he says. "I want to watch them grow up healthy – to care for their medical needs, and to care for their mothers' and fathers' medical needs. That will make me happy."

"These doctors have the potential to make a dramatic difference," says Dr. Scott Shannon, who coordinated the training program in Kenya. "Not only will they be providing clinical services in areas that have been without, they will also serve as county health supervisors in the public health infrastructure that will be implementing preventive immunization programs and organizing care for women in the area of childbirth."

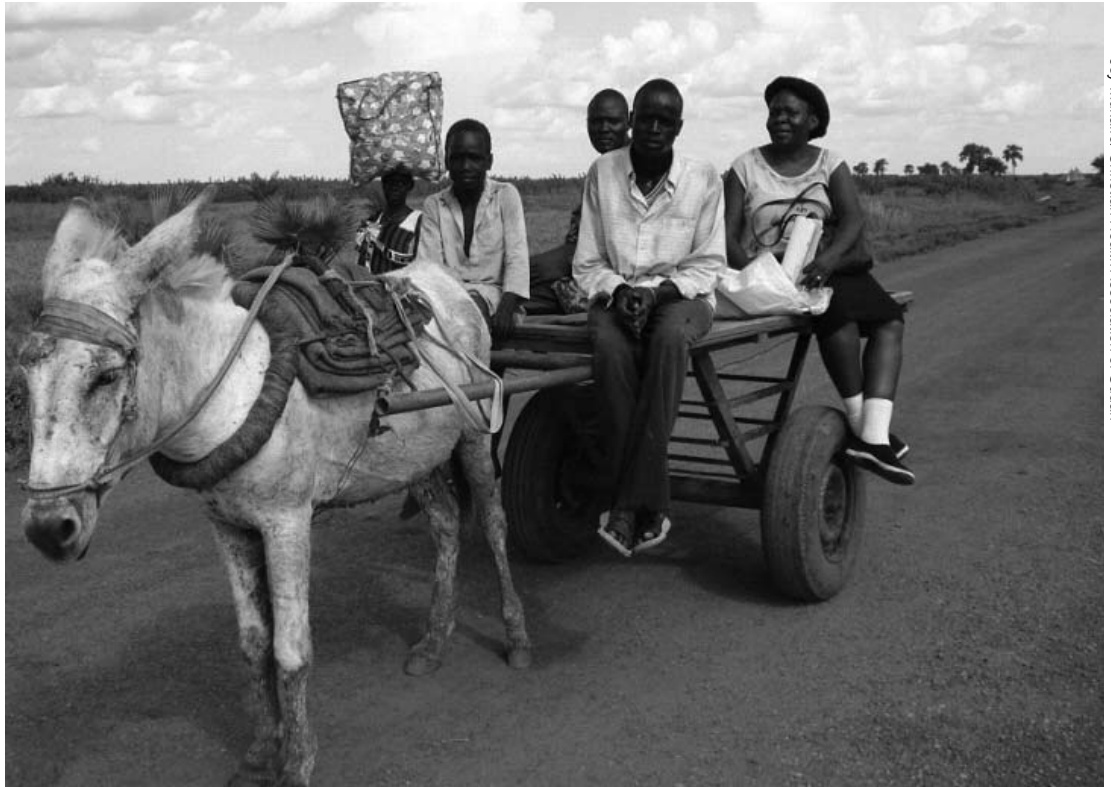
Kiarie adds, "This program to train and post 15 doctors will not just improve access to quality health services, it will without a doubt save the lives of thousands of Southern Sudanese children and adults."

The doctors know that many more health care providers will be needed in Southern Sudan, but they are optimistic about the

*"An increase of 15 doctors would be small in most countries, including African countries, but for Southern Sudan this is highly significant."*

Travel and transport in Southern Sudan is not straightforward. For health workers based in remote rural areas travelling in this post-conflict country can be a challenge. Security of travellers is still a major concern and this is compounded by the poor road network. Furthermore Sudan suffers from both drought and flash floods which render many rural places inaccessible by road.

In this photo, a staff of Christian Health Association of Sudan uses a donkey cart to travel from one health centre to another while visiting member CHAs in Juba, South Sudan



Joy Mukaire/ Christian Health Association of Sudan

*If we send even one doctor to run one health clinic, that clinic would help more than 10,000 or 20,000 or 30,000 people*

impact they can make. "If we send even one doctor to run one health clinic, that clinic would help more than 10,000 or 20,000 or 30,000 people," Dr. Thon Duop told the BBC radio program Outlook on December 4, 2006.

For his part, Dr. Thon Duop is home to stay. "I have come back and I'm determined that as long as people need my services, I'll be working in Southern Sudan."

Currently, all the 15 physicians that returned from Canada in 2006 are still working in Southern Sudan. The doctors working for the government get their salaries and benefits from the government while those working for Non-Governmental Organizations (NGOs) get their salaries from the NGOs.

The returnees has been getting continuous professional development through medical camps sponsored by the University of Calgary and Samaritan's Purse, both in Canada. Three medical camps have been held, each one lasting one week. Two of the camps were held in the rural areas where Canadian, American and Kenyan physicians gave lectures on various medical topics. In addition, Samaritan's Purse and University of Calgary organized a two-week training on public health in

2008 in Juba, which was sponsored by IMA. The returnee doctors look forward to more opportunities for formal continuous professional development in the near future.

Reproduced from **Voices from the Capacity Project**. The Capacity Project, funded by the United States Agency for International Development (USAID) and implemented by IntraHealth International and partners, helps developing countries strengthen human resources to better respond to the challenges of implementing and sustaining health programs.

# BUILDING CAPACITY THROUGH HEALTH WORKER TRAINING

## Kenya's National Reproductive Health Training Plan

In January 2008 the Ministry of Health (MOH) in Kenya launched its 2007-2012 National Reproductive Health Training Plan. The USAID-funded Capacity Project, led by IntraHealth International, provided key technical leadership and facilitated the plan development process, which included engaging a large stakeholder community to achieve consensus on goals and content.

Capacity Project supported the development of the family planning continuing education process and strengthened the reproductive health component of the national pre-service nursing/midwifery curriculum to improve family planning related performance of graduates. A project secondment led the national effort to integrate updated family planning and reproductive content into the nursing and midwifery curriculum in alignment with the plan. The Project also worked with the MOH to train pre-service tutors as master trainers, who then train new hires and colleagues on FP-HIV integration in alignment with the plan.

Reproductive health training involves, enabling couples to plan the number and spacing of their children, which is crucial to safe motherhood and healthier women and children. The benefits of voluntary family planning counseling and services include:

- Meeting demand to reduce unwanted pregnancies and to space births;
- Improving maternal health and child survival;
- Reducing the number of high-risk pregnancies;
- Fighting the HIV/AIDS pandemic by raising awareness of the virus and how it is transmitted, providing access to condoms and reducing mother-to-child transmission;

- Supporting the empowerment of women and their opportunities for education and employment.

While significant progress has been made in decreasing total fertility rates in most countries around the world, the number of women with unmet needs for family planning and reproductive health services continues to increase, especially in the poorest countries. The worldwide decline in fertility has been geographically uneven, with a disproportionate share of growth occurring in sub-Saharan Africa, where the human resources for health situation is most acute.

The Kenya Reproductive Health Training Plan provides overall guidance for the design, planning, coordination and implementation of training activities in line with Kenya's national reproductive health needs and priorities. The goal of the plan is to "ensure that health personnel are in adequate numbers, at all appropriate levels, and have the knowledge, technical skills and positive attitudes, to handle reproductive health issues" within a comprehensive and integrated system of reproductive health care, offered by the public, NGO and private sectors. All projects and development partners will be expected to use this plan to support training on the provision of reproductive health services in Kenya.

The **Capacity project**, funded by the United States Agency for International Development (USAID) and implemented by IntraHealth International and partners, helps developing countries strengthen human resources to better respond to the challenges of implementing and sustaining health programs.

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# MANAGING HUMAN RESOURCES THE CHRISTIAN WAY

*The following reflection has been prepared by Manoj Kurian of World Council of Churches*

Jesus Christ initiated the greatest human resource mobilization drive in the history of humanity. Christianity or 'the Way', as the movement was called in the first century, was galvanized by a small group of disciples, both women and men, in Palestine, who lived and learned with Jesus Christ for a period of three years. The experience of living with Jesus – to see Him live His life and sacrifice it for humanity, to see Him resurrected, to listen and learn from Him, to see Him give hope and courage while effectively challenging injustice, to see Him heal and reconcile – prepared the followers to form the early Christian community. The precepts laid down by Jesus formed the basis of the spiritual community and succeeded in transforming individuals as well as the world. Two thousand years ago, this local revolutionary movement started to spread worldwide, setting new norms and standards for society and changing the way that people thought and lived.

In my opinion there are key aspects of this movement that can help us succeed at human resource management today:

- Unity of vision,
- Living the values that we claim to follow,
- Mentoring and empowering,
- Documenting teachings and practice.

## **Unity of Vision**

Jesus attracted followers from all sections of society. Their backgrounds were very different: ranging from highly educated people like John, fishermen such as Peter; radical revolutionaries such as Andrew and Judas; exploitative tax collectors such as Matthew; women from various walks of life such as His own mother Mary, Mary Magdalene the mother of James and Joseph, the mother of the sons of Zebedee, Salome, Tabitha, and the sisters Mary and Martha.

Although the disciples of Jesus were diverse in background, they were united in creed through a vision of the world that was transformed according to the Kingdom values that Jesus taught – a world with transformed relationships where people treat each other and all creation with dignity, respect and love; a world striving for fullness of life, righteousness, justice and equity for all. The disciples were united by the 'good news' that was given to humanity, that each and every human being is a precious creation of God. The good news taught all to see God in the other: the stranger and the familiar, the enemy and the friend, the oppressed and the oppressor. Moreover, the good news demanded responsibility from individuals and from society, being accountable to God and to people.

We should bear this lesson in mind when reflecting on human resources management in our own institutions. Do all the people in our institution have a united vision? Are we motivated to give all we have to achieve our goals?

## **Living the values that we claim to follow**

The early Christian community was resolute in ensuring that the core principles they propounded were put into practice. As such, they lived together, sharing talents and resources. Early in church history, the leaders realized that some vulnerable members of the community were being discriminated against during the distribution of food due to their origins. They corrected this injustice swiftly by placing seven individuals, with great integrity and wisdom, to be responsible for the distribution of food. Stephen, one of the dependable seven, was the first follower of Jesus to be martyred. He was brave enough to share the good news and face death. He was also deemed good enough to serve the poor with humility and accountability (Acts 6).

Actions speak louder than words. We should go beyond giving lip-service to the values we claim to follow and ensure that these fundamental values are evident in the daily functioning of our institutions. This is a sure way of boosting the morale of staff members and encouraging sincerity and motivation in our work.

### **Mentoring and empowering**

“Very truly, I tell you, the one who believes in me will also do the works that I do and, in fact, will do greater works than these, because I am going to the Father”. (John 14:12).

During a period of three years, by sharing His life in a transparent manner and investing time and energy, Jesus mentored and empowered His followers. He did not hold anything back, neither knowledge nor inspiration. He gave them the responsibility and the authority to share the good news and imparted to them the courage to challenge injustice and hypocrisy. By defeating death, He helped His followers dispel the fear of death. He also gave them the power to heal; the magnanimity to forgive; the ability to reconcile; the breadth of vision; and an inclusive approach to break free from narrow religious, ethnic, tribal or national divisions. It is because of how He mentored and empowered His followers that the message of Jesus was not wiped out from face of earth by the hegemonic powers of the day, which resisted change and the liberation of the poor and marginalized.

Good intentions, individual dedication and hard work will suffer if there is nobody to pass on the torch to. Holding back from sharing our capacity, authority and knowledge with our colleagues and those next in line, because of a desire to retain control and power, is counterproductive and will result in decreased quality and quantity of output. Jealousy and selfishness have no place in the work place. Human resources should foster synergy in the institution by encouraging senior members to mentor those more junior, and ensuring that

colleagues collaborate rather than compete. This strategy would not only enhance the short-term goal of high productivity, but it would also secure the longer-term goal of guaranteeing the future leadership and sustainability of the institution.

### **Documenting teachings and practice**

For truly I tell you, until heaven and earth pass away, not one letter, not one stroke of a letter, will pass from the law until all is accomplished. (Matthew 5:18).

Jesus did not contradict the fundamental teachings of His faith, but He challenged their selective interpretation, misuse as a means of control and subjugation. He reinterpreted the law in a radically liberating and fresh manner by drawing on the teachings documented by His ancestors over the previous centuries.

Jesus initiated a universal revolution that was not limited to race, religion or region. Imagine what would have happened to ‘the Way’ and its liberating teachings, had they not been documented by His followers during the first and second centuries AD! Jesus may never have attained the following He did, and the history of His movement would have been drastically different, with success an unlikely outcome.

Do we document our principles, policies and practice? Do we benchmark our actions against our stated goals? Do we evaluate our progress? Do we document and assess how each of us works? How do we treat, train and retain our staff? Do we reflect on the directions we have taken? Do we record milestones? Are we able to build upon our successes, and learn from our failures?

Human resource is our greatest resource. Investing in equipment, buildings and assets is certainly important, yet this effort is wasted if it is not accompanied by sincere investments in the right people.

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## RESOURCES

### Tools for Planning and Developing Human Resources for HIV/AIDS and Other Health Services

Management Sciences for Health and the World Health Organization bring together in this collection many valuable, tested tools and guidelines for policymakers, health program managers, and human resource planners. These materials will help decision-makers build leadership capacity and develop a strategy to mitigate the impact of HIV/AIDS, for both a short-term emergency response and longer-term strengthening of human resources for health.

Jointly Published by Management Sciences for Health and World Health Organization; 2006, 136 pages.

ISBN: 978-0-913723-29-6

To order by e-mail: [bookstore@msh.org](mailto:bookstore@msh.org)

### Increasing access to health workers in remote and rural areas through improved retention

After a year-long consultative effort, this document proposes 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.

Published by WHO; July 2010; 79 pages

ISBN: 9789241564014

Available online at:

[http://whqlibdoc.who.int/publications/2010/9789241564014\\_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241564014_eng.pdf)

### Assessing financing, education, management and policy context for strategic planning of human resources for health

This document provides guidance for the evaluation of the health workforce situation and for the development of health workforce strategies. It contains a method for assessing the financial, educational and management systems and policy context, essential for strategic planning and policy development for human resources for health. This tool has been developed as an evidence-based comprehensive diagnostic aid to inform policy-making in low and middle

income countries with regard to human resources for health development.

Authors: Thomas Bossert, Till Bärnighausen, Diana Bowser, Andrew Mitchell and Gülin Gedik

Published by WHO; 2007; 86 pages

Available online at:

[http://whqlibdoc.who.int/publications/2007/9789241547314\\_eng.pdf](http://whqlibdoc.who.int/publications/2007/9789241547314_eng.pdf)

### Africa Health Strategy: 2007-2015

This strategic document highlights main challenges faced by African health systems and outlines a broad strategic framework for African nations to achieve the health Millennium Development Goals, complementing existing national and sub-regional strategic documents. The strategy calls upon African countries to promote all aspects of human resources for health development and retention, addressing policies, strategic plans, information, training, recruitment, deployment and retention, administration, working and living conditions and the health of staff

Published by: African Union: 2007, 30 pages

Available online at:

[http://www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13%20avr/doc/en/SA/AFRICA\\_HEALTH\\_STRATEGY.pdf](http://www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13%20avr/doc/en/SA/AFRICA_HEALTH_STRATEGY.pdf)

### Addressing the health workforce crisis. A toolkit for health professional advocates

This toolkit was created to assist health professionals, health professional associations, and civil society organizations to develop advocacy strategies to address human resource and health financing issues in their countries. It is organized into chapters that correspond to the process a coalition might follow in developing an advocacy campaign. Each section has basic explanations of key advocacy considerations as well as sample worksheets and background documents that can be used by coalitions to support the planning process.

Published by: Health Workforce Advocacy Initiative; 2008; 76 pages

Languages: English

Available online at:

[http://www.healthworkforce.info/advocacy/HWAI\\_advocacy\\_toolkit.pdf](http://www.healthworkforce.info/advocacy/HWAI_advocacy_toolkit.pdf)

**Contact** deals with various aspects of the churches' and community's involvement in health, and seeks to report topical innovative and courageous approaches to the promotions of health and healing.

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