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Human Resources for Health and Development

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1. Introduction

The purpose of this paper

Human resources are one of the key components of health systems. Not only do salaries represent up to two-thirds of recurrent health expenditure, but also it is the performance and attitudes of health staff that shape client perceptions of how well their health is being looked after and influence how well available resources for health are converted into effective health outcomes.

However, health systems operate within a larger framework, wherein the emergence of a global market, resulting from mobility in labour, capital and technology has an impact on health workforces. Within the global health labour market, health professionals have great mobility and seem to be highly sensitive to "push" and "pull" factors such as pay, working conditions, job satisfaction and economic prospects.[1] As a result of these push and pull factors, global inequalities in health care provision are increasing. Many countries are now facing severe staff shortages that are threatening to undo many of the public health gains achieved over the last 30 years.

Given the central role of health human resources to the effectiveness of health programmes, it is disturbing that so little attention has been paid to this area in the past. This neglect, combined with the effects of the global labour market has led to what has been described as a crisis situation in many countries in the developing world.

This paper aims to develop an understanding of the multiple dimensions of human resources in health systems and to explore some of the most critical human resource problems that are now confronting governments. The paper ends with a summary of challenges that need to be confronted by governments and their cooperating partners if the aims of health reforms or the Millenium Development Goals for health are be achieved.

The Dimensions of Human Resources

The World Health Report 2000 defines human resources as "the stock of all individuals engaged in the promotion, protection, or improvement of a population's health".[2] This definition covers clinical service providers, managers and support staff employed by the service delivery organisations, public health personnel working in organisations responsible for

health service regulation, education and research, community health workers and broader social sector personnel.

The focus of efforts in the human resource arena in health has been traditionally restricted largely to the area of training and, to a lesser degree, quantitative planning. The areas of human resource policy, improving performance, health worker motivation and retention, personnel management, and promoting effective links with the public services as a whole have been largely ignored – partly because of their sheer complexity. A World Bank official once said that too often fundamental human resource management problems have been put in the file marked "too difficult to handle".

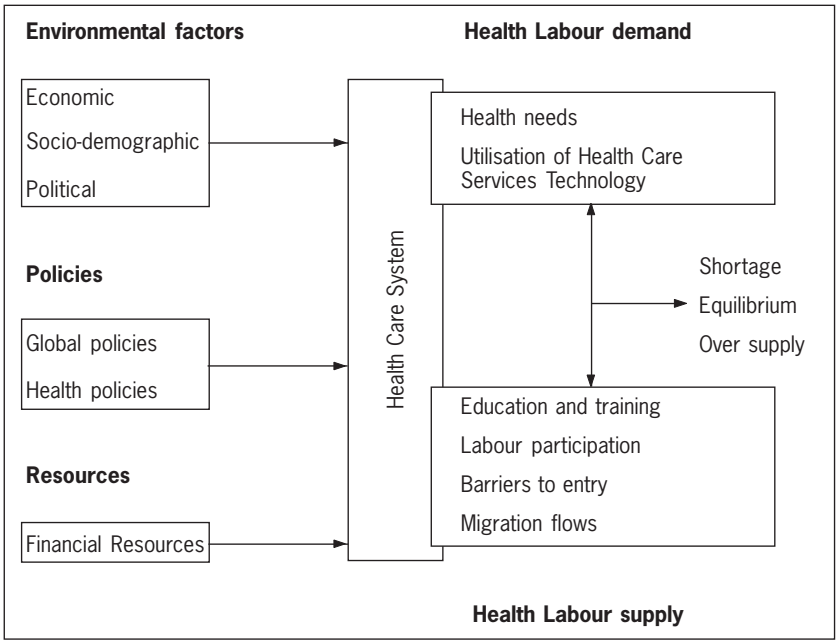
In an attempt to cover the breadth of the human resources for health field arena, this paper uses the following classification of human resource functions:

Human Resource Dynamics:	ensuring that the right number of appropriately trained staff are in the right place at the right time to meet health service demands.
Sustainable Capacity Building:	providing an adequate supply of the right kind of human resources with the appropriate skills to the labour market.
Performance Management:	ensuring that once staff are in place they get sufficient support and encouragement to enable them to perform their roles effectively.
Incentives and Motivation:	ensuring that health workers are treated with respect as partners in health efforts, are deployed in line with priorities and plans, and promptly receive their dues in line with employment policies.

Human Resource Dynamics

Ensuring that sufficient numbers of the right types of skills are available at the right time is the dilemma facing those planning and managing health systems in all countries – and no country has consistently succeeded. The National Health Service in the United Kingdom has failed in the past to ensure a steady supply of the right kinds of medical specialists and is currently struggling to attract and retain sufficient numbers of nationally trained nurses.

The diagram below, presented at a consultation on imbalances in the health workforce in Canada in 2002 [\3], depicts a framework for examining the human resource dynamics of a health system.



The demand for health labour is based on the definition of health needs, on client expectations and utilisation of health services, and on the emergence of new technologies for diagnosis and treatment. The supply of health labour is a function of the patterns of education and training, of the influence of the health professions or unions on the provision of training and health services, of barriers to entry into the profession driven by regulation, and on regional or international migration of health workers. All of the above are shaped by the economic, socio-demographic and political context of the health system, by national and international policies, and by the financial resources made available to the health sector. The result of all these factors is the workforce available to provide health services. Some of these issues are examined in more detail in the paragraphs below.

2. Human Resource Issues Confronting Developing Countries

The Changing Labour Market

As mentioned in the Introduction, health professionals have become very mobile and wealthier countries are able to offer salaries, working conditions and career development prospects that induce those from poorer nations to seek more rewarding employment. Although some countries and regions have restricted access to the employment of health professionals from elsewhere to those who meet certain certification standards, these restrictions can be adjusted when a shortage of key categories becomes acute. In Africa, labour restrictions for health professionals are minimal and the result is a continuous migration of health professionals to countries such as Botswana and South Africa. A recent study in South Africa found that only a quarter of rural doctors are natives of that country, the remainder mainly coming from other African states.[4]

Over the last 15 years, a rise in employment opportunities, both in an expanding private health sector and other fields, together with increasing salary expectations, have significantly reduced the numbers seeking government employment. This is particularly so for Ministries of Health where professional motivation has been undermined by poor resourcing with the consequential shortage of the drugs, equipment, supplies and transport to enable health workers to perform effectively. A staff survey conducted in Zambia in mid 1995 indicated that "professionalism" (the satisfaction gained from being able to provide effective care for patients) was stated as the most significant reason for working in the government health services.[5] A similar survey conducted in Zimbabwe in 1999 found that the inability to offer effective care, due to lack of the necessary equipment, drugs and supplies was the reason quoted most frequently for resigning from the Ministry of Health.[6]

Even though the choice of careers may be expanding, in some countries the supply of suitable school leavers is not keeping up with demand. Recent statistics from Malawi indicated that the pass rate for the School Certificate of Education was less than 20% and the 20 first year places at the Medical School could not be filled due to lack of adequately qualified applicants.[7] Similarly, of the one million black children entering school in South Africa, only 1,000 eventually got maths and science at matric at a level sufficient for entry into medical school.

At the same time as entrants in the health labour market are becoming more scarce, many of the health professions, possibly following the lead of the developed world, are raising their entry requirements for professional health training. Across Southern Africa, certificate (2 year) level training for such professions as nurses, medical assistants, environmental health technicians, and laboratory technicians is being phased out. This restricts entry into training to those with higher school qualifications and extends the training period to a 3-year diploma course. The diploma training is usually internationally recognised and allows graduates access to jobs in other countries, including Europe and the USA.

The highest impact of this move has been felt in the nursing profession. For example, Zimbabwe abolished its 2-year training for State Certified Nurses in 1987 and this has resulted in a halving of its nurse outputs.[7] The resulting shortages of supply have been felt most keenly at the primary health care level since the diploma graduates would prefer to work in hospitals in urban and peri-urban areas with better social amenities.

Attrition from government to the private health sector is on the increase and despite the fact that at least health professionals who make this move continue to provide health care within the country, the problem is that access to the private health sector is restricted to those who have the means to pay. The Council of Nurses and Midwives in Ghana lost 328 nurses from its register in 1999 which is the numerical equivalent of Ghana's entire output of registered (diploma) nurses for 2000.[8]

Losses Due to AIDS

Another important factor influencing staff supply is the rising death rate amongst health staff. At best, AIDS has its toll on health staff at the same rate within the general population, although the risks faced by health staff, combined with a frequent lack of protective supplies could mean that they are at a higher risk. However, studies suggest that although occupational risk is increased in the course of providing health care, this risk is limited.[9]

Although governments do not track reasons for death, it is a fair assumption that AIDS is a major cause of death of health workers in Sub-Saharan Africa. The box below provides some details on the numbers of government health staff in Malawi, Zimbabwe and Zambia who died whilst in service during 1998 or 1999. As shown, death represents the most significant cause of loss, particularly in Malawi and Zimbabwe.

Deaths of Government Health Staff [10]

	Doctors		Nurses		All Staff	
	No.	%	No.	%	No.	%
Malawi (97/98)	n/a	n/a	44	43%	296	53%
Zambia (99)	2	8%	85	45%	313	19%
Zimbabwe (98)	4	6%	45	12%	330	38%

% is the percentage that death represents of all leavers

When deaths are compared with the capacity to train replacement staff, in Malawi the number of deaths among nurses represents 40% of the average annual output of nurses from training. In Zambia the situation is only slightly better with the loss of 185 nurses in 1999 representing 38% of annual outputs.

National Inequities in the Distribution of Health Staff

Although not directly an issue of absolute shortage of health staff, the question of the distribution of available health staff within a country also has an impact on supply. Hospitals have the need for the greatest number of staff and hospitals tend to be situated in urban areas. Health professionals are largely trained in hospitals with opportunities for community experience severely limited due to financial and transport constraints and graduates often have a preference for remaining to work in the type of environment in which they have been trained. The rising status of health training (from certificate to diploma) also makes hospital employment more attractive to the graduates, as do the opportunities to work alongside professional colleagues and to be more easily visible to those in charge of promotions or selection for higher training. The result is that Governments are finding it increasingly difficult to attract and retain staff at the primary health care level in the rural areas.

Distribution of Professional Health Staff[10]

	Central and Provincial Hospitals	Rural Health Centres
Malawi	54%	16%
Zambia	41%	19%
Zimbabwe	51%	5%

Thus, as shown in the box alongside, even though an objective of health reform is likely to be to provide equity of access to care at the most cost-effective level, the reality is that countries are often faced with the problem of a severe maldistribution of the human resources they actually have available.

A study in the Gambia showed that the problem of maldistribution is gendered in nature; females are more likely to resign with the first five years of service than their male counterparts.[11] Though the reasons for this were not fully corroborated, it appeared that insensitive posting policies were forcing females who were just starting a family to resign rather than take up a posting that would be "too difficult to handle".

In 2000, it was reported that the Greater Accra Region in Ghana (excluding the teaching and referral hospital) had 12.6 doctors for every one doctor posted to the Upper Western Region. Similarly, there were 107 nurses in Greater Accra to every nurse in the Upper Western Region. The population ratio between the two areas was 3.5 (Greater Accra) to 19 (Upper Western Region).[8]

The Planning and Monitoring of Human Resources

Early warnings of the growing human resource crisis in health have been few and far between. Few Ministries of Health have invested in the development of a human resource plan that analyses and documents decisions on staffing needs and projects the actions necessary to bring human resource needs/demands into balance with likely supply. Equally importantly, information on the current health workforce – the numbers by category, their distribution by level of care, outputs from professional health training programmes, the retention of graduates and the rates of leaving – is not routinely available, thus preventing the routine monitoring of human resource trends to stimulate action.

Even where Ministries of Health have developed human resource plans, they are rarely used consistently to guide day-to-day decision-making. Unfortunately, these human resource plans are often funded by donors and developed with extensive technical assistance that can reduce the government's ownership of the results and commitment to taking appropriate action. This is often compounded by donors' "project" view of the plan; its development is a project goal that has been met and little attention is paid to encouraging the government to report progress against the plan and to enter into a dialogue with stakeholders on how to deal with identified imbalances and shortfalls.

Health Workforce and Public Sector Reform

Problems in the supply of health staff can also be exacerbated by steps taken by governments in pursuance of public service reform. Although the health and education sectors are usually intended to be exempt from payroll reductions, in several countries this agreement has been overlooked. Public sector reform often involves a ban on hiring, even to replace those who have left. In Zambia 11% of all professional health staff applied for the "voluntary separation package" offered by the Government in efforts to reduce the public service payroll.

Public sector reform often involves the alignment of public sector salary structures, through the use of task analyses to band jobs according to the level of responsibility (which is usually measured in terms of decision-making authority over the allocation and use of resources).
This usually results in health professionals being banded quite low in the salary structure and can increase the likelihood of health professionals seeking more lucrative employment elsewhere.

These are examples of how public sector reform efforts lead to reforms which exacerbate human resource problems and make the public health sector a less desirable employer for highly trained staff.
There needs to be a more explicit diagnosis of key human resource problems early in a public sector reform process. There needs to be increased advocacy for human resources for health which highlights that investment in the health workforce can lead to improved health of the population which in turn is one of the most effective means of promoting economic growth.

3. Sustainable Capacity Building

The number of health professionals entering into the labour market will be largely determined by the outputs of the country's pre-service training schools. The quality and appropriateness of the skills of these health professionals are determined by the quality and the content of their training. Hence the area of education and training is crucial to the successful staffing of health services.

The Relevance and Quality of Pre-Service Training

Pre-service training is an important investment by governments. Given the numbers of health professionals required – both by the public and the private health sectors in the country, the investment is also large.

Although it is usually difficult to determine expenditure on pre-service training (since the costs are often embedded in the accounts of the schools' 'host hospita', in Zimbabwe in 1998 the cost of training one registered nurse was estimated at US$8,200 for the 3-year training period and the annual expenditure on nurse training was estimated at US$2.7 million.[\6]

The term 'appropriately skilled' is intended to mean that graduates of the training are able to effectively perform their defined duties to meet the needs of their clients. This means that the training curricula need to be designed to prepare students to be able to deal appropriately with the problems they are likely to face with the resources they are likely to have available.

Several factors are undermining the value of the investment governments make in their pre-service training in the health professions.

Firstly, pre-service training curricula are increasingly aimed at international standards rather than the local demands for service delivery. This is a sensitive area, since western critics can be accused of retaining a colonialist mentality. Nevertheless, the investment in training is made by government on behalf of its people, and therefore there is a moral imperative that this investment produces results that can benefit these people – not just benefit those receiving the training.

Where health training institutions are run by Ministries of Health, pre-service training has to compete against service delivery for financial resources. Given the increasing resource constraints faced by most developing world governments, pre-service training schools tend to lack equip-

ment, reference and training materials. Even more importantly, they often lack both the transport and the funds to be able to fulfil curriculum intentions for field practice outside of the host hospital.

Where health training institutions are run by a Ministry other than the Ministry of Health, such as is the case of most university-based programmes for the training of doctors, pharmacists and sometimes other health technologists, this adds additional difficulties. The Ministry of Health in such cases, as a significant end user of the graduates, has to try to influence both the content and the quality of the training provided by another Ministry.

The practice in many health training institutions is that of learning by rote, with little opportunity to question and explore and this is poor preparation for working at the frontline in the public health services where guidance from superiors may largely be absent. In addition, tutors in government schools generally have poor career opportunities are not in the main stream for promotion, for selection for further training or conference opportunities.

All of the above have meant that standards of training in health training institutions have tended to have fallen over recent years. Graduates of the training schools are often found to be ill prepared for the problems they face at work and this has led to the next problem.

Institutional Capacity for Training Related Services

Donors interested in supporting health programmes in areas such as child health, safe motherhood and family planning usually find, in their initial assessment of service quality, that health worker performance and their knowledge is inadequate.

These findings often lead to inclusion of in-service training for staff in the programme of support. The local costs of this training is funded by the donor and often includes technical assistance for the design of the training, the training of trainers (if it is believed that there are individuals with the experience and capacity to be trained as trainers) or the costs of foreign trainers to conduct the training.

As shown in the example given in the box below, this directs attention away from the appropriateness and quality of pre-service training, it is usually a short-lived exercise and covers only a small proportion of all service providers. Perhaps most importantly, this approach does nothing to build the capacity of local training institutions or trainers and is usually not a sustainable strategy for the government to maintain service quality over the long term.

IMCI Training in Zambia

The impact of this widely acclaimed training in the integrated management of childhood illnesses is now being questioned. In Zambia, this in-service training has been supported by WHO and USAID over the last 7 years. Whilst this training has been shown through evaluations to have had an impact on health worker performance, the problem is that as soon as donor support is withdrawn, the government cannot continue the training. At the same time, throughout the duration of the IMCI support, no efforts have been made to incorporate the content or the training approaches used in the in-service training programme into the pre-service curricula of doctors, clinical officers and nurses. New graduates will leave their pre-service training with no understanding of the principles upon which the IMCI training is based.

Of equal concern is that in-service training such as IMCI will only have the desired results if the health staff trained can apply their their knowledge in their subsequent work. The impact of IMCI training relies upon the availability of the appropriate drugs to treat the childhood illnesses diagnosed. Where these drugs are not available (which is often the case in rural settings), the best that health staff can do is to send the family off to buy the drugs at a private pharmacy, which many cannot afford. Thus, training alone is rarely the answer.

The Gap Between Training and Service Delivery

Although the pre-service health training institutions are responsible for producing the next generations of health workers and need to be kept abreast of changes in service delivery protocols and of how their graduates are actually performing in the field, the reality is that the training institutions are often isolated from the realities of the workplace and from new service delivery practices.

If the relevance of training is to be improved and maintained and if the training institutions are to contribute effectively to the quality of service provision, they need to be active partners to the service delivery managers. Training faculty need to be involved in the design and implementation of in-service training and in consultations about changes in employment policies and service delivery protocols. They need to be involved in decision-making about how to manage the human resource for health dynamics in the country in order to promote better equilibrium in the demand-supply balance. In addition, the performance of the training institutions should be regularly evaluated in relation to both the quantity of graduates produced, graduation rates and quality of the training they offer.

In summary, if sustainability is to be developed in the health sector's capacity building this means that the crucial role of the health training institutions needs to be recognised and investments in their own capacity-building need to be made. Institutional capacity in training means that training institutions and trainers need to develop experience in conducting training needs assessments in order to be able to make recommendations on whether a particular problem will be solved through training and to define exactly how training will effectively address the problem. It also means the ability to design training programmes, learning approaches and materials so that these will have a direct influence on the identified problem. It requires the management capacity to plan and organise the training and to budget appropriately. Finally, it requires the capacity to conduct evaluations of the impact of training on service quality and performance.

4. Performance Management

Performance management means the processes and the actions taken to ensure that staff are given the necessary guidance, encouragement and support to perform their expected roles effectively – both in terms of productivity and in terms of the quality of work. Within public health sectors in the developing world, this area can often be a significant disincentive to staff retention since staff perceive that their contribution is not considered important by their employer. Three aspects of performance management are reviewed here: the definition of expected performance; incentives for good performance; and supervision practices.

Definition of Expected Performance

There tends to be a lack of clear expectations about performance for staff working in the public health sector. Although in hospitals it is more common to find work procedures and standards and there are supervisors, based at the hospital, to monitor behaviour and its results. However, staff posted to a health centre rarely have a job description and are rarely given any induction into their job before being sent out.

New graduates straight from their training institution may not be given any guidance on the practicalities of what they are expected to do at their health centre, such as who should they inform (and how) if they run out of drugs or supplies, how and where should they refer patients who require higher level care, how should they work with their local communities, what are their responsibilities towards community health workers in their area, how should they maintain their records at the health centre so that the health information system will function effectively, and so on. These are not issues that are taught during their pre-service training theory classes and few of them will have spent sufficient time at a health centre on community practice blocks to gain sufficient information or experience.

Incentives for Good Performance

In most traditional public service organisations there is little incentive for staff to perform well. Firstly, there are no clearly agreed and disseminated expectations about performance (as described in the section above). Secondly, there are rarely systems to reward good performance in the public sector, especially in relation to staff working at the periphery.

Thirdly, although there tend to systems and procedures for disciplining staff who break the rules or perform poorly, these are usually not effective.

In most countries, the local manager or supervisor who is closest to the health worker and who can therefore make an informed judgement about the worker's performance does not have the authority to recognise good performance in any form other than verbal or written appreciation.

Although this recognition is important, there should also be other actions taken to demonstrate that good performance influences career progression. For example, selection of individuals for higher (post-basic) training is seldom reliant on a local manager's report on performance.

Promotions are usually based on the availability of a vacancy at a higher grade and length of service (with the longest serving member being selected for advancement), not on how well an individual has performed. Selection for special duties or attendance at meetings or conferences is rarely based upon the recommendation of the local manager in terms of performance.

Performance appraisal systems in most government health services are viewed with suspicion by staff and managers alike. The reporting format is often based on an individual's assumed character, rather than on specific performance achievements, and the system is usually "closed" (meaning that the staff member is often not allowed to either see or even given any feedback on the report) so that an opportunity to influence future performance is lost.

Another factor that undermines performance related rewards is that in many countries staff rely upon the protection of a senior manager based on family, traditional clan alliances, or past assistance or favours. This undermines the authority of the local manager and can make punishment or even transfer of staff almost impossible. Such "nepotism" demoralises staff and reinforces the separation between job performance and career consequences.

An area of performance management that is often neglected is the management of absence and its impact on institutional performance. Staff absence impacts negatively on the workload of other staff members and affects the performance of the whole institution. Reasons for absence from work include genuine sickness (on the increase due to AIDS), attending funerals (also on the increase), caring for other family members (also on the increase) and "moonlighting" in health or other related work. Data on absence is rarely collected or monitored, however a study of nurse in one large hospital in Ghana showed a loss of 11,564 total days in one year, equating to an average of 11 days per year per nurse.[12] A sample of registered nurse absenteeism in Zambia in one District showed an average of 30 days absence in one year (excluding normal leave, but including sick days) at a total cost of US$220,000.[13]

Supervision

A vital component of performance management is that of supervision – the process of regularly reviewing what a worker has achieved, of providing guidance where necessary, of helping the worker to determine how to improve their performance in the future, and of agreeing with the health worker any steps that the supervisor needs to take to provide the neces-

sary support. In government health systems the supervisory structure usually adheres to the following pattern: the centre supervises the provinces and or districts, the district supervises the health centre, and the health centre supervises the community health workers. Hospitals tend to be treated as self-governing entities, with the hospital director and his management team supervising the work of all hospital staff.

However, supervision tends to be extremely weak. There is often a lack of resources (transport, money for allowances, and supervisory staff time) to carry out regular supervision and health centre staff in more remote locations may be lucky to receive a visit from their supervisor once a quarter. Once they there, supervisors rarely understand the purpose of supervision and the visit can turn into a litany of criticism with little effort to understand what the health workers know, what problems they face and what could be done to improve performance.

There is a strong tendency to believe that a supervisor should know everything and that the correct behaviour is to give instructions, not to try to understand what is happening and offer help to improve performance. There is little understanding or acceptance of the fact that the performance of staff is a key indicator of the performance of the supervisor.

In conclusion, performance management has been a particularly neglected area of human resources for health. Much can be learned from staff management experiences in the business sector and much could be done if Ministries of Health are convinced of the importance of this area, especially since many improvements could be made without significant costs, at least other than in terms of management time.

5. Staff Retention

Staff retention is influenced by many of the issues discussed in earlier sections of this report, but it is also influenced by decisions related to career structures, pay levels, conditions of service and incentive schemes, and the systematic implementation of these decisions. Employee relations refers to the manner in which an employer ensures that staff are given key information about likely changes that may affect their employment and consults staff on the design of changes in work practices or on decisions on how to improve performance.

It has been estimated that the cost of losing a staff member in the health sector equates to 3–6 months of pay in terms of hiring a replacement and getting the new staff member in a position where they are able to work effectively.[14] Therefore reducing staff turnover would have significant financial rewards as well as influencing the sense of teamwork and morale of the workforce.

Salary Levels and Salary Relativities

A prerequisite for retaining staff and for achieving a minimum level of acceptable performance is an adequate reward package for staff [15] "Adequate" has two dimensions: that of the absolute level of pay and that of pay relativities.

Absolute levels of pay for health staff in some countries are at subsistence levels. Health staff in these countries may devote time and energy to "moonlighting" (to taking on other jobs) to earn sufficient money to enable them to provide adequately for themselves and their families. Or health staff may leave government employment to seek better rewards in the private or NGO health sectors or in employment outside of health. Although this fact is recognised, some governments are not in a position to increase salaries, given the need for fairness across the public service and given the constraints on public sector expenditure.

Salary relativities, as perceived by health staff, are also important to a sense of fairness. In many countries there are significant differences between the starting and maximum salaries of the various professional groups employed in the public service, even if the length of training for these professions is identical.

For example, a dental technician may enter service after graduation at a salary 50% lower than a radiographer, even though the entry qualifica-

tions and period of training are identical. These salary differentials are not related to the perceived importance or scarcity of a particular profession; rather they appear to have evolved over time as professional associations negotiate pay awards, or as professional titles and training curricula are developed and associated salary scales are revised.

Then there are the salary differentials between the public sector and the NGO and private sectors, which are sometimes very large. For example, it has been found that doctors in Portuguese-speaking Africa could earn the equivalent of one month's salary by seven hours of private practice, whilst some doctors in Angola could earn the same in one hour.\16 In most countries NGOs and donor-funded projects offer salaries to health professionals that are 50%–100% higher than what they would receive in the public service and often these organisations progressively raise their salary levels so that they can "poach" from each other.

Although these facts may help to retain health professionals in their country, they also have a significant influence on the retention and morale of staff within the public sector.

Employment Benefits

Salaries, whilst clearly important to health staff, are not the only employment benefits that can influence retention.

Other benefits that have been tried in various countries and which seem to influence health staff decisions on whether to remain in government employment include assistance with housing, attempts to post husbands and wives who are both health professionals together, assistance in finding appropriate work for spouses, assistance with schooling for children, and financial loans for house construction or car purchase.
In countries where there is a significant difference in amenities between urban and rural areas and where there are inequities in the distribution of health staff between these areas, attention to identifying what benefits are viewed as important by professional health staff and then to seeking ways of providing some of them could have an important impact on staff retention.

Career Advancement Potential

Career advancement potential relates to the opportunities for an individual to progress within his/her chosen career. A career structure is the number of promotional steps available within a particular profession. However, in most public services, there is a constraint in that the number of posts available at each of the promotional levels is determined by the establishment (the authorised posts at each level and location which the government will pay for).

In most countries, there are multi-level career structures for doctors and nurses, however for other professions the career advancement potential is very limited indeed. Even where there are 2 or three career steps available, the number of actual posts authorised at the more senior levels are very restricted. For example, in Zimbabwe there are 153 posts for pharmacy technician, but there is no promotional opportunity at all within that profession.

Similarly, for environmental health technicians, there are a total of 829 posts, but there is no career advancement possible. In Zambia, there

are 68 posts for pharmacy technicians/ technologists, but of the 61 individuals on the basic grade, only one in 10 will be able to achieve promotion to the senior grade and only one of these 10 will be able to achieve the principal grade, and this can only happen once the incumbent at the senior level has left the service.

Perhaps another critical factor here is that decisions on who to promote tend to be based not on performance or any assessment of an individual's potential, but on length of service.

Personnel Administration in Practice

Personnel administration (the implementation of policies related to employment) within government service tend to be units that are poorly staffed in terms both of numbers and quality, have low status and are rarely involved in or consulted on decisions which will affect employees.

Since personnel administration is usually centralised within the Ministry of Health, this causes difficulties in communication and relaying of information and results in long delays in decisions being implemented.

It is common for newly-appointed staff to wait for months after they start work before their first salary arrives. Promotion usually requires some lengthy procedures to be followed with written reports, which local managers often do not know how to complete correctly, which causes further delays and frustration.

Health staff understand all too well the implications of having a centralised personnel function and if seeking a change of posting, a promotion, or approval for further training, will take the time to travel to the Ministry of Health to make sure that the issue in question is on top of the personnel officer's pending tray. At worst, this situation can lead to payment or some other favour to gain the assurance from the personnel officer that the desired action will be taken.

Personnel Units in Ministries of Health tend to have no written procedures specific to health staff (there may be public service manuals), tend not to have any documented standards to guide their performance (such as deadlines for completing certain actions), and tend not to have had any training in human resources.

Employee Relations

Employee relations in many countries is not a major area of concern, at least not until there is a crisis, such as a nurses' or doctors' strike. Unions are weak in some countries and professional associations tend to have few material or human resources to enable them to fulfil their mandate.

Regular consultation and sharing of information between management and staff is not the normal practice, since retention of information is often seen as a source of power for managers. Neither staff nor their union or professional representatives are asked to contribute towards the solution of problems, thus resulting in a missed opportunity to gain staff understanding and support.

6. Challenges for the Future

This paper has reviewed some of the major problems affecting the situation in relation to human resources for health, with a particular focus on Africa. In considering these problems, it is important to remember that they are not the "fault" of governments alone; the interests and actions of donors have made significant contributions to these problems.

The reluctance of international aid agencies to openly recognise the human resource issues confronting the countries they are working in and their unwillingness to get involved in this complex area has most certainly encouraged governments to close their eyes and hope that time will result in improvements. Even worse, the telescope vision of some aid agencies in relation to the specific health programmes they are authorised to support and are expected to have beneficial impact upon, has in some cases magnified the human resource problems of the health sectors as a whole.

The human problems confronting governments as outlined in this paper need to be addressed urgently, given that human resource decisions taken today often take several years to bear fruit. This section outlines some of the major challenges confronting governments and their co-operating partners if they are to begin to tackle the problems related to human resources and sustainable capacity building for health and development.

1. The need to build the capacity for and commitment to human resource reforms in support of health sector reforms.
2. The need to build the capacity and commitment for the development of effective systems for projecting and analysing the demand and supply of human resources for health.
3. The need to create the right mix of staff and their effective distribution across the country, with particular attention to how to improve the availability of health staff in under-served areas.
4. The need to develop sustainable strategies for pre-service (production of new health staff) and in-service training that help to promote training appropriate to the needs of the country and to build institutional capacity in the country.
5. The need to develop and test out schemes for the implementation of incentives and management practices that promote higher staff motivation and improve the retention of health staff.

6. The need to develop strategies for ensuring that there are sufficient human resources for the scaling up of key interventions and programmes.
7. The need to influence regional and global dynamics related to labour markets and the migration of workers.
8. The need to study the impact of the HIV/AIDS epidemic on human resources for health and to formulate strategies to mitigate the impact on health sector performance.
9. The need to ensure that health sectors' needs for human resources are taken account of in Civil Service reforms and closely linked to the macro economic situation.
10. The need to ensure that governments have the funds necessary to implement reforms of their policies and strategies for human resources for health.
11. The need to improve the effectiveness of development assistance to governments in their efforts to improve their situation in relation to their human resources for health.

7. Priorities for Action

The list of challenges listed above represents a long term agenda if governments and their cooperating partners are to achieve effective and sustainable improvements in the situation of human resources for health. This final section attempts to identify where to start to put this agenda into action.

Awareness Raising about Human Resources

Unless policy makers and managers have an understanding of the need to place human resource issues in a prominent position in their agenda, little progress will be made. It is imperative to broaden and deepen the understanding of these key individuals on the wide scope of human resource management and planning and the importance of getting it right if their agenda for health is to be achieved and the implications of getting it wrong. Over the last couple of years, efforts in this direction are being made on a global level, however more action is needed now at the country level. Cooperating partners have a key role to play here, to help governments to develop this understanding and to encourage them to place human resources on their agenda for constant attention and action. Seminars on human resource issues and information exchange through study tours can help managers to learn from the experiences of others. and to determine the scope of the human resources changes required.

Capacity Building to Support Human Resource Changes

Once there is commitment to effect changes in the human resources for health situation, there is a need to carry out an assessment of the current capacity (skills, time and willingness) to implement the changes. This assessment should reveal key areas for intervention and for capacity building. Those responsible for human resources in Ministries of Health are often junior administrative officers inexperienced in planning and without the power to influence change.

The translation of change requirements in the area of human resources will almost certainly require substantial development of systems and skills (such as those required for the development of information strategies) and this is usually underestimated.

Development of the Necessary Information Base for Decision Making

To guide decision-making for effective change in the human resource field there is the need for information on the current human resources for health situation. Without this, decision-making will be based on assumptions and anecdotes. Decision makers need evidence of who is employed and where, evidence of movements in and out of the health workforce, and evidence of the results of investments in pre-service training. Information on human resources for health in a country, in a form which allows for analysis of the human resource flows (rather than lists of employee names) is a pre-requisite for effective human resource planning and management, but is usually not available.

Building the Commitment of the Health Workforce

Although not directly a strategy for effecting change in the human resources for health arena, the issue of recognising the reactions of the health workforce to planned changes is key to the long-term success of the change programme. Effecting change in the human resource situation is extremely difficult. In general, people resist change, especially if there is some perceived threat to their jobs or to their status.
Preventing the development of active and organised opposition from the workforce is better than having to deal with problems with fire-fighting actions. This requires an appreciation of the possible impact of reforms on jobs and the likely reaction of staff. It also requires the establishment of effective communication systems between employer and employees so that changes do not come without some understanding of the reasons for change and negative effects of the changes on employees are addressed openly.

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