

Using Evidence for Human Resources for Health Decision-Making: An Example from Uganda on Health Workforce Recruitment and Retention

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A strong and well-distributed health workforce is necessary for providing access to high-quality health care and achieving national and global health goals. Since the spotlight became focused on the global health workforce crisis ten years ago (Chen et al. 2004), efforts to bolster national human resources for health (HRH) strategies have intensified, including for attracting and retaining health workers to serve posts in rural and remote areas (WHO 2010). Developing and implementing policies to effectively address health workforce challenges demands relevant data for evidence-based decision-making. However, even when there is abundant evidence on which to base policy-making and other important decisions to improve HRH systems, such as health worker retention strategies, the availability of evidence does not guarantee that it will be used for decision-making.

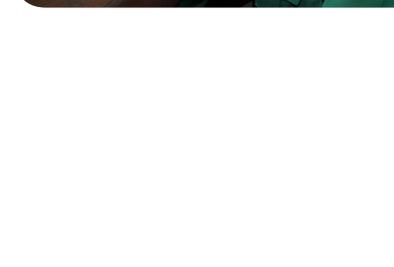
Based on a literature review and our experience in Uganda related to addressing health worker recruitment and retention, we offer six recommendations to help national stakeholders transform evidence into policy decisions and subsequent action. In considering the Uganda example, we illustrate how the development and sharing of evidence can support decision-making for change in health workforce recruitment and retention policies. This technical brief focuses on policy decisions as the endpoint. An examination of the implementation or evaluation of retention strategies and their impact on service delivery—which we recommend as next steps—is beyond the purview of this brief.

Six Recommendations to Guide Use of HRH Evidence for Decision-Making

1. Ensure that evidence generation informs and drives a country-owned mandate.
2. Assess the costs of implementing the evidence-based policy intervention.
3. Involve relevant stakeholders, including technical experts and those with decision-making authority, in evidence dissemination and review.
4. Once agreement on the need for policy change has been reached, maximize momentum so that evidence is converted into action.
5. Ensure that an accountable stakeholder leadership group oversees a defined process for bringing an evidence-based policy decision to action.
6. Mitigate the effects of stakeholder turnover.

Ensure that evidence generation informs and drives a country-owned mandate

National stakeholders should ensure that the data being generated for policy-making purposes are directly responsive to and aligned with expressed national or local needs. If



capacity for generating such data does not already exist, then it should be built within national institutions and entities. Data should also respond to current priority HRH questions within the health sector, for both public and private entities (HWAI 2008; Maliselo and Magawa 2013). For example, strategic HRH planning in Namibia considered the important role of both private-not-for-profit and private-for-profit organizations in delivering key HIV/AIDS services (SHOPS 2013). This will help to ensure that the evidence follows a country-driven and country-owned mandate

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(United States Government 2012), while promoting autonomy to generate additional evidence in the future. Moreover, gathering evidence in a country-responsive manner will increase the evidence's acceptability and garner subsequent support for using the evidence to take action (Health Policy Initiative 2010).

Example

Uganda's midterm review of its Health Sector Strategic Plan II (2005/06–2009/10) in 2008 revealed that high turnover, absenteeism, and low productivity resulted in poor health workforce performance, which was a "major constraint" (Ministry of Health [MOH] 2008, 4) to achieving the plan's goals to reduce maternal and child mortality, fertility, malnutrition, the burden of HIV/AIDS, tuberculosis, and malaria as well as disparities in health outcomes. An MOH (2008) study that measured health worker satisfaction, motivation, and intent to stay in the health field to serve the country found that health workers considered both financial and nonfinancial incentives important. In response, the MOH developed a motivation and retention strategy for HRH to "strengthen the capacity of the health system to improve the attraction, retention, equitable distribution, and performance of the health workers" (MOH 2008, 12). To address high vacancy rates and low motivation, the MOH included improved recruitment and retention of health workers as an important part of the Health Sector Strategic Plan III (2010/11–2014/15) and its quality improvement framework (MOH 2010a; MOH 2010b).

Building on the evidence and in support of national goals, in 2010, *CapacityPlus*, in collaboration with the USAID Uganda Capacity Program, built the capacity of MOH staff to apply the Rapid Retention Survey Toolkit (<http://www.capacityplus.org/rapid-retention-survey-toolkit>) to conduct a discrete choice experiment among health professional students and currently practicing doctors, nurses, pharmacists, and laboratory technicians. The purpose was to determine their motivational preferences to increase the probability of health workers accepting and continuing in job posts in rural and remote areas (Rockers et al. 2012). The findings provided evidence regarding which combinations of incentives and interventions would be most effective in attracting and retaining health workers in the public sector.

Concurrently, the MOH used data from its human resources information system on the actual staffing levels and compared them with the staffing standards for various health facility levels to identify the health workforce shortages in the country—notably the underrepresentation of doctors in health centers level IV and of midwives and nurses in health centers level III.

Assess the costs of implementing the evidence-based policy intervention

Before implementing any policy or strategy, it is important to gather information about the costs of evidence-based policy recommendations and their fiscal context (HWAI 2008). In addition to other factors, the cost of implementing a given policy solution and the ability to sustain the costs over time may influence whether decision-makers view it as politically feasible, and can shape their willingness to adopt it. Ditlopo et al. (2013) found this to be a challenge in the case of the South African nursing retention incentive strategy. Competing national priorities (such as roads, infrastructure, education, or energy) may constrain the fiscal and political space. Depending on the type of policy, strategies should be presented with high, moderate, and low investment options so that stakeholders can make choices based on the budget that is available currently, and likely to be available in the foreseeable future for strategies that require continuous support or long-term implementation (Health Policy Initiative 2010). Conducting a cost-benefit analysis using

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discrete choice experiment, costing, health outcomes, and HRH data can show the full value of recruitment and retention policies by identifying the incentive packages "that are more likely to result in lower net costs (relative to the initial direct costs) or even generate a net benefit from the societal perspective, given the indirect health benefits conferred in each package," as was done in Lao People's Democratic Republic (Keuffel et al. 2013, 990). Cost information is most useful when it is available concurrently or soon after presenting the proposed strategy to avoid any lag that could stall decision-making and action (Bhuyan, Jorgensen, and Sharma 2010).

Example

In Uganda, after the discrete choice experiment survey identified which incentive packages would be most likely to motivate health workers to work in rural areas, a technical team used iHRIS Retain (<http://retain.ihris.org/retain>), open source retention intervention costing software, to cost many different scenarios of retention incentive strategies for each cadre and estimate their budget implications. The incentive package most-preferred by health workers represented a comprehensive approach to improving the work environment, including interventions to increase salaries, improve facility infrastructure and management, and provide

support for continuing education, but necessitated a substantial financial investment. Another package provided an optimal preference by health workers but moderate financial cost as the facility infrastructure improvements were limited to primary care facilities. The minimum investment scenario of incentives appealed to the fewest health workers, as it did not include improvements to facility infrastructure.

Involve relevant stakeholders, including technical experts and those with decision-making authority, in evidence dissemination and review

During evidence dissemination and review, it is important to consider the diverse stakeholders who need to be involved in decision-making, and tailor communications to these decision-makers accordingly. The key stakeholders critical to policy changes often have differing perspectives and mandates, meaning that data review and related advocacy messages must be appropriate for each context.

MOH officials may have specific priorities, technical knowledge, and spheres of influence within the health sector. Members of a parliamentary body, on the other hand, must consider issues across all sectors, may not have a specific technical background, and likely face different political pressures. In addition, many policy changes related to HRH systems affect multiple sectors and stakeholders. Consequently, it is vital to consider how the roles, responsibilities, and management structures of the political landscape influence the policy environment and decision-making process (Zulu et al. 2013).

Based on the specific HRH issues under consideration, the key stakeholders should include a mix of representatives from the central and local government (ministries of health, education, finance, planning and economic development, and public administration); training institutions, health professional associations, councils, and unions; donors and other partners; and civil society. For example, in 2005, Kenya's MOH effectively assessed key stakeholders and involved them in a policy review on human resources guidelines resulting in the expansion of voluntary HIV counseling and testing services to include all health cadres (Taegtmeier et al. 2011).

Evidence dissemination may offer a chance to identify champions who are compelled by the evidence to advocate for HRH policy change.

A technical working group (TWG) or other stakeholder leadership group composed of technical experts and individuals knowledgeable about HRH systems and management structures can be an effective coordinating and review board for proposed HRH decisions. Stakeholders with high-level decision-making authority—in particular, individuals who make funding decisions or have access to those who do—should either be part of the group or have the evidence review and policy recommendations directly communicated to them to promote informed HRH policy decisions. A helpful approach is first to present results from health workforce studies to an HRH TWG, so that members

can review the data and recommendations and propose a way forward to engage higher-level policy-makers. In addition, evidence dissemination may offer a chance to identify champions who are compelled by the evidence to advocate for HRH policy change. For example, an advocacy campaign in Tanzania—where hiring freezes had prevented a majority of graduates from health training institutes from practicing in the public sector—used relevant locally collected data on staffing disparities and their detrimental effect on safe motherhood efforts, resulting in the president's office issuing a letter permitting all graduates from health training institutions to be hired into the public sector (Ministry of Health and Social Welfare 2008; Songstad et al. 2012; Health Policy Initiative 2010). The letter subsequently encouraged the deployment of almost 4,000 new health workers to address critical HRH shortages and improve maternal health, resulting in a 33% increase in staffing levels (Health Policy Initiative 2010).

Example

Established in 2001, Uganda's HRH TWG is composed of diverse stakeholders from the health, finance, gender, and public service sectors, as well as representation from civil society, training institutions, the private sector, donors, and faith-based organizations (Howard-Grabman and Jaskiewicz 2013). While the Uganda HRH TWG illustrates that sustaining a group over such a long period of time through changes in leadership, membership, and political context is not easy, the group has been able to assist in achieving important policy changes. To overcome challenges, stakeholders have at times been able to work through a smaller group on behalf of the larger TWG. With technical assistance from the Uganda Capacity Program and using data generated with technical support from *CapacityPlus*, a subgroup of HRH TWG members reviewed human resources information system data showing health worker shortages by type and location and discrete choice experiment results to formulate retention strategy and policy recommendations. The group sent its recommendations to the MOH's Senior Management Committee, which reviewed them and proposed policy options for consideration by the MOH Health Policy Advisory Committee and finally the Top Management Committee, led by the minister of health. The Top Management Committee then took these recommendations to advocate with the Ministry of Finance. As a result, an additional \$20 million, or a 16% increase, was allocated for the health wage bill. This allowed the MOH to offer jobs to 8,353 new health workers in one fiscal year (2012–2013), of whom 7,211 were deployed to their posts by June 2013. MOH recruitment had previously averaged about 500 health workers annually. In addition, the health wage bill doubled the pay of medical doctors working at health centers IV to attract more doctors to work in these lower-level facilities located mostly in rural areas and increase access to family planning, HIV/AIDS, and other essential health services.

Once agreement on the need for policy change has been reached, maximize momentum so that evidence is converted into action

The political environment can shift rapidly. It is helpful to be aware of broader political, economic, or sectoral changes and

trends and reflect on how these may affect the content and timing of a proposed policy and/or its implementation. When appropriate, it can be useful to seek support from multiple political parties or contingencies. There may be finite windows of opportunity for introducing a policy, and if additional time passes, momentum may be lost. As national priorities or political and fiscal climates shift, one can consider either making adjustments to the proposed policy intervention or taking a phased approach. When strategies are particularly innovative or comprehensive, they may be viewed as too expensive, introducing too great a change,

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and/or requiring action by too broad a range of implementers. In these cases, stakeholders may end up implementing the policy in a piecemeal or stepwise manner rather than as a complete package. It is not always possible to achieve a collective vision for full implementation of a policy. Major, comprehensive reform does not happen often or without considerable investments of time and advocacy. In addition, in some instances, decentralization may limit the ability of central authorities to impose policies on districts, particularly where local management committees oversee health facility administration. Thus, if HRH policies are to be implemented at the district level, it is recommended that there be district-level involvement in policy development, particularly in the evidence review and decision-making processes.

Example

Where there are windows of opportunity, such as budget development, policy revision, or strategic planning cycles, it is useful to take advantage of those periods to push for action. It may take a few cycles to see a result. In Uganda, the initial impetus for a retention strategy—the health worker motivation study—took place in 2008. The discrete choice experiment was conducted and costed two years later, and the results of the exercise were shared with the HRH TWG, including a presentation of costed incentive packages for doctors, nurses, pharmacists, and laboratory technicians (Rockers et al. 2011). It was not until the end of 2012—four years after the motivation study—that the consistent advocacy efforts resulted in the government’s substantial wage bill increase and the corresponding massive recruitment of health workers mentioned above. While the proposed retention strategy was not adapted in its entirety, decision-makers must weigh not only the technical aspects of a strategy but also its political, economic, and social implications. Further, it is important to note that personnel functions within the MOH, such as human resources recruitment and management, are decentralized to District Service Commissions (Ssengooba et al. 2007). Thus, components of the discrete choice experiment-elicited health worker job packages and other aspects of the overall retention strategy may have fallen outside the realm of the central MOH.

Ensure that an accountable stakeholder leadership group oversees a defined process for bringing an evidence-based policy decision to action

Having a strong stakeholder leadership group has become an increasingly important means of ensuring follow-through on decisions made, pushing for further action, and alerting stakeholders to new or unresolved HRH issues. The establishment of TWG subcommittees can be useful to deepen strategic thinking and further attribute ownership of key HRH strategy areas, such as retention (Howard-Grabman and Jaskiewicz 2013). A multisectoral stakeholder leadership group can play a critical role in taking stock of the political landscape as well as establishing and monitoring HRH goals, targets, and indicators, including reporting on outcomes achieved to date (Health Policy Initiative 2010). Ghana’s HRH stakeholder leadership group, for example, applied leadership guidelines developed by CapacityPlus to ensure that a strong secretariat supported the involvement of a broader group of stakeholders to drive the development of the 2012–2016 National Human Resource Policy and Strategy for the Health Sector (McCaffery et al. 2013). It is also important to have a high-level body or department to which the stakeholder leadership group’s regular reports of implementation progress can be directed, so as to maintain accountability for following through on policy decisions. As found in Zambia, stakeholder leadership group members’ ongoing advocacy for health workforce retention issues can bring additional strategy components to the table to be addressed (Zulu et al. 2013). Indications that a stakeholder leadership group has

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achieved some momentum in bringing a policy to action include demonstrated funding allocations (such as budget line items), an implementation workplan, and/or a monitoring and evaluation plan.

Example

In Uganda, as around the world, no single department or ministry is exclusively in charge of HRH issues, though leadership in this area is often spearheaded by the MOH. To overcome some of the challenges experienced by the HRH TWG and other TWGs, in 2013 the Uganda MOH approved guidelines for governance and management structures to stipulate how TWGs relate to policy decision-making. Specifically, the TWGs function to prepare and review policies, and the HRH TWG shall “review health workers production, deployment/recruitment and exit from workforce...and propose new HRH interventions” (MOH 2013, 19). These guidelines helped to ensure that the TWGs’ terms of reference and scopes of work were clearly defined, as well as to outline membership criteria and representation. In consideration of issues that remain unaddressed, the HRH TWG is now working to periodically evaluate its performance on ongoing efforts to improve health worker retention and other

challenges, and to consider which opportunities may exist to support decision-making to take forward additional HRH strategy interventions.

Mitigate the effects of stakeholder turnover

If key stakeholders leave their positions during the policy-making process, one should consider whether and how to orient newcomers while maintaining the process, or whether to start the process anew. A lot will depend on the stage in which the transition of key stakeholders takes place—from evidence dissemination and review, recommendations-setting, and advocacy to final decision-making on policy issues. The loss of continuity and institutional memory resulting from turnover of key staff, as well as the frequent changeover of health sector management positions and political appointees, can disrupt the ongoing discussions that are necessary for a policy's eventual implementation (McCabe et al. 2008). Turnover can also contribute to lost momentum. Any of these factors may prevent HRH strategies from moving

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forward. An HRH TWG's secretariat function, which is important more generally (Gormley and McCaffery 2011), is critical to ensure that changes in membership are appropriately addressed. To maintain the TWG's institutional memory, it is important to document issues, meetings, and discussions as appropriate. Responsibilities and accountability measures for these actions could be made official within a stakeholder leadership group's bylaws, and could help to mitigate the effects of stakeholder turnover.

Example

In Uganda, when individuals representing a key stakeholder left that organization and thus the HRH TWG, a new representative was not always named. This resulted in the loss of that organization's engagement in the issues under discussion. Key informant interviews with the Uganda HRH TWG revealed several recommendations for mitigating such negative effects of turnover: first, a TWG secretariat could be vigilant to request (or require) the organizations with departing members to name a new organizational representative to the group (Howard-Grabman and Jaskiewicz 2013). In addition, acting members could be named when it is anticipated that permanent members may take more time to be identified. Whenever possible, outgoing members should orient the incoming representative. Further, if key members are frequently absent, the secretariat could send them notices to remind them of the importance of their organization's participation (Howard-Grabman and Jaskiewicz 2013). The Uganda MOH (2013) Guidelines for Governance and Management Structures clearly stipulate the purpose, responsibilities, and membership of TWGs and provide guidance on the functions of the chairperson, secretariat, and members. With this new definition and protocol, the HRH TWG is working to improve its governance mechanisms and mitigate the effects of stakeholder turnover.

Conclusion

With planning and forethought, it is possible to ensure that stakeholders use available evidence when making policies and decisions intended to improve HRH systems in general and health workforce recruitment and retention in particular. As the Uganda example illustrates, these steps can help build interest, momentum, and political will to make policy decisions for retention strategies to strengthen the health workforce and improve access to high-quality health care for the population. Moving forward from their evidence-based retention policy decisions, it is important for stakeholders to evaluate policy implementation and its effect on service delivery.

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