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and Other Health Services

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ISBN-13: 978-0-913723-29-6

Interior design and composition: Ceallaigh Reddy
Proofreader: Kristyn Stem

Funding for earlier versions of chapters 1, 5, and 6 of this publication was provided by the Office of Population and Reproductive Health, Bureau for Global Health, US Agency for International Development, under the Management & Leadership Program, cooperative agreement number HRN-A-00-00-00014-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of USAID.

Printed in the United States of America on acid-free paper by Malloy, Inc.

♾ The paper used in this publication meets the minimum requirements of the American National Standard for Information Sciences—Permanence of Paper for Printed Library Materials, ANSI Z39.48-1992.

Library of Congress Cataloging-in-Publication Data

Tools for planning and developing human resources for HIV/AIDS and other health services.

p. cm.
ISBN-13: 978-0-913723-29-6 (alk. paper)

1. AIDS (Disease)—Patients—Care—Planning. 2. Medical personnel—Supply and demand—Planning. 3. Health facilities—Personnel management. 4. Manpower policy—Planning. 5. Health planning. I. Management Sciences for Health (Firm)

RA643.8.T66 2006
362.196'9792—dc22 2005058391

10 09 08 07 06 05 1 2 3 4 5

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Introduction

Shortages of trained health staff represent a crisis of epidemic proportions in the developing world. In some of the poorest countries, health systems are in danger of collapse due to a lack of health staff to deliver services. Years of underinvestment in human resource development, combined with restrictive employment policies and fragmented, time-consuming, and ineffective human resource management systems, have resulted in health workforces being underpaid, unskilled to deliver new health services (such as antiretroviral therapy), demoralized, and unable to meet demands for even basic health services. Many workers have migrated to other countries or have left the health field all together. The AIDS pandemic has intensified this already serious situation.

While commendable efforts have been made to improve access to prevention, diagnosis, treatment, care, and support for people living with HIV/AIDS in developing countries, efforts to develop the human resources required to deliver and sustain these services have lagged. The AIDS crisis, along with globalization, has worsened imbalances in the distribution of health workers.

Public-sector spending caps imposed over the past decades have exacerbated the human resource crisis. Although spending caps were intended to help meet macroeconomic and fiscal goals, these caps barred expansion of the health workforce and often led to deterioration of human resource capacity when it was most needed to respond to population growth and the increase in workloads caused by the fast-multiplying numbers of people who require HIV/AIDS care. Globalization, meanwhile, has resulted in both larger flows of goods and services, and people seeking employment elsewhere in response to the demand for service providers in resource-rich countries that have not invested adequately in the production of service workers.

Thus, significant staff losses have been incurred in many poor developing countries due to migration as poverty and service conditions have worsened in many public-sector employment areas, particularly in health. Double employment often characterizes the situation in many health service systems, with staff having to make ends meet

by working in both the private and public health sectors. These staff thus cannot provide care of the quality needed in the public environment.

Generalized HIV/AIDS epidemics lead to rising employee attrition, increasing absenteeism, and low productivity in all organizations. Health organizations are no exception; the prevalence of HIV infection among staff and their families reflects their communities' rates and those associated with risks in their workplaces. There are frequent absences from work due not only to illness but also to attendance at funerals and care needs of family members in the most highly affected countries. Managers need to help minimize the effect of HIV/AIDS on their organization's or program's workforce, even as they must prepare to meet growing demand for HIV-related health services.

Lack of basic supplies and life-saving drugs for HIV/AIDS has added to a sense of powerlessness which, in turn, has demotivated staff. Low morale has been exacerbated by lack of access to protective gear and equipment to address staff members' perceived or real infection risks when dealing with HIV patients, reinforcing stigma and fear surrounding the disease. Managers should organize training for their staff, to make sure that they have the information they need to protect themselves and their patients from infection and that staff understand stigma and how to reduce it in health care settings.

If they are working in countries that are decentralizing their health systems, managers are also learning new roles and responsibilities to better serve local populations. All these factors require that health policymakers and managers plan well to maintain adequate numbers of staff and to develop staff skills to meet the challenge of HIV/AIDS while continuing to deliver other essential health services.

Human resource managers can play a key role in developing an effective organizational response to HIV/AIDS. Because they are responsible for recruiting, retaining, and developing staff and supervisors, and for establishing policies and practices, it is essential that they secure executive commitment to assess, improve, and sustain these human resource management (HRM) functions over time. At present, HRM systems are weak and fragmented in most countries. HR professionals are not routinely in place at health facilities and as a result vacancy rates soar, promotions lag, workload increase is routine, job descriptions are out-of-date, and morale is low. In addition, inequities in compensation are becoming more common as donor-funded programs pay some health staff more as an incentive. Inequities stress the morale of teams providing care when some members feel left behind.

In a high-prevalence HIV/AIDS environment, HRM investments may require some hard choices. Human resource managers need to recognize this and convey to others that any investment in strengthening the human resource capacity of an organization is an investment in the people who will make the difference between success or failure in the fight against HIV/AIDS.

Challenges to Scaling Up Access to Human Resources for HIV/AIDS Care

Countries that wish to increase access to HIV/AIDS prevention and care services on a national scale face many constraints, in particular when adding antiretroviral therapy

(ART) services. ART is a new and relatively labor-intensive intervention. It requires an appropriate organization of services to accommodate recurring needs for services such as monitoring patients' progress and deciding about changes in drug regimens. Given the huge treatment needs in some countries, demand will be cumulative. Knowledge about how to organize services for this new kind of chronic care is emerging only now, after service systems have evolved from small beginnings a few years ago. But each country that intends to expand access must study the environment within which services are delivered: the share of the public sector, NGO contributions, and the role of the private-for-profit sector. It is particularly important to analyze the mix of systems and employment in health service delivery systems, which have become increasingly pluralistic. This understanding will help define how the service load can be structured and divided among the players and how human resources need to be developed and made available for deployment throughout the service system.

To scale up services, it is essential to review what staff—in clinics or in communities—are currently allowed to do. Rules and regulations governing the authority to diagnose and treat may need to be adjusted so that more categories of health workers can deliver care. If larger segments of the population are to have access to services, training and re-training that will meet their needs must be established. Service providers have to acquire skills in areas such as nursing, counseling, and pharmacy advice and distribution in order to carry out high-quality services. The vital and increasing role of patients and community members in providing care should also be considered in scale-up operations. Planners need information about the number of clients to determine how to expand services beyond clinics. Then they must review the division of tasks and roles between service providers, on one hand, and patients, their families, and community volunteers, on the other hand, to strike the right balance between service providers' responsibilities for HIV/AIDS prevention and care and the contributions of the community.

Finally, people who have received pre- and in-service training must have supplies and equipment for diagnosis when they return to their duty stations. In other words, all the logistics systems for making services available have to be synchronized. Otherwise staff training may be wasted because supplies, equipment, and pharmaceuticals are not aligned with program activities.

The Purpose of This Book

The tools and guidelines collected in this book will assist health program managers, policymakers, and leaders to assess the impact of HIV/AIDS on the health workforce and its capacity to deliver and scale up HIV/AIDS services. The book provides materials to help decision-makers develop a strategy to mitigate the impact of HIV/AIDS, for both a short-term emergency response and a longer-term plan to strengthen HRM systems. This compilation also includes a tool developed by the World Health Organization to help HIV/AIDS programs to achieve a more sustainable workforce appropriately trained to provide ART. Management Sciences for Health presents a model for building leadership capacity to manage changes that will improve health services.

How This Book Is Organized

Chapter 1, The Human Resources for Health Framework, provides a pathway for national, regional, or district managers to develop a comprehensive plan for addressing the critical shortage of health staff in HIV/AIDS and health services in general.

Chapter 2, Measuring the Impact of HIV/AIDS on Human Resources for Health, presents a comprehensive set of questionnaires and a process to assess the impact of large-scale epidemics on human resources in terms of absenteeism, review of rules and regulations, staff motivation to work in the health services under the impact of HIV/AIDS, and school leavers' disposition to work in the health sector.

Chapter 3, Increasing Access to Antiretroviral Therapy: A Model for Assessing Health Workforce Needs, is a spreadsheet-driven method for assessing the human resources needs for scaling up access to ART based on skills and task distribution.

Chapter 4, Updating Health Workforce Policy, offers a useful approach to developing policy for any setting in which the health workforce is inadequate.

Chapter 5, the Human Resource Management Rapid Assessment Tool for HIV/AIDS Environments, provides an organized approach to assessing and planning actions to strengthen human resource management systems in both public-sector institutions and private-sector organizations.

Chapter 6, Leading Change for Human Resources for Health, contains a model and step-by-step guidance and activities to strengthen leadership at all levels in order to address challenges and improve services.

Chapter 7, the Indicator Guide for Developing and Implementing a National Plan for Human Resources for Health, provides indicators for use in monitoring progress in the HRH planning, assessment, strategy development, and implementation phases.

Together, these materials will help decision-makers shape service development for HIV/AIDS services and identify the accompanying education and training needs.

1 The Human Resources for Health Framework

The Human Resources for Health (HRH) Framework was developed by representatives of multilateral and bilateral agencies, donors, partner countries, NGOs, and the academic community at a technical consultation in Washington, DC, on December 14–15, 2005. WHO and USAID sponsored this meeting, of which the goal was to agree on a simple but comprehensive technical framework to help countries develop a national HRH strategy that can be supported by donors and implemented in a systematic manner. Several existing frameworks were examined as part of the process, including the Human Capacity Development (HCD) Framework developed by MSH with support from USAID.

The HRH Framework provides a pathway for governments and health managers to develop a comprehensive plan for addressing the critical shortage of health staff in HIV/AIDS and health services in general. The benefits of developing and implementing a comprehensive HRH plan include:

- an adequate supply of well-trained health staff;
- high levels of teamwork and staff performance;
- cost savings because of reduced absenteeism and staff turnover;
- a more motivated workforce;
- a healthier population.

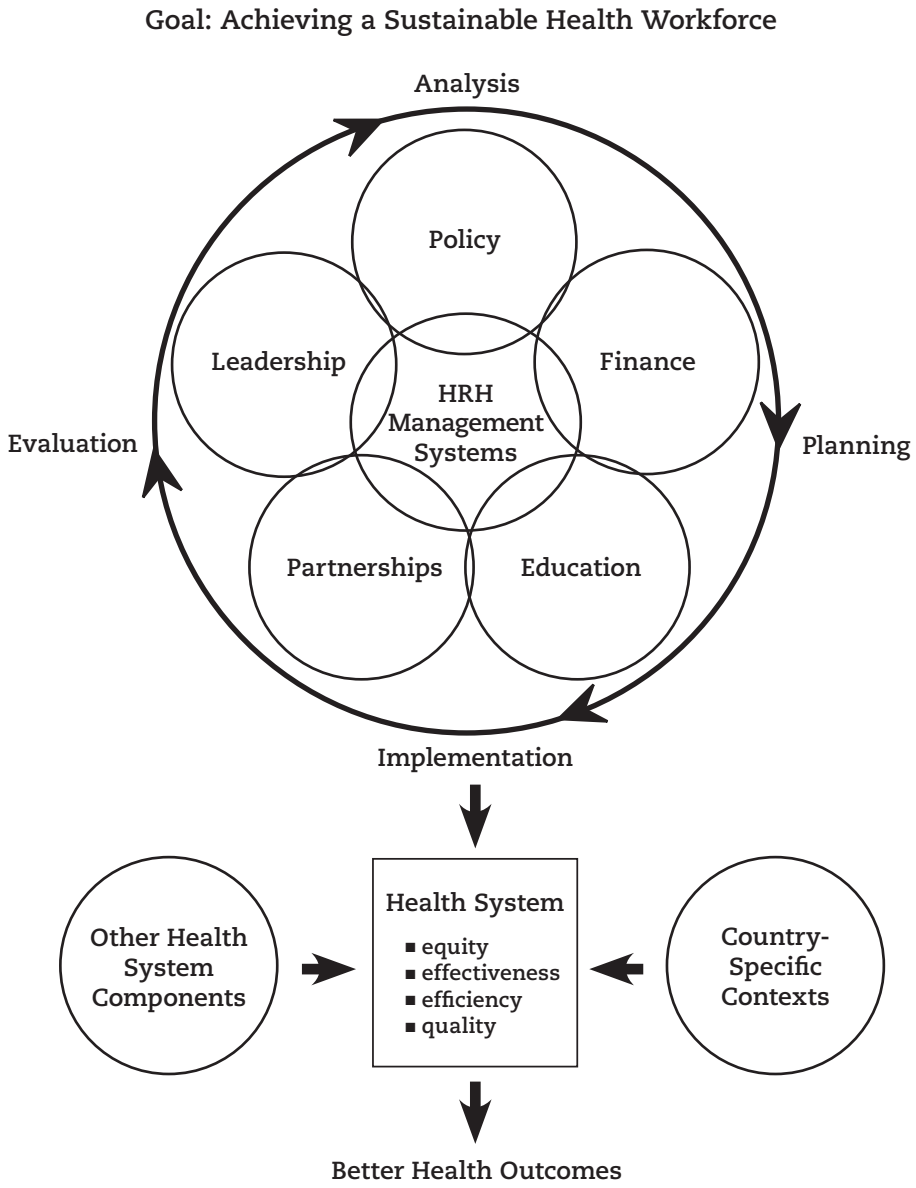
Purpose. To identify and analyze human resource challenges and develop a comprehensive strategy for addressing human capacity development in response to the human resource crisis, especially as it relates to scaling up HIV/AIDS services

Audience. Health program managers, HIV/AIDS program directors, and decision-makers in development

Based in part on "Tackling the Crisis in Human Capacity Development for Health Services," *The Manager* (Boston: Management Sciences for Health), vol. 13, no. 2, 2004. This issue was written by Mary O'Neil and Ummuro Adano. Mary O'Neil is a Principal Program Associate of the Center for Leadership and Management at Management Sciences for Health (MSH). Ummuro Adano serves as the Senior Program Officer of MSH's Africa Regional Office in Nairobi, Kenya.

Process. The HRH Framework (Figure 1.1) presents steps for developing a strategy that will help managers sustain a supply of adequately trained health staff. It examines six components of planning and managing the workforce so that appropriately trained staff are available in the right places at the right time. This framework also suggests actions managers and policymakers can take to address issues in six areas: human resource management, policy, finance, education, partnerships, and leadership. Human resource management systems are at the center of the diagram because of their importance in integrating all the other components.

Figure 1.1. **The Human Resources for Health Framework**



Understanding Health Workforce Development

Health workforce development is a comprehensive process of creating the will, capabilities, and human resource management systems to enable governments and organizations to respond effectively to the human resource crisis. In the health sector, the goal of health workforce development is to develop and sustain an adequate supply of skilled health workers who are motivated to perform at a high level.

Distinguishing Health Workforce Development from Human Resource Management

While human resource management systems are at the center of health workforce development, the latter relies on a comprehensive, multisectoral strategy to increase and sustain the human capacity needed to manage and deliver health services. This strategy focuses on identifying and finding solutions to personnel barriers not only in human resource management, but also in policy, finance, education, partnerships, and leadership. Sustainable human capacity for health services depends on several ministries, agencies, and sectors working together, not just the Ministry of Health.

In contrast, human resource management concerns *internal* organizational management systems and is one of the key building blocks of a comprehensive HRH strategy. Human resource management provides the means by which institutions can translate an HRH strategy into effective human resource practice.

HRH Challenges

While there is growing recognition of the human resource crisis, knowledge about how to tackle it is limited. Funding for HRH and leadership to advocate for a comprehensive, long-term approach are lacking. Donor support tends to focus on HIV/AIDS without taking into account health services as a whole. Problems in HRH are viewed as MOH problems, but solutions require a multisectoral approach. Human resource planners need to fully consider the capacity of communities.

Health managers and donors, who sometimes equate HRH with training, may propose incomplete solutions, such as ad hoc hiring and training. Although training is an essential component of HRH, as a service manager you should plan it in the context of effective human resource management. In some countries, for instance, trained staff are transferred before they have a chance to apply their new skills. Training plans, therefore, should include ways to retain trained staff, such as an agreement with the responsible agency not to transfer newly trained staff for at least two years. An approach that integrates training into a comprehensive HRH strategy will allow you to achieve more sustainable improvements in HRH.

Steps in Developing an HRH Strategy and Plan

Sustainable health workforce development is based on a comprehensive HRH strategy. You need leadership, multisectoral collaboration, and a long-term commitment to create such a strategy, but the results are worthwhile. Begin by establishing an HRH strategy team, which will be responsible for taking the steps in the next section. Then you and the strategy team can decide on actions to overcome the problems in delivering health services that concern your program the most.

Putting Together an HRH Strategy Team

A coordinated effort is essential to address human capacity. This effort involves ministries of health (including the office in charge of health sector reform), education, and finance, the Public Service Commission, representatives of provincial and local health commissions, and representatives of professional associations, labor unions, health training institutions, and the private sector. If you are working at the national level, your HRH strategy team should include leaders from these agencies and institutions who are knowledgeable about human resource issues. They will need to support the implementation of the HRH strategy with sound policies and innovations that foster efficiency and effectiveness in institutional arrangements. You will need their support to develop and implement an HRH strategy that will produce streamlined human resource management systems and strengthen links among stakeholders at all levels of the health system.

The team should be small enough to allow for rapid decision-making and have the authority to pull together larger groups as needed to provide information on specific HRH issues. The team should ideally have a budget to hire consultants to gather data (on current levels of health staff, attrition rates, and numbers of students in pre-service health programs) make projections of the human resource supply, and coordinate and record the activities of the team. See Box 1.1 for criteria for choosing team members.

Box 1.1. Criteria for Choosing Members of an HRH Strategy Team

Seek team members who:

- represent various sectors and institutions;
- have high-level authority and have demonstrated leadership;
- have a history of successful collaboration;
- are knowledgeable about human resource policy and issues;
- understand the staffing requirements for delivering health services;
- can think creatively and comprehensively.

At the district level, the team should include representatives from district health facilities, the District Health Office, nongovernmental and community organizations, and the local hiring authority (for example, the District Service Commission in Uganda).

There are six steps you can follow to develop an HRH strategy with the support and guidance of the HRH strategy team. See Box 1.2.

Box 1.2. Developing an HRH Strategy

Step 1: Gather data. Gather data about the current human resource gaps in health services, and try to project future needs. You will need to document the numbers and types of health workers currently providing services, as well as loss rates. Consider your assumptions about the future before projecting human resource requirements.

Step 2: Compare the data to the requirements of your services. Compare the data to the current requirements of health services at your level, and try to project the impact of changes on those requirements.

Step 3: Identify constraints. Identify constraints to addressing the human resource gaps in step 1. Examine the root causes of constraints to identify actions you can take.

Step 4: Develop a plan to deal with high-priority issues. Prioritize the HRH issues that need to be addressed and that can be addressed at your level. Then develop an action plan with timelines and recommendations that deals with the most pressing issues first but does not neglect entrenched HRH problems.

Step 5: Develop an advocacy strategy. Develop a strategy to advocate for change on HRH issues outside your authority. You can prepare a proposal to present to a ministry, donor, or other stakeholder.

Step 6: Seek leadership for implementation. Assemble a multisectoral team of decision-makers to help implement and monitor the results of the action plan.

Applying the HRH Framework

You should use the HRH Framework to identify the key findings and analyze constraints to addressing human resource gaps in the following six components:

- human resource management
- policy
- finance
- education
- partnerships
- leadership

Table 1.1 shows ways to address all these components in developing a strategic approach to HRH.

Table 1.1. The HRH Framework

Component	Goal	Factors in achieving the goal
Human resource management (HRM)	HRM systems are in place that result in adequate and timely staffing, staff retention, teamwork, effective planning and good performance	■ HRM capacity in health facilities, local governments, and local health offices ■ effective personnel systems: planning, recruitment, hiring, transfer, promotion, firing ■ staff retention strategies ■ training aligned with job requirements ■ human resource information systems ■ workplace programs for HIV prevention
Policy	Employment process in government is streamlined; appropriate HR policies are in place and enforced	■ national civil service rules ■ government policies and structure for HRM (such as centralized hiring and firing) ■ authorized scopes of practice for health cadres
Finance	Approved budget is adequate to sustain projected health workforce requirements. Allocation authority is aligned with technical and management planning and decision-making.	■ health expenditures ■ salary structures ■ incentives to prevent migration of health staff ■ support for pre-service and in-service training ■ administrative costs for recruitment, hiring ■ supervision ■ accountability
Education	Pre-service training institutions have the capacity to meet demand for essential health workers and to adapt curricula as needed for new content requirements	■ enough institutions to train all required health cadres ■ adequate number of lecturers and tutors who meet quality standards for both content and teaching capacity ■ training programs that match demand for health cadres and include essential content (clinic management, health management information systems, etc.) ■ availability of equipment and supplies needed for pre-service training
Partnerships	Planned linkages among sectors, districts, and nongovernmental, community, and religious organizations increase human capacity	■ effective linkages among public-sector, private-sector, and community networks ■ collaboration between MOH and ministries of finance and education
Leadership	Managers at all levels demonstrate that they value health workers and provide staff with leadership to face challenges and achieve results	■ visionary leadership ■ advocacy for reform of human resource policies ■ leadership development for managers at all levels

You can do many things to address each of the six components of the HRH Framework but a fragmented approach to HRH will not result in sustainable change, although it can provide short-term relief in one area. As you develop an HRH strategy, you will need to deal with all six components at the same time. For example, it is critical to address the policy and financial implications of health sector reform. But success in these components will not improve health services if the human resource managers in your facility cannot turn these policy changes into practices that create positive workplace conditions. Likewise, even a well-managed health facility will not be able to cope with the overwhelming demands related to HIV/AIDS if you do not form partnerships with the community. Finally, leadership at all levels is critical for each component, to develop human capacity that can be sustained.

The following sections focus on the six components of the HRH Framework and how you can use them to gather and analyze data (steps 1–3) and plan and advocate HRH interventions (steps 4–5). The policy and finance components are more relevant for the national level, but regardless of the level of your HRH strategy team, there are actions you can take.

Component 1: Improve Human Resource Management

Your objective is to make sure that human resource managers have the systems, capacity, and authority to foster adequate staffing, retention, teamwork, and performance. Fragmented, politicized human resource management systems and lack of human resource managers are two barriers to achieving this objective.

Human resource management systems are fragmented. Weak personnel systems (for example, lack of job descriptions) contribute to poor staff morale. In many countries, human resource management systems in the public sector are fragmented. Politicization and fragmentation of the recruitment, deployment, and promotion processes often prevent the health workforce from achieving its potential. For example, the people responsible for human resource planning in health are often in the Ministry of Health, while the authority for recruitment and hiring rests with the Public or Civil Service Commission. Most countries and organizations also lack a long-term training plan for health workers, which results in ineffective training.

There are few human resource managers. Further, most health facilities do not have a human resource manager with decision-making authority. The current system of personnel administrators who keep track of administrative decisions is inadequate because they have limited authority to address problems. Trained and experienced human resource managers can play a vital role in developing strong human resource management systems that integrate the planning, hiring, deployment, training, and development of health staff. With proper authority, human resource managers can also lead an organizational response to problems such as staff attrition, low morale, and inequities in salary, promotion, and allowances.

You can assess the strengths and weaknesses of your HRM system using a tool such as MSH's Human Resource Management Rapid Assessment Tool for HIV/AIDS Environments (see chapter 5). Use the results of your assessment to develop an action plan to address the most pressing issues. Actions could include those shown in Box 1.3.

After developing your action plan, you can improve human resource management by addressing priority issues such as staff retention, lack of financial resources, training, and supply management. Good human resource management (for example, salaries paid on time and rapid response to complaints) can prevent staff from becoming frustrated and seeking employment outside the health sector.

Work to retain staff. The most important goal of a human resource manager is to retain qualified staff. While most local facilities cannot increase salaries, there are things you can do to foster retention. Consider equalizing salaries and benefits, providing supportive supervision and opportunities for staff development, and cultivating a workplace climate that respects and values the work of staff. Participatory decision-making and reasonable workloads contribute to workers' satisfaction.

Make the most of limited resources. You can improve the capacity and performance of health staff—and sometimes their numbers—even if you have limited resources. For example, even district health management teams with few resources can conduct on-site training to motivate staff. (Off-site training is impractical when there are staff shortages.)

Box 1.3. Actions to Improve Human Resource Management

- Designate a senior manager to be in charge of human resource management (and provide training for her or him if needed).
- Introduce workplace HIV prevention strategies to minimize staff infection.
- Plan for minimizing the impact of HIV/AIDS through flexible staffing, training, collecting employee data on attrition, absenteeism and use this data for planning.
- Extend the benefits program to maximize staff retention.
- Develop and enforce policies that do not discriminate against people with HIV in hiring, transfer, promotion, and discipline.
- Work with professional associations to redefine authorized scopes of practice of health staff.
- Streamline the planning, recruitment, and hiring process.
- Strengthen supervision, performance management, supply management, and information systems.
- Work with service providers to plan and develop on-the-job, skill-based training.
- Address inequities in staff workload, salaries, and allowances.

Plan training as part of HRH. Your HRM system should include a training plan, with criteria for selecting participants and means of tracking who has been trained and of monitoring the impact of training. Training alone, however, will not solve HRH problems. In the area of maternal/child health, for instance, many countries have tried to address the lack of midwives by training traditional birth attendants. Substantial resources have been invested in this approach, but maternal mortality has not been significantly reduced, partly because the major causes and timing of maternal deaths were poorly understood. This problem is now being recognized, and many countries are investing more in training and supporting midwives rather than traditional birth attendants.

Manage supplies. Good supply management is also critical to prevent common problems such as drug stock-outs and equipment shortages. Using human resources well depends on the timely provision of these components of care, which affect service quality, staff morale and attitudes, patient satisfaction, and ultimately health.

Component 2: Address Policy Requirements

Your objective in addressing policy requirements is to help streamline the employment process in government and develop policies that support HRH in both the public and private sectors. You will need to consider how to deal with detrimental personnel policies, low salaries, and barriers posed by national civil service rules.

Unfavorable personnel policies result in shortages. Many countries have unknowingly made staff attrition worse by ignoring detrimental personnel policies, such as mandatory retirement ages, and by not providing opportunities for promotion. Such policies result in experienced staff leaving their jobs at a time when they are still needed. In some cases, national medical boards do not authorize health staff to perform services they could easily provide. In other cases, national governments have adopted policies that have resulted in production of an inadequate number of health workers. For example, in the early 1990s, many programs for community health nurses were abandoned in favor of programs for professional nurses, who are now being lured to other countries, adding to the human resource shortage in the country that trained them.

Low salaries lead to migration. Low salaries are one of the major causes of staff migration: For example, the World Health Organization reports that nurses in Australia receive 25 times the wages of nurses in Zambia, 14 times the wages of nurses in Ghana, and about twice the wages of nurses in South Africa. Differences are similar for physicians (WHO, Oct. 2003). Most managers cannot address this issue, however, since low salaries are tied to poor economic conditions and inappropriate priorities for public expenditure. But good leadership and policy reform can result in more equitable distribution of salary and allowances. Improving management can allow you to increase health expenditures and wages.

Box 1.4. Actions to Address Policy Requirements

- Conduct a survey of the health workforce to identify gaps in staffing to use as a baseline for your HRH strategy. You can use the WHO questionnaires in chapter 2, "Measuring the Impact of HIV/AIDS on Human Resources," to obtain this information.
- Collect data on numbers of staff who leave the health sector, and develop policies and incentives to minimize staff migration.
- Gather data on the numbers of staff leaving due to illness or death from AIDS, and develop an HIV workplace prevention program.
- Address constraints in national civil services rules and decentralization to managing human resources more effectively throughout the health system.
- Analyze barriers in personnel policy that contribute to staffing shortages, and make or recommend policy changes.
- Realign activities that health cadres are authorized to perform to allow more flexibility and efficiency in providing services.
- Advocate for changes in policies that fall outside your authority. For example, in Mombasa, Kenya, Coast Provincial General Hospital gathered data on workload figures and staffing levels, which were used to substantiate the need for five new laboratory technologists.

National civil service rules contribute to inadequate human capacity. Government policies often do not fully provide managers with the authority to carry out important human resource functions or budget funds to carry out those functions. For example, in many countries, the central level must approve all promotion and hiring decisions, causing long delays in promotions for health workers. In most countries, the health

facility must request positions and wait for them to be established and funded by the Ministry of Finance. Then the health facility may have no influence over who is hired. For example, in some countries, the Ministries of Public Service and Finance establish and fund positions. But since the District Service Commission is responsible for filling positions at the district level, staffing is delayed because the District Service Commission has no funds to carry out recruitment and hiring.

Begin by gathering data (step 1) about policy and financial requirements you need to address. You can use that information as a basis for making or advocating for changes, as the list of actions in Box 1.4 illustrates.

Component 3: Finance

Your objective in addressing the finance component is to ensure that the personnel budget that is approved is in line with the expenditure needed to develop, deploy, and sustain an adequate health workforce. This budget will include expenses for salaries, allowances and benefits, as well as pre-service training, in-service training, and staff development. Money will also need to be budgeted to support incentive programs, such as rural posting packages, and to support basic management functions, such as planning, recruitment, hiring, and human resource information systems. It is also important that financial allocation authority be vested with those who are responsible for making program design and management decisions.

Low salaries contribute to migration. Even the most talented, motivated staff are likely to become demoralized when they are poorly paid, and will seek opportunities elsewhere. Low salaries are tied to poor economic conditions and inappropriate priorities for public expenditure. Good leadership and policy reform can result in more equitable distribution of salaries and allowances. If salaries are not adequate to meet basic living needs, service staff cannot devote full-time to their service roles.

Pre-service and in-service education. With the increasing toll that migration is taking on the health sector, funding for training health workers must be re-assessed. Often scarce funds are being used to train the cadres of health staff that are most exportable at the expense of training cadres who are more likely to stay in-country. With the more highly skilled staff migrating, in-service training for staff who remain is more critical. Opportunities for staff development not only help staff acquire needed skills, but are also one of the most important factors in an effective retention strategy. Re-examination of the roles of cadres and the training and certification associated with them may change the structure of financial allocations.

Incentives. Pilot programs in several countries (such as Ghana and Zambia) are showing that incentive packages for rural postings can be effective in maintaining the delivery of health services to rural areas. These usually include a salary top-off, housing and education benefits for family members, and guaranteed opportunities for further career development. Funding for successful pilot programs needs to be guaranteed beyond a pilot period. When linked to productivity targets, well-designed incentive programs can lower costs in relation to desired results.

Recruitment, hiring, and deployment. Long delays in recruitment, hiring, and deployment contribute to a loss in the productivity of the health system. Adequate funding must be allowed to support trained human resource managers to carry out these functions in a timely manner.

Information from steps 1–3 of the HRH strategy process will help you develop a list of actions to improve finance. See Box 1.5 for illustrative actions.

Box 1.5. Actions to Improve Finance

- Undertake a salary survey to determine what levels of salary would meet all basic living requirements and contribute to attracting and retaining quality staff.
- Assess existing compensation packages to determine inequities in salary and allowances for staff.
- Review the factors that are motivating desired productivity and target those areas for additional investment.
- Carry out an assessment of training needs to determine the feasibility of offering targeted career development options for health staff.
- Partner with the Ministry of Education to build the capacity for the training needed by health cadres.
- Work with the Ministry of Public Service to determine what financing is needed to streamline the recruitment, hiring, and deployment of staff.

Component 4: Education

Your objective is to ensure that pre-service training institutions have the capacity to meet the demand for health services. You will need to work with the Ministry of Education as well as health managers to understand the critical gaps in the supply of health cadres, including what cadres are migrating in great numbers to other countries. It is not good practice to continue spending the limited resources available on health workers for whom there are no jobs in the system or for health workers who leave the country soon after graduating. The cadres themselves may not be defined in a way that meets current health system goals and requirements.

The leaders of pre-service institutions can be influential in leveraging necessary changes in established or traditional service systems if they are brought into the policy discussion early. Curricula must include essential elements that lead to effective service delivery (such as clinic management skills, supportive supervision, community outreach, and methodologies for monitoring and evaluation and quality assurance). Often pre-service training institutions are unable to meet the demand for health workers because of a shortage of qualified and effective lecturers and tutors, and of equipment (for instance, laboratory equipment to train laboratory technicians). Box 1.6 suggests actions to take.

Box 1.6. Actions to Improve Education

- Analyze data to understand what cadres are being trained more for "export" than to serve the needs of the country.
- Re-examine the roles of the service cadres to determine what is useful for current health goals and what might be changed.
- Review pre-service curricula to verify that the management and planning skills required for effective service delivery are being taught to the right cadres.
- Assess the impact of HIV/AIDS on lecturers and tutors (consider not only mortality, but also functional capacity and quality of instruction).
- Implement an HIV/AIDS education program for the staff of training institutions.
- Incorporate training in antiretroviral therapy, TB DOTS, and community outreach into curricula.
- Work with the Ministry of Education to consider educational incentives as part of an overall retention strategy. (This has been done in the Family Medicine Program at Makerere University in Uganda.)
- Link continuing education to supervision and salary systems.
- Add support programs in teaching and career counseling skills for lecturers and tutors.

Component 5: Establish Partnerships

Your objective in establishing partnerships is to expand the capacity to deliver health services through planned linkages among sectors, districts, and nongovernmental, community-based, and religious organizations.

Use the potential of community health workers. Statistics cannot convey the magnitude of the human resource crisis in health care and the burden of infectious and chronic diseases. Nurses are especially overloaded with duties that could be done by community caregivers. For example, where nurses are burdened with trying to respond to the needs of people living with HIV/AIDS, community partners can provide home and hospice care, nutritional and psychosocial support, and assistance in fostering adherence to ART. Community health workers can also provide support for tuberculosis services and integrated nutrition programs.

Seek partnerships with the private sector to expand services. Partnerships with the private sector are critical, for example, to expand the capacity to provide laboratory services for HIV testing and diagnosis. In most rural areas where health services are provided by nurses, laboratory and pharmacy services are lacking except where there are private providers and people have the ability to pay. Formal agreements between the health sector and these private providers can expand services for all.

Actions such as those listed in Box 1.7 can help you expand the reach of services while relieving overburdened staff.

Box 1.7. Actions to Establish Partnerships

- Create structures, such as hospital boards and community health committees for clinics, to allow community representation in health services.
- Facilitate joint planning between viable local nongovernmental, community-based, and religious organizations, and district health offices.
- Train staff of these organizations in fundraising, governance, and financial and project management.
- Build the capacity and advocacy role of traditional leaders and healers.
- Train district health management teams in developing service-level agreements with civil society groups.
- Increase the participation of groups and departments concerned with education, social development, agriculture, finance, youth, and women's issues to expand resources for and the reach of activities related to health.

Component 6: Build Leadership

Your objective is to develop the ability of managers at all levels to handle challenges in HRH and achieve results in complex conditions. While leaders who set an example by their ethical behavior are needed at the highest level, you can start to address HRH problems at any level by modeling the behavior you want to see in your staff.

Committed, visionary leadership is needed. Visionary leaders are needed at the highest level in all sectors to advocate for HRH and human resource reform and to coordinate a national response to high-priority health problems. Decentralization and new initiatives to improve health sector performance require that senior managers exhibit competencies and attitudes that may not have been rewarded in the past. As the system changes, the people who lead have to change the way they relate to key stakeholders and where they focus their attention. Because people at the top set the tone and are watched by others, they have tremendous influence on the rest of the system and the work climate in which health care providers operate.

At the same time, managers and staff at all levels must guide and support others to face challenges and make progress in improving health outcomes. The human resource crisis is most keenly felt at the service delivery level: staff may face long lines of clients, lack of equipment, shortages of pharmaceuticals, and delays in getting laboratory results. Managers at these sites must take the initiative to solve these problems to the best of their ability with the resources they have.

You can take the kinds of actions shown in Box 1.8 to develop your own leadership capacity and that of your staff and to improve working conditions. See also chapter 6, "Leading Change for Human Resources for Health," in this book.

Box 1.8. Actions to Develop Managers Who Lead

- Conduct an assessment of your work group's climate as a basis for discussing with staff actions you can take to improve work climate. Work with teams to carry out those actions.
- Clarify the job duties of staff, giving supportive feedback, and show appreciation for the work they do.
- Involve employees in setting and monitoring progress toward goals.
- Develop a leadership development program at your level that focuses on teamwork to identify and solve problems, and train local facilitators to carry out this program widely.
- Create a positive work climate by treating people fairly with respect to salaries and benefits.
- Develop mentoring programs for new managers.
- Align key leaders around planning and implementing a coordinated national (or regional, provincial, local, or community) HRH strategy.

Prioritizing and Planning

An HRH assessment is not just a "head count," although it is important to know the total numbers of staff employed in each cadre. But overall numbers of staff do not automatically translate into health system performance. In a human resource assessment, you also need to determine the capacity of HRM systems to absorb, train, supervise, and retain staff, and the national (or regional) capacity to provide both in-service and pre-service training. Once the assessment is complete, analyze the data using the HRH strategy process and HRH Framework. Then you can create a comprehensive set of recommendations for policymakers, donors, and other stakeholders to consider. Include both short-term options to address the immediate crisis and long-term options to build human resource sustainability. Table 1.2 illustrates how you could present options for strengthening human capacity to carry out HIV/AIDS services.

Taking Action to Address HRH Challenges

Longstanding human resource issues, especially in the public sector, will take time to resolve. While you are establishing a long-term HRH strategy, immediate human resource gaps need to be filled to implement critically needed health services. For example, where there is an inadequate supply of trained health workers, you need to identify and coordinate stop-gap measures and seek funding for them. These measures could include:

TABLE 1.2. Sample Recommendations for HRH for HIV/AIDS Services

Component	Short-term activities	Long-term activities
Human resource management	■ Appoint human resource managers at the facility level ■ Institute workplace HIV prevention programs (including postexposure prophylaxis) and psychosocial support groups for staff working in HIV/AIDS services ■ Review staff allowances and incentives to remove inequities	■ Use a multisectoral team to streamline human resource planning, recruitment, hiring, and promotion ■ Implement a performance management system to reward good performance and address poor performance
Policy	■ Advocate lifting hiring freezes for all health cadres ■ Build housing for health workers in rural communities	■ Revise (or advocate revision of) scopes of practice of health cadres
Finance	■ Correct salary inequities among existing staff ■ Conduct salary surveys to determine what level of salary is competitive for attracting and retaining quality staff	■ Lobby relevant policy bodies for competitive salaries and benefits for health workers ■ Review incentives, such as funding education for the children of health professionals in rural areas
Education	■ Assess gaps in skills related to delivering HIV/AIDS services and adjust training accordingly ■ Implement HIV/AIDS education programs for staff and students of training institutions	■ Improve infrastructure of pre-service training to improve the availability of equipment, supplies, and technology
Partnerships	■ Partner with community care groups and develop performance contracts with them	■ Develop a process for joint planning at the district level for the public and private nonprofit sectors
Leadership	■ Conduct a work climate assessment to determine which leadership practices need to be strengthened ■ Implement a leadership development program at all levels	■ Strengthen nongovernmental, community-based, and religious organizations (including organizations of people living with HIV/AIDS) to work at the national level to influence HRH policies

- providing funding for recruitment to groups that are responsible for filling approved positions so they can carry out hiring in a more timely manner;
- directly employing health staff at government salaries to fill critical positions, such as laboratory technicians, until the national government can absorb them;
- changing scopes of practice to enable cadres to carry out work normally done by other cadres if needed;
- exploring other temporary staffing arrangements, such as contracts with skilled foreign nationals;
- providing training and technical assistance on HRM skills to selected staff so they can become human resource managers;
- deploying human resource managers to health facilities;
- providing technical assistance to in-service training institutions to standardize curricula and develop new systems to scale up training rapidly;
- developing formal partnerships with established community service groups to relieve nurses of some of the social-work aspects of care that nurses currently handle.

2 Measuring the Impact of HIV/AIDS on Human Resources for Health: Questionnaires and Guidelines for Administering Them

World Health Assembly resolution 53.14 of May 2000 called upon the World Health Organization to develop a global strategy on HIV/AIDS, which was placed before the Executive Board in 2001. The World Health Assembly approved the strategy to deal with the impact of HIV/AIDS on health workers in 2002 and reaffirmed the commitment to health systems strengthening. A 2002 resolution also called for health services to scale up the availability of antiretroviral therapy. Doing so implied large-scale retraining of existing staff, and it added surveillance of treatment regimens and follow-up to the staff workload. Scaling up also meant that new human resources and infrastructure were needed to deliver these programs. This survey was created to provide the information to develop policy options for human resources in response to the epidemic.

Purpose. WHO developed the questionnaires in this chapter to:

- study the impact of the AIDS epidemic on human resource development and responses;
- provide information on the extent to which HIV/AIDS affects the staffing levels necessary to maintain population health while responding to the unfolding epidemic;
- provide data on additional staffing needs caused by increased HIV/AIDS workload requirements;

Reprinted from Norbert Dreesch, Mario Dal Poz, and Charles Gilks, "Human Resources Development for Health and HIV/AIDS: Study Protocol" (Geneva: World Health Organization, Nov. 2002). Norbert Dreesch is a Technical Officer in WHO's Department of Human Resources for Health, in which Dr. Dal Poz serves as Coordinator for Tools, Evidence and Policy. Charles Gilks is Director of Treatment and Prevention Scale-up in the Department of HIV/AIDS. The forms for this tool are available at http://who.int/hrh/tools/en/.

- obtain planning data for staffing needs resulting from new strategies to reduce mother-to-child transmission of HIV/AIDS and accompanying antiretroviral treatment (ART) goals;
- identify staff training and retraining needs to implement new ART strategies.

Audience. This tool can be used by health program managers, human resource planners, HIV/AIDS program managers at all levels of service planning and administration, and human resource advisors to ministries of health.

Process. After a nationally representative sample of facilities is established, the series of questionnaires in this study is used to collect facility-based information. A pilot study will determine the feasibility of using record reviews for HIV/AIDS morbidity/mortality assessment and identify further data collection needs through staff interviews.

As shown in the workplan (Table 2.1), the HIV/AIDS impact parameters are:

- morbidity/absenteeism
- mortality
- infection risk assessments for different staff categories
- workload assessments for different staff groups
- staff morale
- HIV/AIDS staff infection prevention
- HIV/AIDS and staff workload reduction by enhancing community care
- enabling environment for workforce recruitment
- staff losses.

Table 2.1. **Workplan**

Area	Activity	Rationale for Collection
Morbidity/ Absenteeism	Identification of staff numbers in different staff categories who suffer from HIV-related ill health, e.g., TB per annum at specific time intervals. Review over the last 5–10 years, if records allow; if impossible, perhaps by interviews using the "sisterhood" approach. (This method, which was developed to determine maternal mortality ratios, involves asking women whether they had sisters who died during childbirth. This allows researchers to estimate mortality experience for a specific condition throughout a defined community.)	To assess the staff time required caused by lost working availability
	Review of levels of absences of health staff due to illness and other causes of increased spells of absence (funeral attendance, heightened levels of stress, etc.) during comparative time periods	To assess the staff time required caused by lost working ability
	Review of public service regulations governing long-term illness and capacity to liberate posts for refilling if incumbents face long periods of illness (Problem: Staff on extended sick leave stay in their posts during this period. Administrative rules may need to be changed in light of long-term diagnoses for post incumbents.)	To assess legal hurdles preventing replacement of lost staff working ability

Area	Activity	Rationale for Collection
Mortality	Mortality statistics for different staff categories by cause of death related to AIDS (to include TB and further causes to be specified)	To assess the replacement intake due to death of staff caused by HIV/AIDS
Infection risk assessments for different staff categories	Facility reports and statistics on injuries on duty related to nosocomial infections such as hepatitis B caused by, for example, needle injuries and other modes of virus transmission	To assess the possible magnitude of staff losses caused by HIV by staff category and help to determine replacement needs. Assumptions will need to be developed for survival and remaining service time.
Workload assessments for different staff groups	Facility-based time series data on hours worked and overtime development over comparable time periods. Representative sample studies may suffice to establish a magnitude indicator of the problem.	To assess the staff time required through the introduction of new treatment and prevention strategies. For example, the increased workload caused by mother-to-child transmission of HIV, need for increased institutional delivery for intrapartum antiretroviral administration, increased postpartum care needs for mother and child, and/or increased TB case load.
	Analysis of emerging/emerged differences in staff task distribution due to decreasing numbers of staff	Counting additional hours beyond statutory requirements will identify emerging gaps to be covered by new recruits.
	Review of emerging differences in regions and specific occupational groups, and gender-specific developments	To assess disequilibria in staffing and provide base data for additional intake
Staff morale	Review of reasons for leaving the health services (check with professional associations, one-year cohort review with training institutions)	To assess professional associations' awareness of constraints in the working environment emanating from HIV/AIDS
	Service staff morale: attitudinal survey among hospital staff faced with increasing numbers of patients dying from HIV/AIDS and related diseases. Survey of staff attitudes at outpatient facilities.	To assess likely negative attitudinal impact on retention
HIV/AIDS staff infection prevention	Review of KAP studies measuring existing knowledge of infection prevention amongst service providers	To assess the knowledge of guidelines for infection prevention in force as part of prevention-enabling environment
	Logistics for and adequacy of supplies of protective materials at all facility levels	To assess the physical possibility of practicing prevention
	Staff perception of infection risk; motivation and retention issues	To assess the staff perception of infection risk and distil educational needs
HIV/AIDS and community care	Community HIV/AIDS prevention, communication, and care needs using existing KAP and DHS studies, module on quality of care received, otherwise sample of antenatal/STD/HIV clinic exit interviews	To assess perceived community care needs and allow for staff time needs/workload assessment
	Staff perception of HIV/AIDS tasks that could be provided by the community	To assess possible reductions in staff time by community involvement in prevention and care (ART)

continued on next page

Area	Activity	Rationale for Collection
Enabling environment for workforce recruitment	Educational intake statistics over the past ten years and population growth projections	To provide background information on workforce ageing. At the same time as a large number of health staff are reaching retirement age, increased losses in countries most affected by HIV/AIDS at ages normally representing career entry (20+) lead to a widening gap between supply and demand, if only a few years of healthy life expectancy remain for those affected.
	Study of school leavers' attitudes toward HIV/AIDS and willingness to study for working in a health profession	To assess young people's attitudes toward working in the health sector, establish attitudes on fears related to working in the health sector, and develop counter-information strategies for schools
	Adequacy of current medical education and other health staff training curricula in general and with specific reference to the HIV/AIDS disease burden	To provide information for re-orientation of curricula toward HIV/AIDS prevention and care needs. An analysis of training needs for nursing staff revealed, for example, gross inadequacies in quantity, quality, and type of nursing staff required in a number of sub-Saharan countries.
Staff losses	Assessment of likely losses of public-sector service staff to NGOs and other sectors over time	To inform HR policymakers about training needs for the country at large for the total health provider network. This should be done within an evaluation of total health system/service coverage established in country.

Protocol

Data Collection

The survey will collect the following types of information:

- Facility characteristics
  - Average number of patients, beds, and staff at distinct time intervals
  - Opening times, procedures for treating patients
  - Basic amenities and physical characteristics of the service and its location
  - Presence of HIV/AIDS prevention materials and equipment (gloves, functioning autoclave, etc.)
- Staff experience of care
- The work environment, via staff reports, and, if necessary, knowledge of colleagues who succumbed to illness related to HIV/AIDS
- Staff health statistics (HIV/AIDS-related morbidity and mortality), via record reviews

Methods of Data Collection

Data collection methods will include record reviews and interviews with the facility manager and representative samples of staff in large institutions. All staff at health center level and below should be interviewed.

Survey Proceedings

The survey will be carried out in two phases: the pilot phase (Phase I) and the survey phase (Phase II).

I. Pilot phase. The piloting of the survey involves a series of steps undertaken before the main phase of the study begins, to test survey procedures and implementation. It provides an opportunity to evaluate the survey procedures on a small scale and to make adjustments as necessary. In this phase:

- have the survey instruments and other materials translated into the local language, if necessary;
- recruit and train investigators and interviewers using the materials;
- carry out the interviews with staff, and evaluate the validity and reliability of tested instruments;
- identify staff health records at facilities for five-year intervals. Determine if different methods for finding information about HIV/AIDS among staff need to be considered.

II. Survey phase. In this phase a facility survey will be conducted. The fieldwork will be supervised and follow quality assurance procedures.

Administrative and Ethical Aspects

The survey will be conducted in accordance with the principles expressed in the Helsinki Declaration. Since this project involves health service institutions, before starting the survey, the collaborating researchers will obtain permission from the relevant facilities and their governing bodies to conduct the survey as part of their ongoing collaboration with national health staff.

Before conducting any staff interviews, the objectives of the survey will be explained to the respondent, and the interviewer will ask respondents to sign an informed consent form. Participation is voluntary and those who refuse to participate will not be re-contacted.

All data collected will be stored and analyzed confidentially. Computerized information will be stored in such a way that access to individual results will be possible only through a separate database of names and corresponding identification numbers in each collaborating center. Identification numbers or similar information will not be transferred from one partner to another. Where applicable, the sample of participants will be registered under data protection registration. If requested, results from the study will be communicated to respondents.

Cover Portion of Each Questionnaire: Identification

Each of the forms includes an identification section like the one that follows, taking into account space concerns and ease of having all information on a single sheet and thus avoiding errors of recording and assignment.

It is important to recall that the interviewer must assure the person questioned of the complete confidentiality of the enquiry before asking question. It is also important to obtain consent from the person being interviewed prior to proceeding.

Name/Code of the Interviewer (All Forms)

The name of the field investigator conducting the interview should be recorded. A unique identifying number should be assigned to each investigator so that later questions can be resolved by asking for clarification.

Questionnaire

Health Service and Human Resources Planning

Country Name: _____

District Name: _____

Investigator: _____

Institution: _____

Information on the Survey

Health Service and Human Resources Planning

Over the last decade health services have come under more and more pressure, with ever more patients presenting for preventive and curative demands. Planning for services and adequate numbers of skilled staff has become increasingly important.

The Ministry of Health would like to address this issue. As you are aware, we are facing a number of problems in health services and their delivery. As health service staff we are, of course, close to the suffering and the burden which old and new diseases impose on us. Working in health services we are faced daily with the consequences of diseases that we all have difficulties in coping with. HIV/AIDS is one of them. It provokes fears and may challenge our own moral convictions and humanity. Working in health services we know this only too well yet we quietly cope with it daily.

But we also need to face the disease with an open mind as health service professionals. The ministry has therefore decided to deepen our understanding of how this disease affects the functioning of services and how we can plan better to maintain standards of care. With the burden of disease also mounting due to HIV infections, we need to assess how much time is needed to attend to patient suffering from diseases associated with HIV as we are planning to rapidly increase access to antiretroviral therapy.

Your cooperation and interest in contributing to better workforce planning are therefore requested. Your answers will provide important information to adjust the workforce and provide training in view of the challenges before us. You may find some of the questions difficult to answer. If that is the case, please say so and if you do not wish to continue with the questions you may stop at any time. This is a completely voluntary survey, and there is no obligation on you to take part in it.

It is, of course, understood that the answers you provide will be used only for purposes of calculating workforce needs. All answers will be handled confidentially. The questionnaires and the form recording your agreement to take part in the study will be kept separately. None of the information collected will be able to be traced back to those providing the information.

You may, however, decide that you do not wish to take part in this exercise and this will be fully respected.

In case you have questions later on, please contact the Principal Investigator:

Name: _____

Address: _____

Telephone: _____

Consent Form

Health Service and Human Resources Planning

Invitation to Participate in This Study

This questionnaire is undertaken on behalf of the Ministry of Health. It consists of one interview of approximately **40 minutes**. Responses will be kept **anonymous** and **strictly confidential**. Your name will not appear anywhere related to this information. The information that you provide will be used solely for the purposes of health and human resource planning.

Main objectives of this questionnaire

(1) to understand the challenges faced by staff in performing their duties
(2) to ask for recommendations on how to improve the delivery of health services

Main goals of this questionnaire

(1) to find out about the state of occupational health and time requirements for HIV/AIDS patient care
(2) to find out about staffing requirements to cope with increased service demand caused by HIV/AIDS

Do you have any questions regarding this study?

The undersigned agrees to participate by answering the following questionnaire to the best of his/her ability, and to release this information to the Ministry of Health for planning purposes.

Signed: _____ Date: _____

In case you have questions later on, please contact the Principal Investigator:

Name: _____

Address: _____

Telephone: _____

Record Reviews and Sample Questions

The purpose of this document is to provide background information about what is intended by each question in the survey. A separate questionnaire should be filled out for each health occupation (doctors, dentists, pharmacists, nurses, etc.). Questionnaires can be completed by means of one or more interviews, examination of relevant documents, or a combination of these. Questions have, to a large extent, been kept in a simple Yes/No format for which the interviewer should either put 1 for Yes or 0 for No. This will provide ease of data entry. In some instances, if the answer of the respondent is positive, the interviewer is requested to ask for a specific time estimate and enter it into the Yes/No box. Again, this cuts down on the number of questions to be asked and allows the data entry cell to be multipurpose.

The investigation has two parts: record reviews on morbidity and mortality, and staff interviews covering similar and additional areas included in the record reviews. The idea is that records on staff morbidity and mortality may be difficult to come by. Therefore, staff will be asked similar questions in order to have at least an experience-based account of the morbidity and mortality development since the HIV/AIDS epidemic started to unfold.

Categories of data to be collected vary from form to form, but this is self-evident. All data types to be collected are explained below. Instructions for interviewers are printed in italics and preceded by "Interviewer."

Administration/Organization Visited (Form 1)

This is likely to be a national administrative office. Record all sources consulted in order to complete the questionnaire.

Name of the Hospital, Health Center, Health Post (Forms 2–7)

Insert the name of the facility where the interview is conducted here.

Type of Facility (Forms 2–7)

To obtain data which will allow for analysis of information for staff at different facility levels, the type of facility should be identified here. The categories proposed are national hospital (1), district hospital (2), health center (3), and health post (4). There are no standard descriptions for these facility types that can be universally applied. Each country needs to decide under which of these broader categories it wishes to have the data recorded.

Health Occupation/Staff (Forms 2–7)

One questionnaire should be completed for each health service provider interviewed. Definitions of the occupations will depend on the criteria or norms used in the country, though the same broad categories should be maintained. Record the name of the occupation under "other" only if an occupation does not fall within the given options.

This section and all subsequent sections should be completed by means of personal interviews and/or examination of relevant documents.

Form 1: Service Regulations

National Survey on the Impact of HIV/AIDS on the Health Services: Service Regulations (Form 1)

Interviewer/Code: Administration/organization visited:

Administrator interviewed:

Instructions for the interviewer:

If a question does not apply, write NA in the box. If staff answer don't know, write DN in the box.

Say the following to the staff to be interviewed: *"I am going to ask you several questions. Not all of them may be related to your work, so let me know if a question does not apply to you or if you don't know the answer. Please be assured that all answers will be kept in strict confidence."*

1	Are regulations in force governing extended sick leave?	Yes = 1 No = 0	
2	If Yes, ask: How many days can staff be away on sick leave?	Days	
3	Do staff continue to receive a salary when they are on extended sick leave?	Yes = 1 No = 0	
4	At the end of extended sick leave, do staff continue to receive their salary?	Yes = 1 No = 0	
5	Is there a fund to pay staff a salary replacement while on extended sick leave?	Yes = 1 No = 0	
6	Can a post occupied by staff on extended sick leave be filled during the absence?	Yes = 1 No = 0	
7	Is there a register of sick leave days at national level?	Yes = 1 No = 0	
8	Is there a register of sick leave days at district level?	Yes = 1 No = 0	
9	Is a register of sick leave absences kept at this facility?	Yes = 1 No = 0	
10	Is sick leave development monitored over the year?	Yes = 1 No = 0	
11	Is maternity leave a statutory right?	If yes, number of days; if no, 0	
12	Is there a staff mortality register?	Yes = 1 No = 0	
13	Is there a registry of injuries on duty?	Yes = 1 No = 0	
14	Are staff losses calculated to monitor service productivity?	Yes = 1 No = 0	
15	Are developments in staff absences reviewed regularly to modify staffing plans?	Yes = 1 No = 0	

1. Are regulations in force governing extended sick leave?

Regulations are all government laws or staff rules which determine how extended absence periods are to be treated by the employing agency (state, private service provider).

2. If YES, ask: how many days can staff be away on sick leave?

This question is to find out when the employer must take action to re-fill a position which is occupied by someone who is ill for a long time. This information will allow a better understanding and permit comparisons of required waiting periods in various settings before staff can be relieved of acting duties for terminally ill colleagues.

3. Do staff continue to receive a salary when they are on extended sick leave?

For filling of positions occupied by terminally ill health staff, it is important to know whether there are provisions to replace salary payments from different sources than the ones which normally provide salary funds. If, for example, health insurance premiums collected every month contain a portion for salary replacement in time of prolonged illness; the community of all insured provides for long-term illness salary replacement. The employer will then be able to replace the person who is away because of long-term illness with a new recruit for the interim period but will not have to finance both the incumbent of the post plus a replacement.

4. At the end of extended sick leave, do staff continue to receive their salary?

In conjunction with question 3, this question exists to find out whether a staff salary which is budgeted continues to be used for staff whose extended sick leave period has come to its end, or whether other funding mechanisms are in place to cover staff unable to take up work after the period has come to its end. Again, knowing about these provisions will enable policymakers to decide on how to deal with the financial implications of staff on long-term illness as happens to be the case with HIV/AIDS sufferers.

5. Is there a fund to pay staff a salary replacement while on extended sick leave?

The answer to this question will show whether the government has put provisions in place to allow hiring replacements from existing budgets while those subject to long-term illness still receive a salary replacement.

6. Can a post occupied by staff on extended sick leave be filled during the absence?

This question is to identify whether there are administrative or personnel rules which bar employers from filling an existing position if the incumbent is ill on a long-term basis.

7. Is there a register of sick leave days at national level?

National human resource planning benefits from information about the level of absences likely to be incurred during a year for each category of staff. This helps to project intake and replacement needs in sufficient numbers.

8. Is there a register of sick leave days at district level?

In case there is no national level sick leave register, district administrations may keep such information.

9. Is there a register of sick leave days at this facility?

In case there are neither national nor district records, it may need to be established whether facilities keep track of absences for each staff category.

10. Is sick leave development monitored over the year?

Proper monitoring of sick leave over the year helps managers plan for regular seasonal variations due to illnesses affecting a high proportion of staff.

11. Is maternity leave a statutory right?

Knowledge of the likelihood of absence due to pregnancy and childbirth will, again, provide valid input data for estimating the correct number of staff needed to provide sufficient staff coverage. If there is such a provision, the interviewer will request and record the number of days of entitlement.

12. Is there a staff mortality register?

It may be that staff mortality is tracked to monitor injury on duty or that a professional association has an interest in keeping these data. The interviewer would need to establish whether such a record exists.

13. Is there a register of injuries on duty?

Information about the number of injuries incurred on duty allows estimation of absence periods for recovery and helps to establish replacement needs.

14. Are staff losses calculated to monitor service productivity?

An annual overview of staff losses helps to establish baseline data for replacements needs.

15. Are developments in staff absences reviewed regularly to modify staffing plans?

Monitoring staff absences helps to establish trends in staff morbidity and mortality. Knowing these trends makes it easier to foresee replacement needs.

Form 2: Mortality

HIV/AIDS is taking its toll on health service staff, as in every other segment of society. A review of staff mortality by cause will illuminate the size of staff losses due to diseases associated with HIV/AIDS. Looking at staff losses due to major categories of cause of death for time intervals of five years since 1990 will help to establish a trend. These data will not be easy to identify, unless there are national or district records kept on staff attrition by cause. Those guiding the research will need to see whether this information can be obtained from existing records. If not, staff interview questions on Form 7 will address the issues in a similar manner.

If data exist, first organize the data for staff mortality according to major causes of death. Then record numbers by cause, add them, and write the totals in the column on the right side.

The categories of staff proposed (doctors, nurses, midwives) need to be seen in light of national definitions governing professional titles and working tasks. Data should be captured for 1990, 1995, and 2000.

Important note: When conducting record reviews, utmost care must be exercised so data are aggregated only in such a manner that it is impossible to trace them back to individuals. It may be useful, therefore, to see if secondary sources of aggregated data are already available in country (e.g., professional associations may already have developed an interest in monitoring staff health and keep such statistics). If not, source data should be obtained in such a way that only data sheets with aggregated data leave the medical statistics or personnel data section, and no data can be traced back to individuals.

National Survey on the Impact of HIV/AIDS on the Health Services: Mortality (Form 2)

Interviewer/Code: Name of the hospital or health center/post:

1 District:
Type of facility (national hospital=1, district hospital=2, health center=3, health post=4): _____
(In hospitals, department: _____)

2 Facility operator (government=1, private, for-profit=2, organizations: nongovernmental=3, charity=4, religious=5): _____

Record review: Number of staff deceased during the following years.

Instructions for the interviewer:

If possible, write down the main causes such as TB and number of deaths in the "Causes" boxes below. Do not write names or other ways to trace back the information in any way.

	Year	Category	Total no. stationed	Cause 1	Cause 2	Cause 3	Cause 4	Cause 5	Total
3	1990	Doctors							
4		Nurses							
5		Midwives							
6		Auxiliary nurses							
7		Auxiliary midwives							
8		Comm. health workers							
9		Pharmacists							
10		Physiotherapists							
11		Laboratory technicians							
12		Cleaners							
13		Drivers							
14		Others (specify):							
15									
16									
17	1995	Doctors							
18		Nurses							
19		Midwives							
20		Auxiliary nurses							
21		Auxiliary midwives							
22		Comm. health workers							
23		Pharmacists							
24		Physiotherapists							
25		Laboratory technicians							
26		Cleaners							
27		Drivers							
28		Others (specify):							
29									
30									
31	2000	Doctors							
32		Nurses							
33		Midwives							
34		Auxiliary nurses							
35		Auxiliary midwives							
36		Comm. health workers							
37		Pharmacists							
38		Physiotherapists							
39		Laboratory technicians							
40		Cleaners							
41		Drivers							
42		Others (specify):							
43									
44									

Form 3: Morbidity 1

Please be aware of the need for privacy protection indicated under Form 2, "Important note."

Absence due to illness is an important factor for planning of human resources. Trends in absence development due to HIV/AIDS need to be studied to enable managers to plan for sufficient amounts of staff on duty. If possible, absence periods should be recorded, by cause, for the staff categories indicated. The total number of sick days for every staff category as well as the total number of staff sick during the reference period should be calculated.

For staff category classification issues, see comments under Form 2.

National Survey on the Impact of HIV/AIDS on the Health Services: Morbidity 1 (Form 3)

Interviewer/Code: Name of the hospital or health center/post:

1 District:
Type of facility (national hospital=1, district hospital=2, health center=3, health post=4): _____
(In hospitals, department: _____)

2 Facility operator (government=1, private, for-profit=2, organizations: nongovernmental=3, charity=4, religious=5): ___

Record review: Number of staff days lost during the years indicated below.

Instructions for the interviewer:

Get the total number of staff first. If possible, find out about the four main causes of ill health such as TB, and write them down under the "Main causes" boxes. Then add up the numbers of sick days for each staff category in the boxes below. If it is not possible to get the numbers by cause, write down only the total number of sick days recorded for each staff category. Finally, record the total number of staff who were sick for each staff category and year.

				Number of sick days reported for staff due to:						
	Year	Category	Total no. stationed	Main cause 1	Main cause 2	Main cause 3	Main cause 4	Other	Total no. of sick days	Total no. of staff sick
3	1990	Doctors								
4		Nurses								
5		Midwives								
6		Auxiliary nurses								
7		Auxiliary midwives								
8		Comm. health workers								
9		Pharmacists								
10		Physiotherapists								
11		Laboratory technicians								
12		Cleaners								
13		Drivers								
14		Others (specify):								
15										
16										
17	1995	Doctors								
18		Nurses								
19		Midwives								
20		Auxiliary nurses								
21		Auxiliary midwives								
22		Comm. health workers								
23		Pharmacists								
24		Physiotherapists								
25		Laboratory technicians								
26		Cleaners								
27		Drivers								
28		Others (specify):								
29										
30										
31	2000	Doctors								
32		Nurses								
33		Midwives								
34		Auxiliary nurses								
35		Auxiliary midwives								
36		Comm. health workers								
37		Pharmacists								
38		Physiotherapists								
39		Laboratory technicians								
40		Cleaners								
41		Drivers								
42		Others (specify):								
43										
44										

Form 4: Morbidity 2

This form is used to establish differences in absence periods for men and women in each staff category. The information on length of periods of illness is a further qualifying factor for planning of human resources. For staff category classification issues, see comments under Form 2.

National Survey on the Impact of HIV/AIDS on the Health Services: Morbidity 2 (Form 4)

Interviewer/Code: Name of the hospital or health center/post:

1 District:
Type of facility (national hospital=1, district hospital=2, health center=3, health post=4): _____
(In hospitals, department: _____)

2 Facility operator (government=1, private, for-profit=2, organizations: nongovernmental=3, charity=4, religious=5): ___

Record review: Duration of illness.

Instructions for the interviewer:

Write down the number of days of illness recorded for the staff categories for the time spans below. Do not write names or other ways to trace back the information in any way.

			Number of staff who were recorded off sick for:									
			0.5–7 days		7.5–14 days		15–30 days		More than 30 days		No return	
	Year	Category	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
3	1990	Doctors										
4		Nurses										
5		Midwives										
6		Auxiliary nurses										
7		Auxiliary midwives										
8		Comm. health workers										
9		Pharmacists										
10		Physiotherapists										
11		Laboratory technicians										
12		Cleaners										
13		Drivers										
14		Others (specify):										
15												
16												
17	1995	Doctors										
18		Nurses										
19		Midwives										
20		Auxiliary nurses										
21		Auxiliary midwives										
22		Comm. health workers										
23		Pharmacists										
24		Physiotherapists										
25		Laboratory technicians										
26		Cleaners										
27		Drivers										
28		Others (specify):										
29												
30												
31	2000	Doctors										
32		Nurses										
33		Midwives										
34		Auxiliary nurses										
35		Auxiliary midwives										
36		Comm. health workers										
37		Pharmacists										
38		Physiotherapists										
39		Laboratory technicians										
40		Cleaners										
41		Drivers										
42		Others (specify):										
43												
44												

Form 5: Overtime

Another way of estimating human resource needs as they develop over time is to look at overtime. Again, the review periods here cover the years 1990, 1995, and 2000. If none of the other information is available, overtime records are likely to be kept at facility level. A trend may be able to be distilled from these data for different staff categories.

For staff category classification issues, see comments under Form 2.

National Survey on the Impact of HIV/AIDS on the Health Services: Overtime (Form 5)

Interviewer/Code: Name of the hospital or health center/post:

1 District:
Type of facility (national hospital=1, district hospital=2, health center=3, health post=4): _____
(In hospitals, department: _____)

2 Facility operator (government=1, private, for-profit=2, organizations: nongovernmental=3, charity=4, religious=5): ___

Instructions for the interviewer:

Write down the overtime for each staff category using the reference used (hours or days) in the records. If the years below cannot be traced, use the ones available, and write down the year. Do not write names or other ways to trace back the information in any way.

			Overtime	
	Year	Category	Hours recorded	Days recorded
3	1990	Doctors		
4		Nurses		
5		Midwives		
6		Auxiliary nurses		
7		Auxiliary midwives		
8		Comm. health workers		
9		Pharmacists		
10		Physiotherapists		
11		Laboratory technicians		
12		Cleaners		
13		Drivers		
14		Others (specify):		
15				
16				
17	1995	Doctors		
18		Nurses		
19		Midwives		
20		Auxiliary nurses		
21		Auxiliary midwives		
22		Comm. health workers		
23		Pharmacists		
24		Physiotherapists		
25		Laboratory technicians		
26		Cleaners		
27		Drivers		
28		Others (specify):		
29				
30				
31	2000	Doctors		
32		Nurses		
33		Midwives		
34		Auxiliary nurses		
35		Auxiliary midwives		
36		Comm. health workers		
37		Pharmacists		
38		Physiotherapists		
39		Laboratory technicians		
40		Cleaners		
41		Drivers		
42		Others (specify):		
43				
44				

Form 6: Injuries on Duty

A review of the injury on duty records may reveal further information on risk development over the past ten years. Data should be collected within the framework of 1990, 1995, and 2000. It should be organized by magnitude of cause of injury and recorded under the boxes Cause 1 to Cause 5 plus the remaining box for "Other" causes. The total of all injuries on duty should be recorded in the column on the right-hand side.

National Survey on the Impact of HIV/AIDS on the Health Services: Injuries on Duty (Form 6)

Interviewer/Code: Name of the hospital or health center/post:

1 District:
Type of facility (national hospital=1, district hospital=2, health center=3, health post=4): _____
(In hospitals, department: _____)

2 Facility operator (government=1, private, for-profit=2, organizations: nongovernmental=3, charity=4, religious=5): ___

Record review: Number of injuries on duty recorded

Instructions for the interviewer:

Write down the number of injuries recorded due to needlesticks and skin cuts. Identify the following main causes and add the numbers reported. Add remaining numbers under "Other." Do not write names or other ways to trace back the information in any way.

	Year	Category	Cause 1	Cause 2	Cause 3	Cause 4	Cause 5	
			Needlestick	Skin cut				
3	1990	Doctors						
4		Nurses						
5		Midwives						
6		Auxiliary nurses						
7		Auxiliary midwives						
8		Comm. health workers						
9		Pharmacists						
10		Physiotherapists						
11		Laboratory technicians						
12		Cleaners						
13		Drivers						
14		Others (specify):						Total 1990
15								
16								
17	1995	Doctors						
18		Nurses						
19		Midwives						
20		Auxiliary nurses						
21		Auxiliary midwives						
22		Comm. health workers						
23		Pharmacists						
24		Physiotherapists						
25		Laboratory technicians						
26		Cleaners						
27		Drivers						
28		Others (specify):						Total 1995
29								
30								
31	2000	Doctors						
32		Nurses						
33		Midwives						
34		Auxiliary nurses						
35		Auxiliary midwives						
36		Comm. health workers						
37		Pharmacists						
38		Physiotherapists						
39		Laboratory technicians						
40		Cleaners						
41		Drivers						
42		Others (specify):						Total 2000
43								
44								

Form 7: Staff Survey

This questionnaire is administered at health facilities at all levels according to the randomized representative sample drawn. The staff survey reviews access to information about prevention of injuries on duty and availability of means to prevent injuries on duty and assesses injuries on duty experienced over the last year (questions 4–12). It then turns toward several issues with reference to HIV/AIDS, namely the impact of HIV/AIDS on work attitude, supportive supervision, and knowledge about HIV/AIDS for counseling and care (questions 13–17, 40). Questions 18–32 deal with estimates of time required for various HIV/AIDS tasks and staff workload assessments. Disposition for continuing to work in the health sector is established from question 33 to question 38. Questions 39–40 use different angles to identify time spent on different duties since the arrival of HIV/AIDS. Questions 41–42 try to identify HIV/AIDS morbidity and mortality through staff members' accounts of their experience. The reason for including these questions is simple: in many countries records on staff morbidity and mortality are not kept systematically or are not kept at all.

National Survey on the Impact of HIV/AIDS on the Health Services: Staff Survey (Form 7)

Interviewer/Code: Name of the hospital or health center/post:

District:

1 Type of facility (national hospital=1, district hospital=2, health center=3, health post=4): _____
(In hospitals, department: _____)

2 Staff interviewed: doctor=1, nurse=2, midwife=3, auxiliary nurse=4, auxiliary midwife=5, pharmacist=6, physiotherapist=7, laboratory technician=8, cleaner=9, driver=10, other=11 (specify): _____ Age: ___

3 Facility operator (government=1, private, for-profit=2, organizations: nongovernmental=3, charity=4, religious=5): ___

Instructions for the interviewer:

If a question does not apply, write NA in the box. If staff answer don't know, write DN in the box.

Say the following to the staff to be interviewed: *"I am going to ask you several questions. Not all of them may be related to your work, so let me know if a question does not apply to you or if you don't know the answer. Please be assured that all answers will be kept in strict confidence."*

4	Do you have guidelines for the prevention of injuries at work (if No, go to 7)	Yes = 1 No = 0	
5	If Yes, ask: Have you been informed about what they say or have you read them?	Yes = 1 No = 0	
6	Do you know how to protect yourself from injuries at work?	Yes = 1 No = 0	
7	Are gloves **always** available when you need them?	Yes = 1 No = 0	
8	Are other protective materials **always** available when you need them?	Yes = 1 No = 0	
9	Is there a risk of getting infected during your work?	Yes = 1 No = 0	
10	Have you injured yourself by handling used needles or infectious material in the past year?	If yes, number of times infected; if no, 0	
11	If yes, ask: How many days were you sick because of these injuries? Note diseases on back.	Number of days off sick; if no, 0	
12	Do you feel adequately protected against infection risk?	Yes = 1 No = 0	
13	Does the number of HIV/AIDS patients affect staff attitude towards work?	Yes = 1 No = 0	
14	Does an increase in HIV/AIDS discourage staff from working in the health services?	Yes = 1 No = 0	
15	Is supervision supportive to cope with increased numbers of HIV/AIDS patients?	Yes = 1 No = 0	
16	Do you think you know enough **to care** for HIV/AIDS patients?	Yes = 1 No = 0	
17	Do you feel you know enough to tell patients **how they can prevent** HIV/AIDS?	Yes = 1 No = 0	
18	Could the community be involved in HIV/AIDS **counseling** and save you time?	If yes, minutes saved daily; if no, 0	
19	Could the community look after **care** of AIDS patients and save you time?	If yes, minutes saved daily; if no, 0	
20	Could the community or family ensure proper treatment regimens?	Yes = 1 No = 0	
21	Has your daily workload increased since the arrival of HIV/AIDS?	Yes = 1 No = 0	
22	How much time do you spend daily on HIV/AIDS prevention, counseling, and care?	If yes, minutes; if no, 0	
23	Do you need additional time for HIV/AIDS patients every day?	If yes, minutes; if no, 0	
24	How much time do you spend every day on caring for HIV/AIDS patients?	If yes, minutes; if no, 0	
25	How much time do you spend every day on treating opportunistic HIV-related infections?	If yes, minutes; if no, 0	
26	How much time do you spend every day on prophylaxis for HIV-related infections?	If yes, minutes; if no, 0	
27	How much time do you spend every day advising patients on how to prevent HIV infection?	If yes, minutes; if no, 0	
28	How much time do you spend every day testing for HIV? (Interviewer: for care staff, it includes preparation of patients)	If yes, minutes; if no, 0	
	Interviewer: If antiretroviral therapy is available, ask the following 3 questions. If not, put NA and go to question 32.		
29	How much time do you spend every day dispensing highly active antiretroviral treatment, with three antiretroviral drugs?	If yes, minutes; if no, 0	
30	How much time do you spend every day laboratory testing for monitoring antiretroviral treatment?	If yes, minutes; if no, 0	
31	How much time do you spend every day on prevention of HIV mother-to-child transmission?	If yes, minutes; if no, 0	
32	Since the arrival of HIV/AIDS, do you spend more time replacing absent colleagues?	If yes, days per month; if no, 0	

continued on next page

National Survey on the Impact of HIV/AIDS on the Health Services: Staff Survey (Form 7)			
	If yes, ask for reasons for increased absence, note on back of the form.		
33	Would you leave the service for another job?	Yes = 1 No = 0	
34	Would HIV/AIDS influence your decision?	Yes = 1 No = 0	
35	Would you prefer to work for a charity health service?	Yes = 1 No = 0	
36	Would you prefer to work for a commercial/private health service provider?	Yes = 1 No = 0	
37	Would you prefer to work outside the health services altogether?	Yes = 1 No = 0	
38	Are counseling services available to you to cope with work stress?	Yes = 1 No = 0	
39	Have you taken on more duties since the arrival of HIV/AIDS?	Yes = 1 No = 0	
	Interviewer: If yes, write down additional duties on the back of the form.		
40	Since the arrival of HIV/AIDS, do you spend less time per day on other duties?	If yes, minutes; if no, 0	
41	Do you think there are colleagues who suffer from HIV/AIDS at the moment?	If yes, minutes; if no, 0	
42	Did colleagues doing the same job as you pass away during the last 5 years?	If yes, minutes; if no, 0	
	If yes, ask for and note down causes of death on the back of the form.		

4. Do you have guidelines for the prevention of injuries at work? (if NO, go to 7)

As part of testing for the enabling environment for prevention of injury on duty, this question seeks to identify the availability of guidance material to staff. If no guidance material is available, the interviewer proceeds to question 7.

5. Interviewer: If yes, ask: Have you been informed about what they say or read them?

The answer to this question will generate knowledge about staff understanding of prevention of injury on duty.

6. Do you know how to protect yourself from injuries at work?

The question tests whether staff consider that they have sufficient knowledge to prevent injury on duty.

7. Are gloves always available when you need them?

The question will yield information whether staff at any of the facilities can protect themselves from injury at any time necessary. The question is phrased in this way to be exclusive. If staff cannot protect themselves every time it is necessary, the system of supplies of protective devices needs to be reviewed.

8. Are other protective materials always available when you need them?

The question will establish the total availability of protective devices.

9. Is there a risk of getting infected during your work?

This question helps to identify the perceived risk of infection. When aggregated for the total sample of facilities and staff interviewed, the data on perceived infection risk for each staff level will become clear for all staff of different categories. They may indicate a heightened need to concentrate on specific staff categories in need of protection.

10. Have you injured yourself by handling used needles or infected material in the past year?

The question will establish the infection risk by staff category for the country and at various facility levels. If the respondent answers "Yes," ask for and write the number of times the respondent was injured into the box provided.

11. Interviewer: If yes, ask: How many days were you sick because of these injuries? Note diseases on back.

This question will identify the number of days lost due to injuries on duty. Ask about diseases associated with injuries on duty and record them on the back of the form. The questions will also identify the causes of illnesses or infections.

12. Do you feel adequately protected against infection risk?

This general question on staff opinion on infection protection will inform managers about the need to investigate further, if high numbers of staff indicate that they are not adequately protected.

13. Does the number of HIV/AIDS patients affect staff attitude towards work?

This question will identify whether staff see the swelling number of HIV/AIDS patients as affecting their work attitude or whether there is no impact. It will help to provide evidence on observations of low morale.

14. Does an increase in HIV/AIDS discourage staff from working in the health services?

This question will provide more specific information about the impact of HIV/AIDS on staff morale.

15. Is supervision supportive to cope with increased numbers of HIV/AIDS sufferers?

Supportive supervision of health workers who see a lot of patients with HIV/AIDS is an important element of maintaining morale. Staff who feel left to their own devices may suffer from burnout, which supervision may help to alleviate.

16. Do you think you know enough to care for HIV/AIDS patients?

The question will establish staff perception of being able to respond to HIV/AIDS treatment needs for each staff category by facility level. Future planning of staff involvement in expanded HIV/AIDS care will benefit from establishing re-training needs.

17. Do you feel you know enough to tell patients how they can prevent HIV/AIDS?

Information about training needs on prevention of HIV/AIDS will emerge from this question.

18.–20. Estimating time savings through community/family involvement

These questions are to illuminate whether health providers think that the community or family could play a role in HIV/AIDS prevention and care. If the answers are affirmative, ask the respondent how much time per day the health worker estimates could be saved by higher community involvement. An average of time to be saved will emerge for each facility and staff level. The contents of community contributions to the care cycle would need to be identified at a later stage.

21.–33. Estimating time for HIV/AIDS care

This set of questions seeks to identify the additional time requirements for staff dealing with an increased patient load due to HIV/AIDS. The most general question (22) on workload increase leads into this section. Starting with question 23, the questions become more and more specific, up to identifying the specific time requirements for the service provider in a setting which provides antiretroviral therapy. By substratifying the sample down to health center and health post levels, different staff time needs for different tasks will emerge. The answers will also reflect the reality of the support infrastructure surrounding the facilities and the resulting time requirements for HIV/AIDS service delivery in diverse settings. An earlier study found that it was difficult for staff to quantify the time spent on particular tasks. This is easy to understand, but you should engage staff in trying to estimate the time requirements.

In the case of positive replies, solicit a time estimate and enter it into the box provided. This will facilitate additional workload assessments to cover HIV/AIDS tasks.

Questions 30-32 are only necessary if antiretroviral therapy is being offered at the facility.

32. Since the arrival of HIV/AIDS, do you spend more time replacing absent colleagues?

33. IF YES, ask for reasons for increased absence, and note on the back of the form.

These two questions will establish the additional time requirements from another angle and in a more general form, in case other, more specific questions yield no results. Analysis of the reasons for absence will substantiate quantitative findings.

34.–37. Impact of HIV/AIDS on retention

The purpose of these questions is to illuminate whether HIV/AIDS influences the decision of service staff to remain working or seek other avenues. They will highlight whether the private/NGO sector is seen as a viable alternative (questions 35–36) or whether leaving the service altogether because of HIV/AIDS is the preferred alternative.

38. Are counseling services available to you to cope with work stress?

The question is related to staff disposition to work in the services and provides further insight on how services cope with increased workload due to HIV/AIDS and staff burnout.

Questions 39.–40.

These two questions will help to illustrate changes in work tasks and whether staff can still perform existing tasks in the same way.

Questions 41.–42.

The last two questions address the sensitive and possibly stigma-laden area of morbidity and mortality due to staff suffering from HIV/AIDS. They have to be posed with tact and empathy, and interviewers may wish to prepare respondents by telling them that they are going to ask two last questions which the respondent may find difficult to answer because of all the suffering that HIV/AIDS has brought about. Remind the respondent that all information given is totally anonymous and confidential, and that the information is needed to better plan for services and sufficient amounts of staff to cope with the burden the disease inflicts on all. If staff answer YES to the questions, ask for the number of colleagues whom staff consider to be currently suffering from HIV/AIDS in the immediate environment. This should be done very tactfully and carefully. This information will complement data from record reviews on HIV/AIDS staff morbidity and mortality, or, if those are not available, will be the only source to estimate staff losses due to the disease complex. All numbers should then be added up and divided by the amount of staff interviewed to arrive at an estimated average.

Form 8: School Leavers' Plans for Working Life

Anecdotal observations and opinions suggest that fear of HIV/AIDS prevents school leavers from choosing a career in health as a viable option. This self-administered questionnaire explores this issue through questions leading up to school leavers' attitudes toward HIV/AIDS and pursuing training for a health services occupation. Some general questions are interspersed to help put respondents at ease and avoid the biased response that might result from an immediate and exclusive focus on HIV/AIDS.

Survey on School Leavers' Plans for Working Life (Form 8)

District: Name of School: Type of School:

Location:

1	Primary = 1; Secondary = 2	

Pupil to be Interviewed:

2	Please write down if you are a girl or a boy, using the following numbering: girl = 1; boy = 2	

Instructions for the interviewee:

Your age:

The questions below aim to see what you want to do after you finish school. You may indicate more than one choice if you are not yet sure what you want to do.

If you answer Yes, put 1 into the box; if you answer no, put 0. You may answer Yes or No to all questions.

If you don't know the answer, write DN in the box.

3	Do you already know what you would like to do after finishing your school?	Yes = 1 No = 0	
4	Would you like to do an apprenticeship?	Yes = 1 No = 0	
5	Would you like to go to another school after finishing?	Yes = 1 No = 0	
6	Would you like to become a teacher?	Yes = 1 No = 0	
7	Would you like to learn a trade?	Yes = 1 No = 0	
8	Would you like to work in the health services?	Yes = 1 No = 0	
9	Can you see yourself working as a laboratory technician?	Yes = 1 No = 0	
10	Is dentistry a profession of interest to you?	Yes = 1 No = 0	
11	Would you like to become a nurse?	Yes = 1 No = 0	
12	Would you like to become a doctor?	Yes = 1 No = 0	
13	Would you like to work for the police?	Yes = 1 No = 0	
14	Would you want to be working in an office?	Yes = 1 No = 0	
15	Are you interested in working as a clerk?	Yes = 1 No = 0	
16	Would you find working in a hospital interesting?	Yes = 1 No = 0	
17	If you are a girl, do you think working as a midwife is a good job?	Yes = 1 No = 0	
18	Do you know how diseases are spread in the community?	Yes = 1 No = 0	
19	Do you think people can be immunized against polio?	Yes = 1 No = 0	
20	Do you think one can be protected against getting HIV/AIDS?	Yes = 1 No = 0	
21	Do you know someone who has passed away due to HIV/AIDS?	Yes = 1 No = 0	
22	Do you think people can prevent themselves from getting malaria?	Yes = 1 No = 0	

23	Please think of reasons why it may be interesting to work for the health services and write down up to five reasons below:
1.	
2.	
3.	
4.	
5.	

24	Please think of reasons why it may **not** be interesting to work for the health services and write down up to five reasons below:
1.	
2.	
3.	
4.	
5.	

3. Do you already know what you would like to do after finishing your school?

The question will provide answers to the distribution of undecided students. This way, an analysis of the data and possible messages for rectifying perceptions can be tailored to meet broad information needs on health service careers for prospective school leavers.

4. Would you like to do an apprenticeship?

This introductory question could help substratify the respondents' attitudinal set.

5. Would you like to go to another school after finishing?

The question will give an overview of predisposition to pursue further studies.

6. Would you like to become a teacher?

This further question will qualify respondents' bias toward particular careers.

7. Would you like to learn a trade?

This is another question about respondents' bias toward particular careers.

8. Would you like to work in the health services?

This question tests respondents' general attitude toward working in health services.

Questions 9.–12.

These questions are directed at identifying interest in particular areas of health services (laboratory, dentistry, nursing, and medicine).

Questions 13.–15.

These questions about other professional avenues (police work, office work) will help to establish a diversified picture of predisposition toward various careers.

16. Would you find working in a hospital interesting?

This question seeks to identify attitudes to a specific health service environment.

17. If you are a girl, do you think working as a midwife is a good job?

While phrased loosely, the question is likely to yield indication of interest in midwifery among future female school leavers.

Questions 18.–19.

These questions are intended to lead into the HIV/AIDS complex area. They are not intended to be of high analytical value.

20. Do you think one be can protected against getting HIV/AIDS?

This question will establish in a fairly superficial way whether school leavers have been exposed to HIV/AIDS information and thought about it. In combination with several other variables, this question will provide analytical data for educational needs as part of providing an enabling environment for choosing to work for the health services.

21. Do you know someone who has passed away due to HIV/AIDS?

In high-burden HIV/AIDS countries the question will provide answers to the level of stigma and fear surrounding the disease if the level of response is low or overwhelmingly negative. De-stigmatization education strategies may need to be devised in that case.

22. Do you think people can prevent themselves from getting malaria?

The question is intended to lead attention away from the possibly sensitive area of HIV/AIDS. The question is not intended to be of major explanatory value.

23. Please think of reasons why it may be interesting to work for the health services and write down up to five reasons below.

This open-ended exercise will yield positive opinions and attitudes about health service work. Interpretation of the answers will be necessary.

24. Please think of reasons why it may not be interesting to work for the health services and write down up to five reasons below.

This open-ended exercise culls negative opinions and attitudes about health service work. Interpretation of the answers is likely to yield the most relevant information.

3 Increasing Access to Antiretroviral Therapy: A Model for Assessing Health Workforce Needs

On World AIDS Day in December 2003, the World Health Organization and UNAIDS proclaimed a strategy to reach three million people with access to antiretroviral treatment (ART) by the year 2005, the so-called 3 by 5 strategy. Through site visits conducted in fall 2003, WHO's Department of Human Resources had collected experience on the way in which ART services were organized and how human resources were deployed. For 3 by 5 to become a reality, it became evident that tools for planning the human resources essential to providing HIV/AIDS prevention and care were needed. The model for planning human resources had to take into account the need to transfer skills from one level of staff to another so that more staff could provide ART services. A flexible model would allow staff in different countries to plan human resources to reflect their situation, so that differences in practices and regulations (such as those allowing service staff to carry out different types of interventions with patients) could be accommodated.

Forecasting human resources needs to adequately train and supply a sufficiently large workforce for 3 by 5 is a challenge. In most countries, particularly the poorest ones most heavily affected by HIV/AIDS, this task is even bigger. Health workers are dying from the disease while at the same time migration and other losses pose a threat to scaling up access to human resources to care for those in need. Broadening the skill base of those available, through training and authorization to practice, are ways to increase access while planning for additional intake at training schools is another intervention that should happen simultaneously.

Purpose. This tool for calculating the human resources needed to treat patients with HIV/AIDS makes possible a snapshot situation analysis and a rapid response. It also helps to illustrate how many more staff are needed given their current use of time in patient contact and other tasks. The model allows planners and managers to estimate the health workforce needs for a defined number of patients and to estimate if the health workforce available is sufficient or not.

Reprinted from Pascal Zurn, Marko Vujicic, and Norbert Dreesch, *Increasing Access to Antiretroviral Therapy: A Model to Assess Health Workforce Needs: User Guide,* version 1 (Geneva: World Health Organization, Department of Human Resources for Health, 2004). The worksheets for this tool are available at http://www.who.int/hrh/tools/en/.

This tool can also be used to estimate the additional workers needed to treat additional patients. Or, if you know the number of health workers treating patients with HIV/AIDS and the number of patients, you can model what would happen if you reallocate tasks among health workers. Since the model defines the time spent by health workers on HIV/AIDS activities, it accommodates HIV/AIDS services that are integrated into other health services as well.

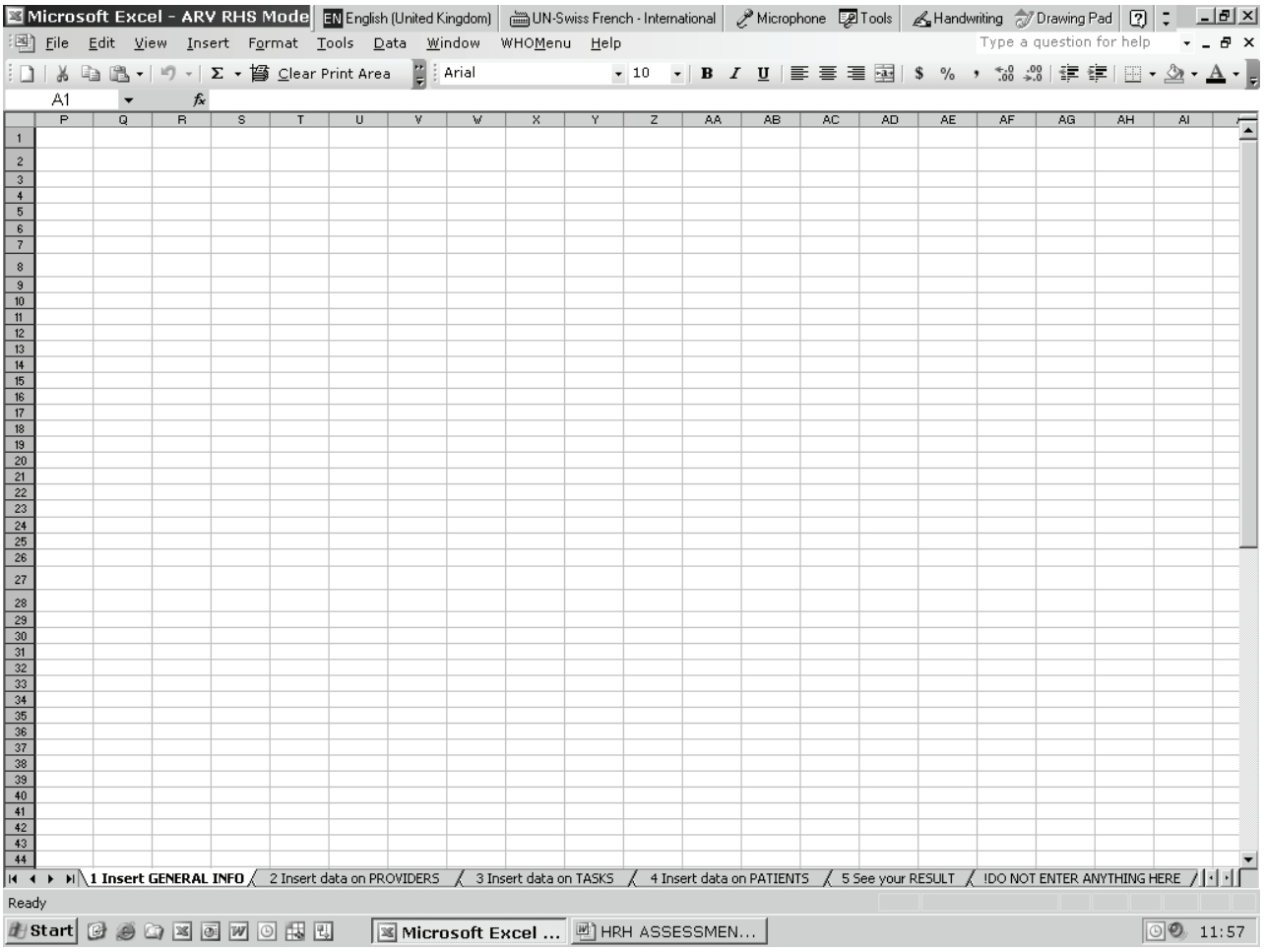
Audience. Human resource planners and managers at the facility, organizational, district, regional, or country level

Process. The model is flexible and easy to use. Using an Excel spreadsheet, human resource planners and staff managers can define the tasks that should be performed to care for HIV-positive patients and associate those tasks with one or more health care providers. This flexibility enables creation of various scenarios for the type of health provider used to deliver care to patients.

Field visits are the best approach to data collection if you want to use the model in a specific context. You can also consider the use of the model for specific health facilities, such as a hospital or an ambulatory care service (outpatient clinic). Depending on the objective, the time required for the data collection will vary.

This tool contains six parts, each of which reflects a worksheet of the program. When you open the file, six different worksheets (screens) appear, as depicted in Figure 3.1.

Figure 3.1. The Components of the Model



The six worksheets (screens) are the following:

1. Insert General Info
2. Insert data on Providers
3. Insert data on Tasks
4. Insert data on Patients
5. See your Results
6. "Do not enter anything here"

The first four worksheets need to be completed so that the system can perform the calculations. The worksheet entitled "Do not enter anything here" performs the calculations in the background, while "See your results" provides detailed results on health workforce needs and capacity.

Getting Started

First make a copy of the master file and create a working copy. This step is necessary so the original sheet can always be restored, and errors are not fatal.

Worksheet 1: Insert General Info

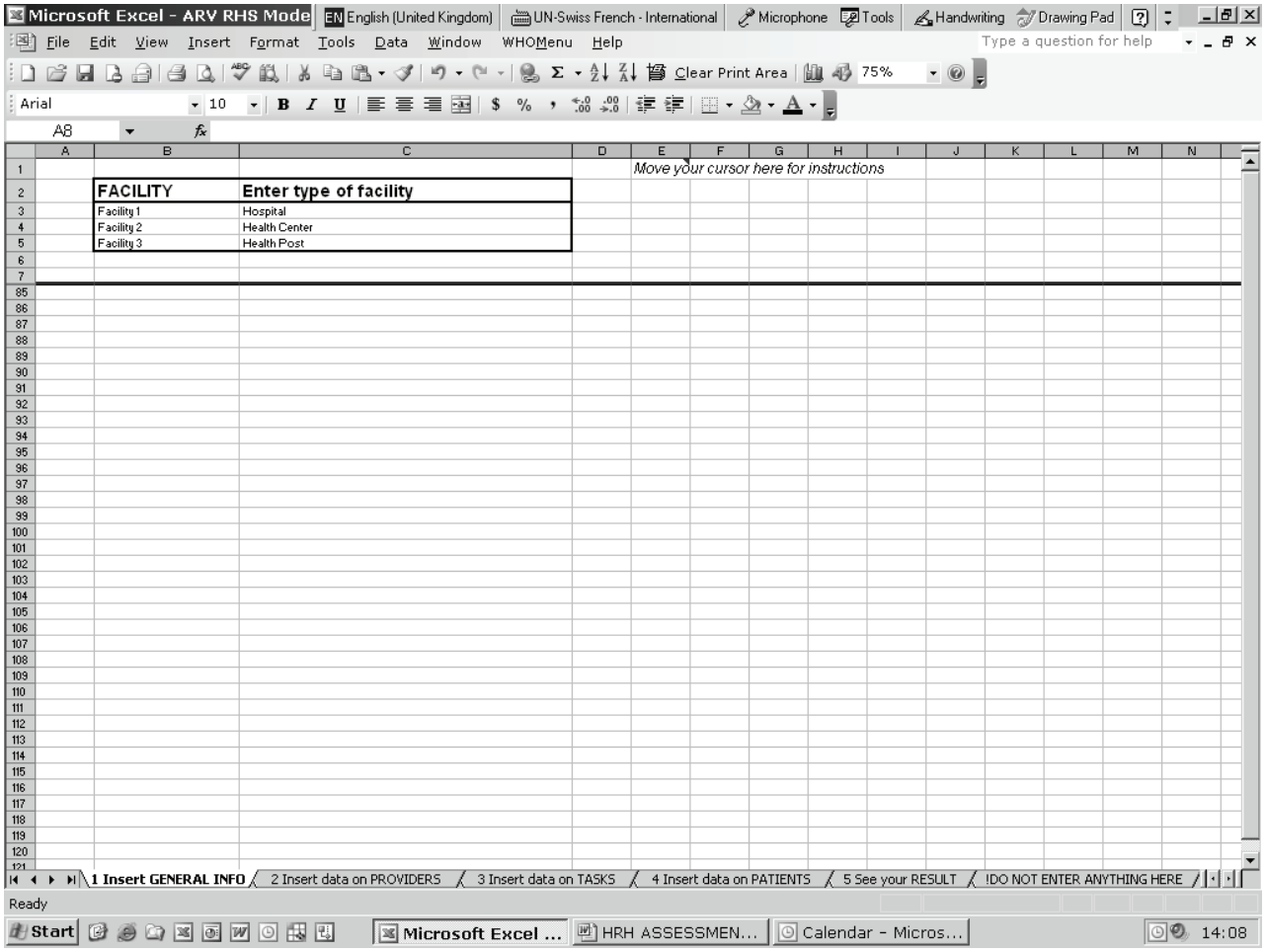
Click on the screen "Data to insert: General Info." In this worksheet you define the baseline data for calculating the workforce required for antiretroviral therapy. Information should be provided on the following elements:

- Types of facilities where care is provided
- Types of providers involved in the delivery of ART
- Tasks performed to provide services to the patients.

Types of Facilities Where Care Is Provided

You can enter up to three different types of facilities which should be defined in cells C3, C4, and C5, as depicted in Figure 3.2.

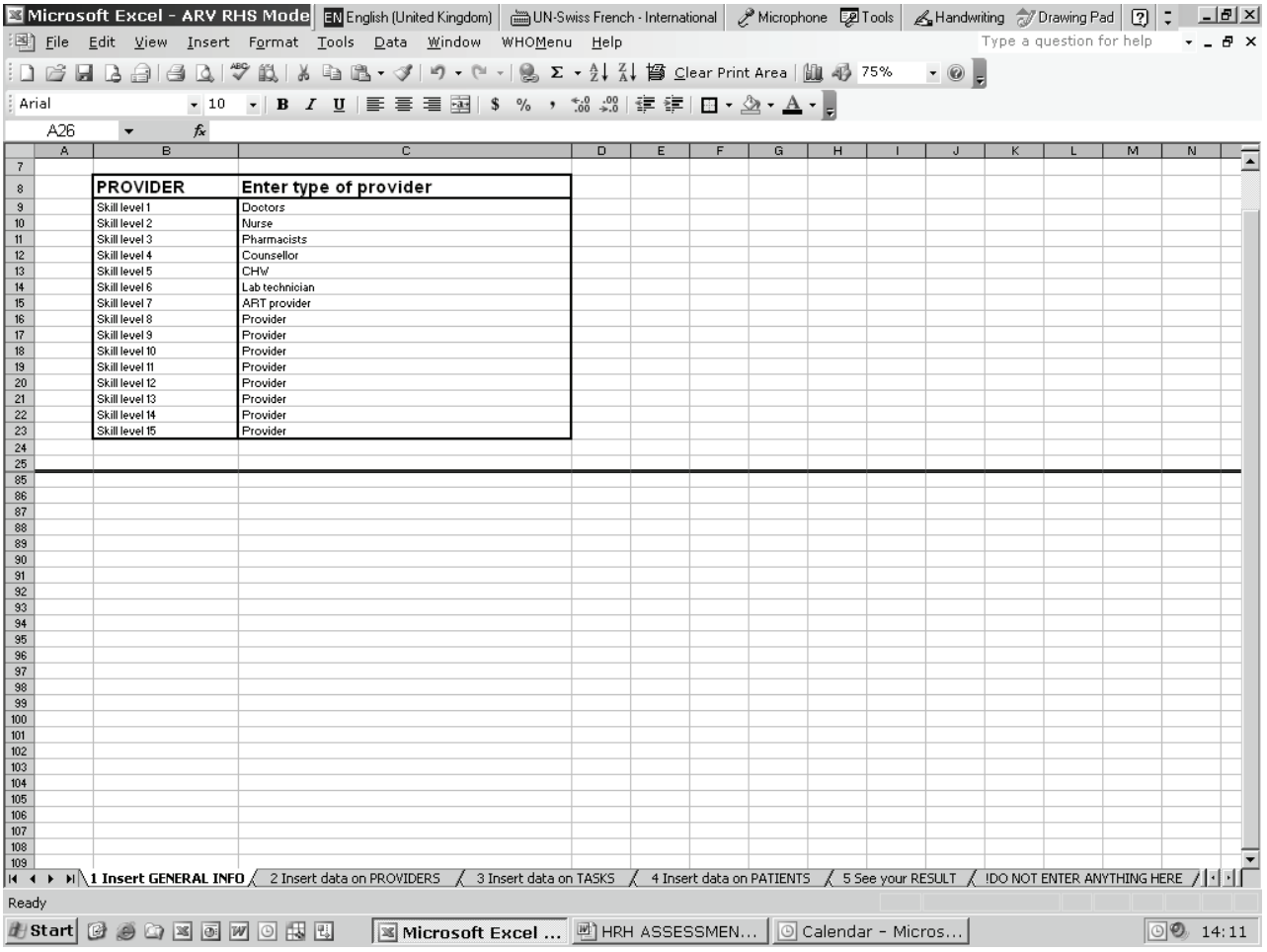
Figure 3.2. Types of Facilities Where Care Is Provided



Types of Providers of Care

Here, you can enter up to 15 different categories of health workers, which should be defined between cells C9 and C23, inclusive, as illustrated in Figure 3.3.

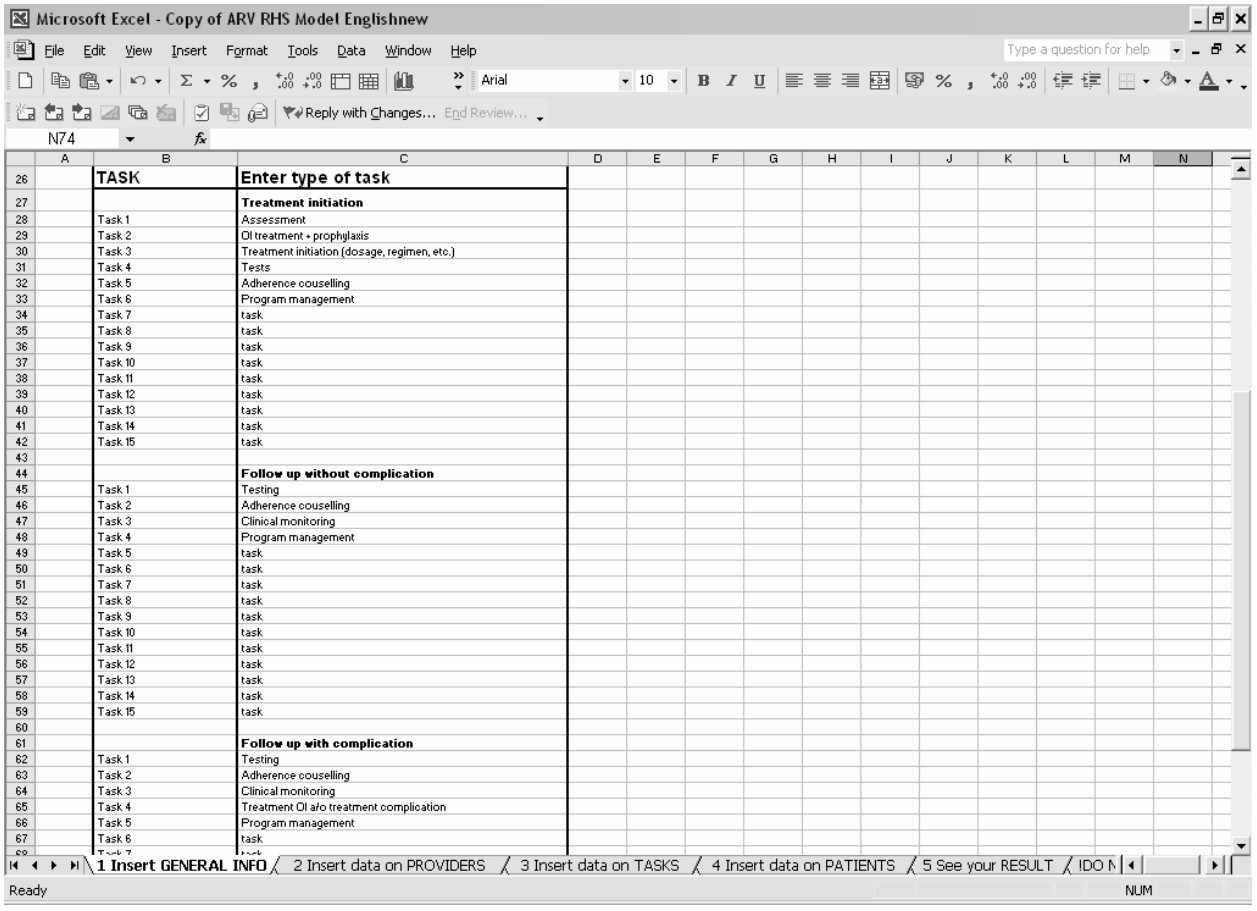
FIGURE 3.3. **Types of Providers**



Tasks Performed to Deliver Services to Patients

In the worksheet shown in Figure 3.4, define various tasks performed in the care cycle. Three main cycles have been predefined: treatment initiation, follow-up without complications, and follow-up with complications. For each cycle, up to 15 tasks can be considered. Those tasks should be introduced between cells C29 and C43, C46 and C60, and finally, C63 and C77.

Figure 3.4. Types of Tasks



All categories printed are given as examples and should be overwritten and replaced with the local categories.

Note that the kinds of facilities, providers, and their tasks will be transported into the next spreadsheets so that they do not need to be re-entered.

Worksheet 2: Insert Data on Providers

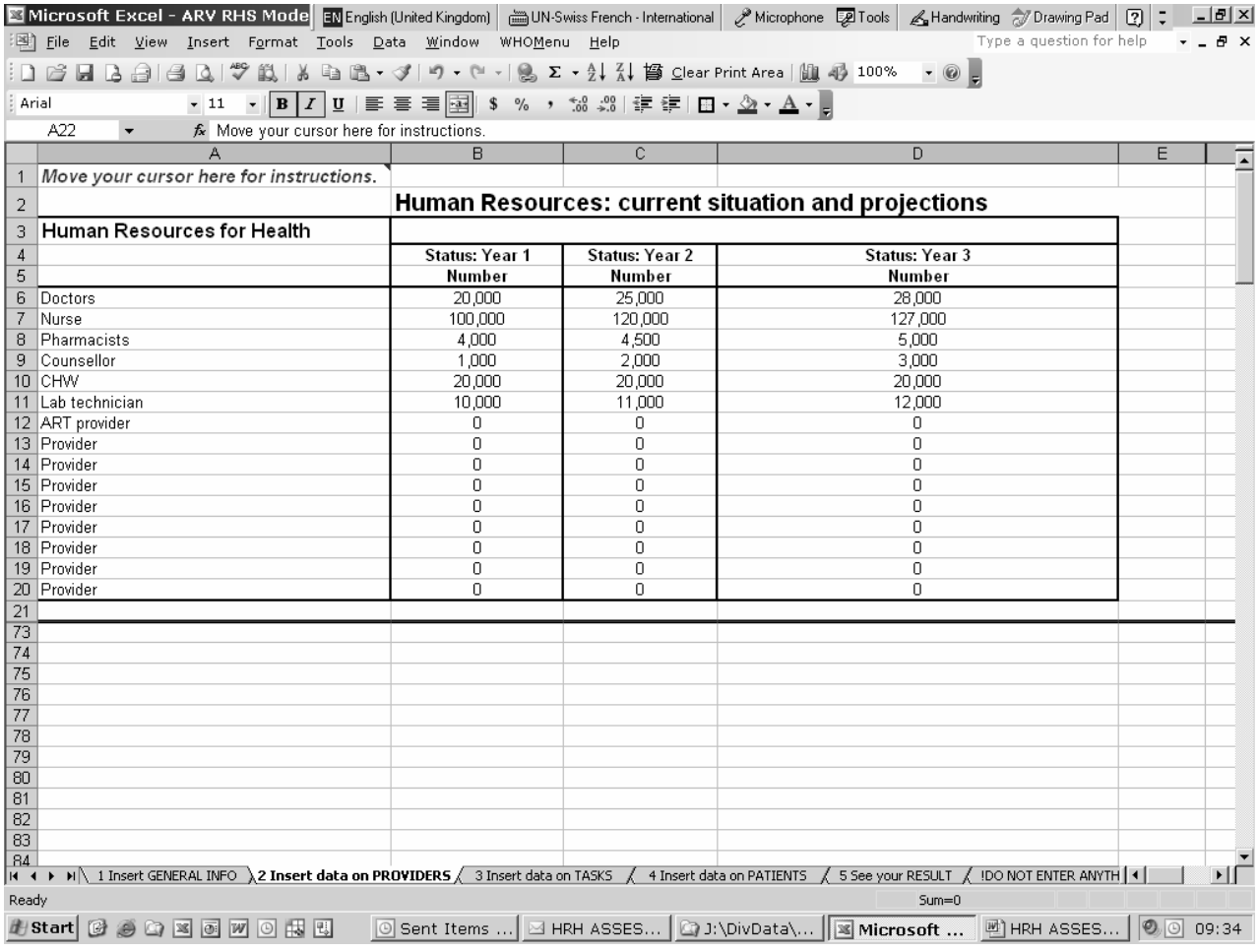
In this worksheet, provide information on the providers that were defined in the previous worksheet (Insert General Info). This worksheet consists of three tables:

- human resources: current situation and projections
- distribution of human resources by type of facility
- working conditions.

Human Resources: Current Situation and Projections

In this worksheet, you define the number of human resources for health for the current year and the following two years for your level (national, regional, district, facility), see Figure 3.5. Year 1 staff are all those available since the beginning of the year plus

Figure 3.5. Number of Human Resources for Health



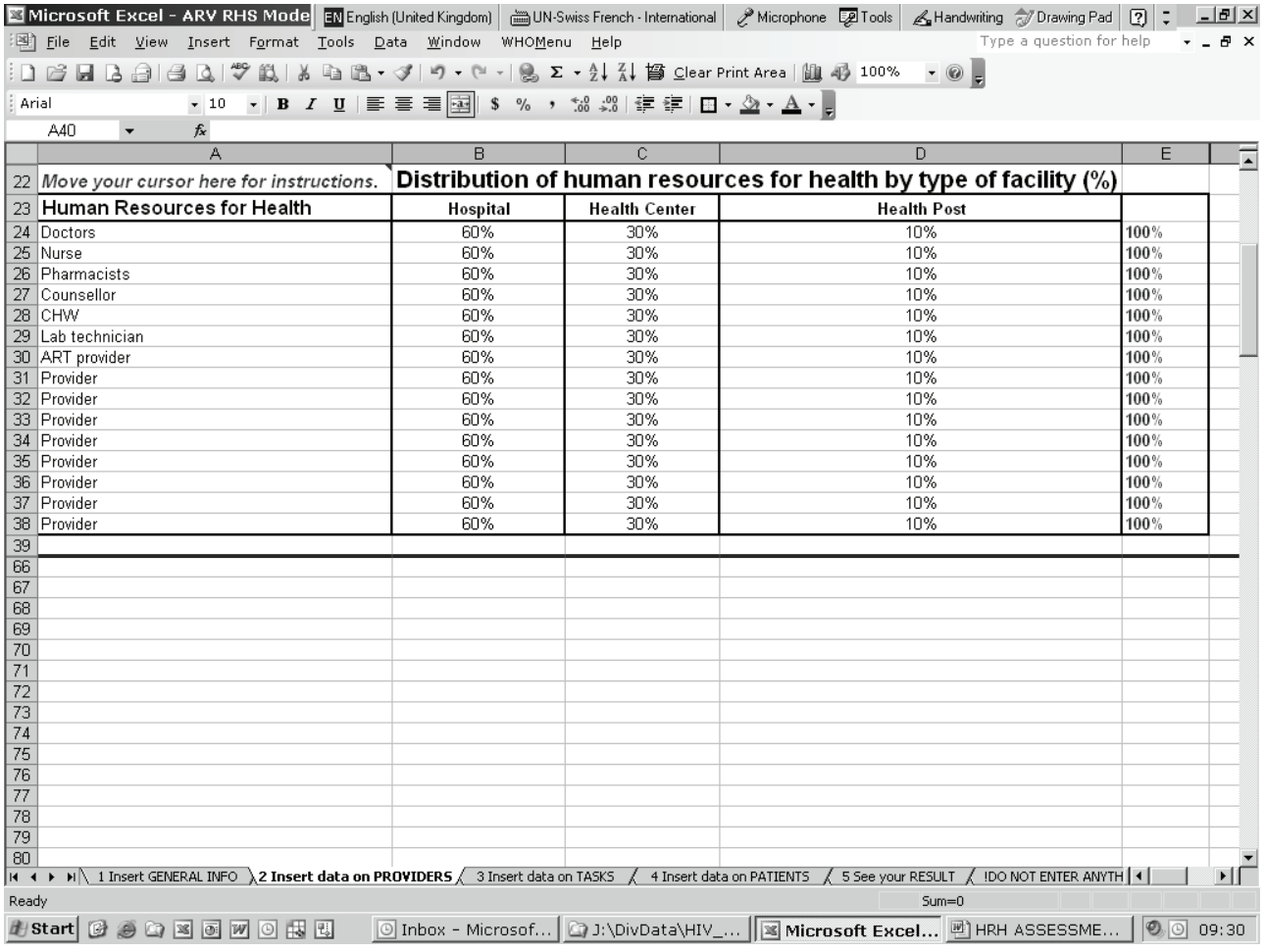
Human Resources for Health	Status: Year 1 Number	Status: Year 2 Number	Status: Year 3 Number
Doctors	20,000	25,000	28,000
Nurse	100,000	120,000	127,000
Pharmacists	4,000	4,500	5,000
Counsellor	1,000	2,000	3,000
CHW	20,000	20,000	20,000
Lab technician	10,000	11,000	12,000
ART provider	0	0	0
Provider	0	0	0
Provider	0	0	0
Provider	0	0	0
Provider	0	0	0
Provider	0	0	0
Provider	0	0	0
Provider	0	0	0
Provider	0	0	0

new graduates expected to enter during the year. Year 2 staff is the total sum of those who were lost during Year 1 (due to retirement, death, or other reasons) and the new graduates entering the service. Year 3 is likewise the sum total of Year 2 losses and new entrants. For year 1, cells B6 to B20 should be filled appropriately, whereas it is cells C6 to C20 and D6 to D20 for year 2 and year 3, respectively.

DISTRIBUTION OF HUMAN RESOURCES BY TYPE OF FACILITY

In this worksheet, you define the distribution (as a percentage) of the health workforce among the different types of facilities, as illustrated in Figure 3.6. In other words, you provide information about the proportion of the health workforce in each type of facility. For example, 60% of all doctors' work in the country could be in hospitals, 20% in health centers, and 10% in health posts. Be sure that the total is 100%. These data are usually not easily available, so you may need to provide an informed guess based on available baseline data.

FIGURE 3.6. **Distribution of Human Resources for Health by Type of Facility**



Working Conditions

This worksheet, depicted in Figure 3.7, helps you estimate the time health staff have available for providing care to ARV patients. There are five steps in this process:

Step 1. Fill in the average number of working days per year for each provider in whole numbers in cells B46–B60.

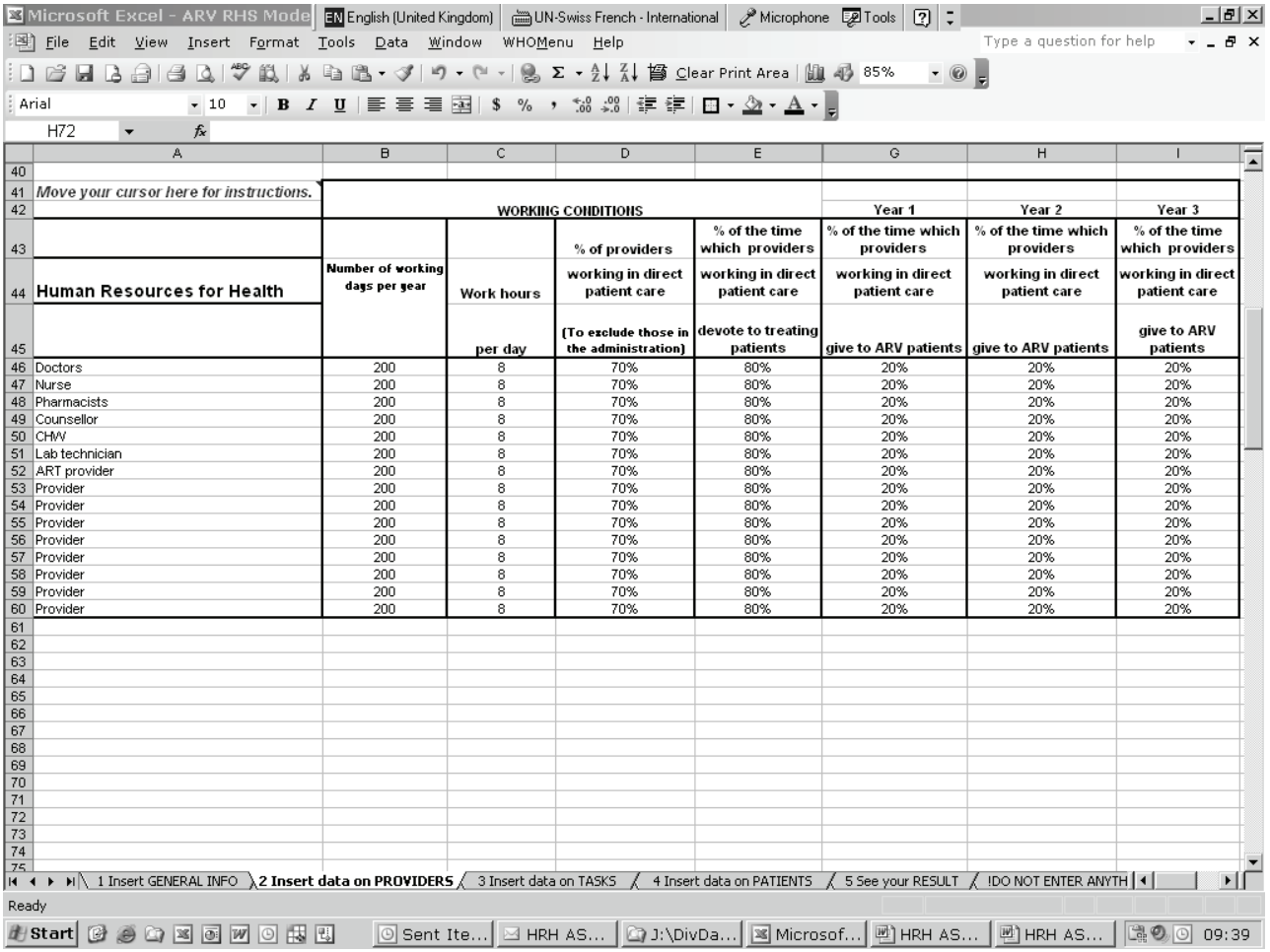
Step 2. Fill in the average number of hours worked per day for each type of provider in whole numbers in cells C46–C60.

Step 3. This step calculates the percentage of providers with clinical skills who actually work in direct patient contact, because a sizable portion of those listed in national human resources statistics such as nurses or doctors actually work in administrative and other jobs and are not available for patient care. Fill in percentages in cells D46–D60.

Step 4. The information recorded here is the percentage of time which those who do provide services to patients actually devote to patient care. This permits a realistic estimate of the time that needs to be deduced for paperwork, educational leave, and so on. Fill in percentages in cells E46–E60. (Column F is hidden because it is not pertinent here.)

Step 5. Use cells G–I to record the percentage of time which those who do work in patient care actually devote to antiretroviral services. This reflects the fact that staff may, for example, be assigned to an outpatient department for only two hours per week,

FIGURE 3.7. **Human Resources for Health Working Conditions**

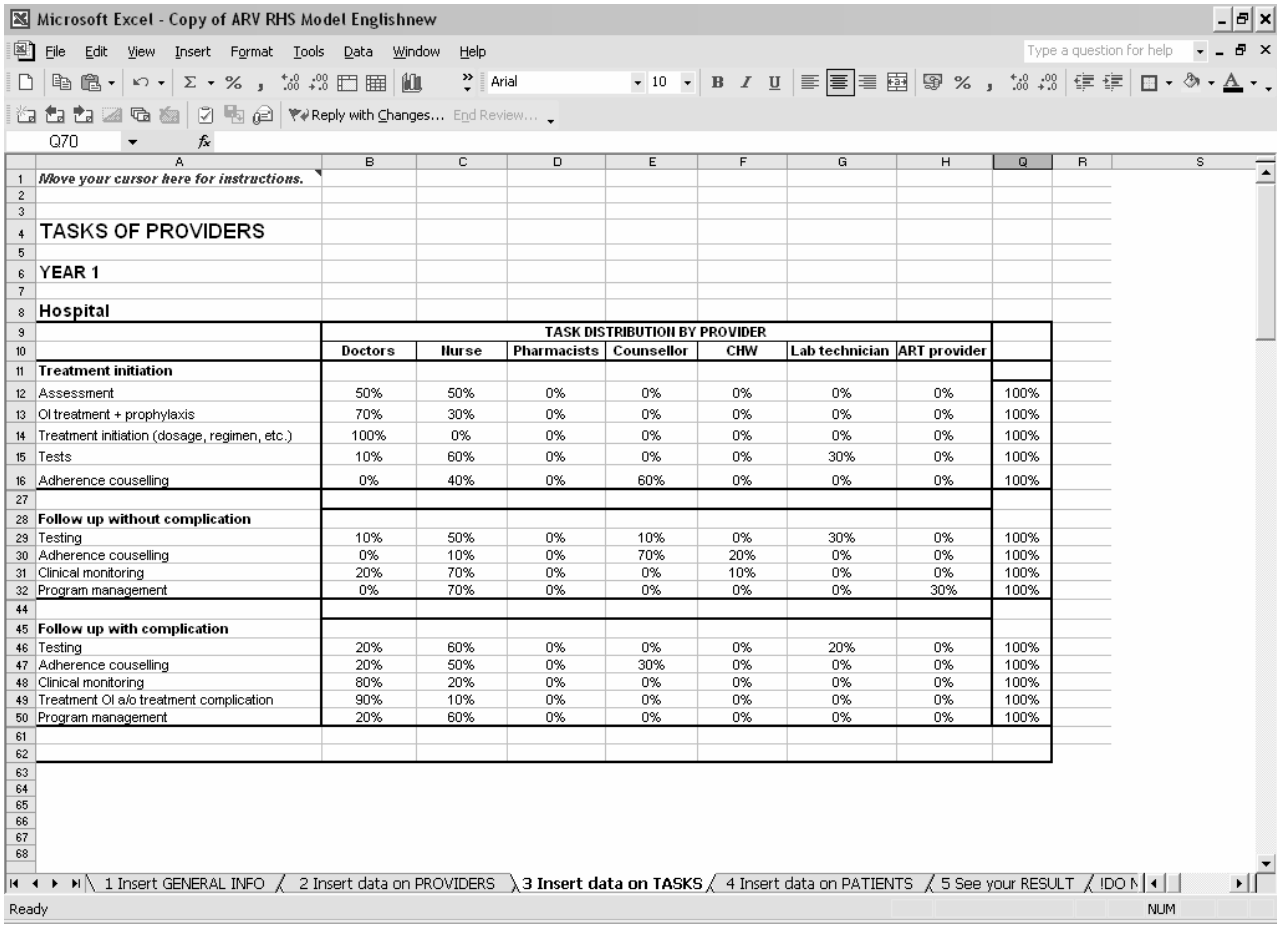


so their full-time commitment to antiretroviral care is only a fraction of all their time spent in clinical care. Figures should be provided for year 1 in cells G46–G60, year 2, in cells H46–H60, and year 3, in cells I46–I60. These data will show changes in time devoted to ARV over the years.

Worksheet 3: Insert Data on Tasks

In this worksheet, you will define how clinical and other tasks are distributed among service providers at the various levels of facilities in the country (hospitals, health centers, and health posts, for example). Figure 3.8 illustrates the distribution of tasks among providers at the hospital level for year 1. This exercise should be repeated for each facility level and for each period, that is, year 1, year 2, and year 3. Therefore, you have nine tables displayed in the worksheet.

FIGURE 3.8. **Tasks of Providers**



For each task, an estimate of the contribution of each provider involved in performing that task (expressed as a percentage) needs to be given. For example, adherence counseling may be assigned to two different providers or just one. In Figure 3.8, adherence counseling is distributed between nurses and counsellors. The total of providers' contributions should equal 100%.

By indicating, for example, who is authorized to request laboratory tests such as CD4 cell counts (doctor, medical assistant, nurse), we can optimize the mix of skills and time among various service providers, once they have sufficient experience in ART.

Worksheet 4: Insert Data on Patients

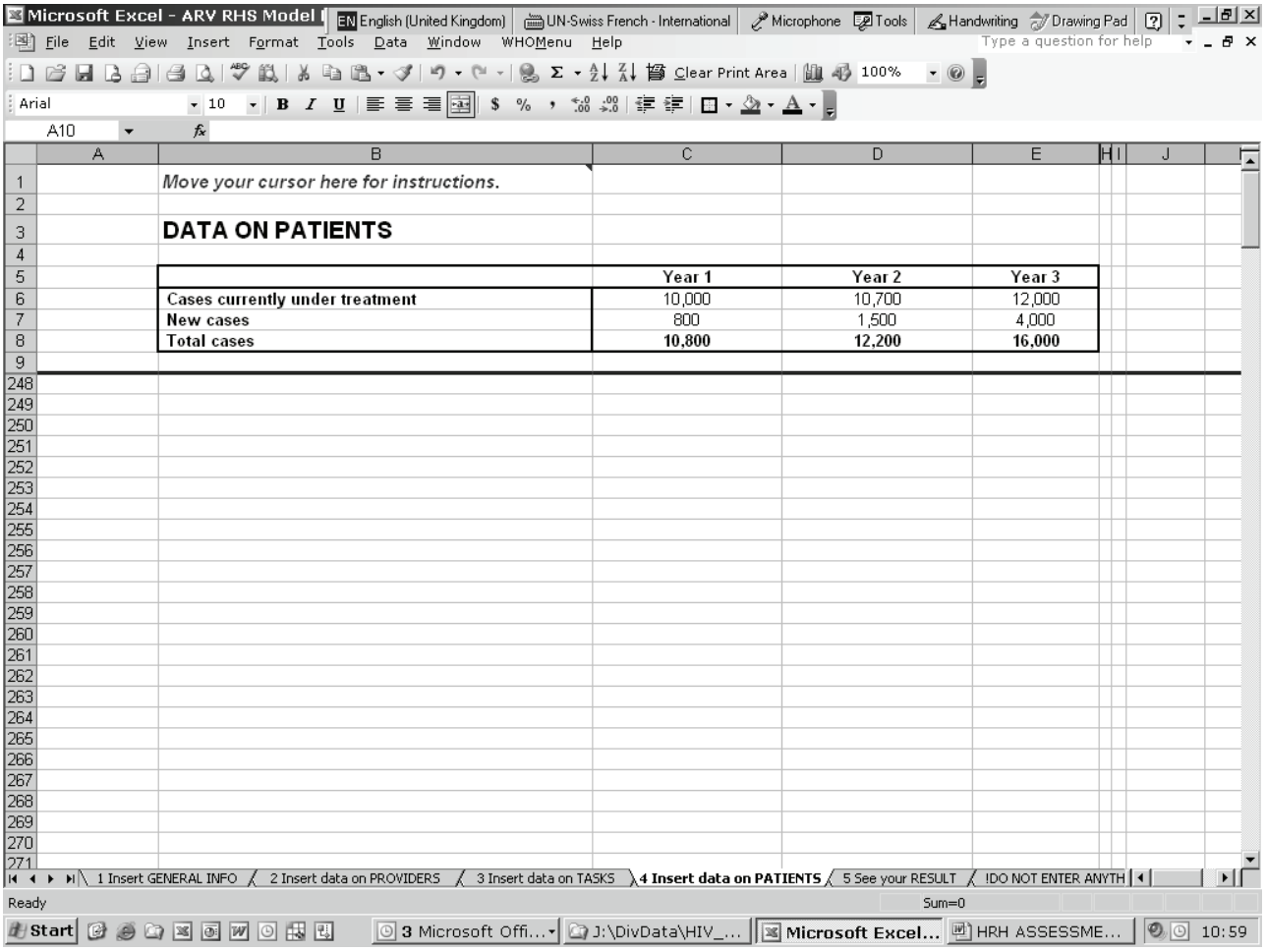
In this worksheet, you should provide four major types of information:

- Number of patients
- Patients with and without complications
- Distribution of patients among types of facilities
- Duration of tasks and number of times that tasks are performed.

Number of Patients

In the part of Worksheet 4 that is shown in Figure 3.9, you should define the number of patients currently under treatment and the planned intake of new patients over the next years. The new patients will increase the workload and have consequences for the composition and number of service providers necessary to reach the coverage targets over the coming years. Some assumptions about the number of patients with complications need to be included, since they will also have an effect on the amount of staff needed.

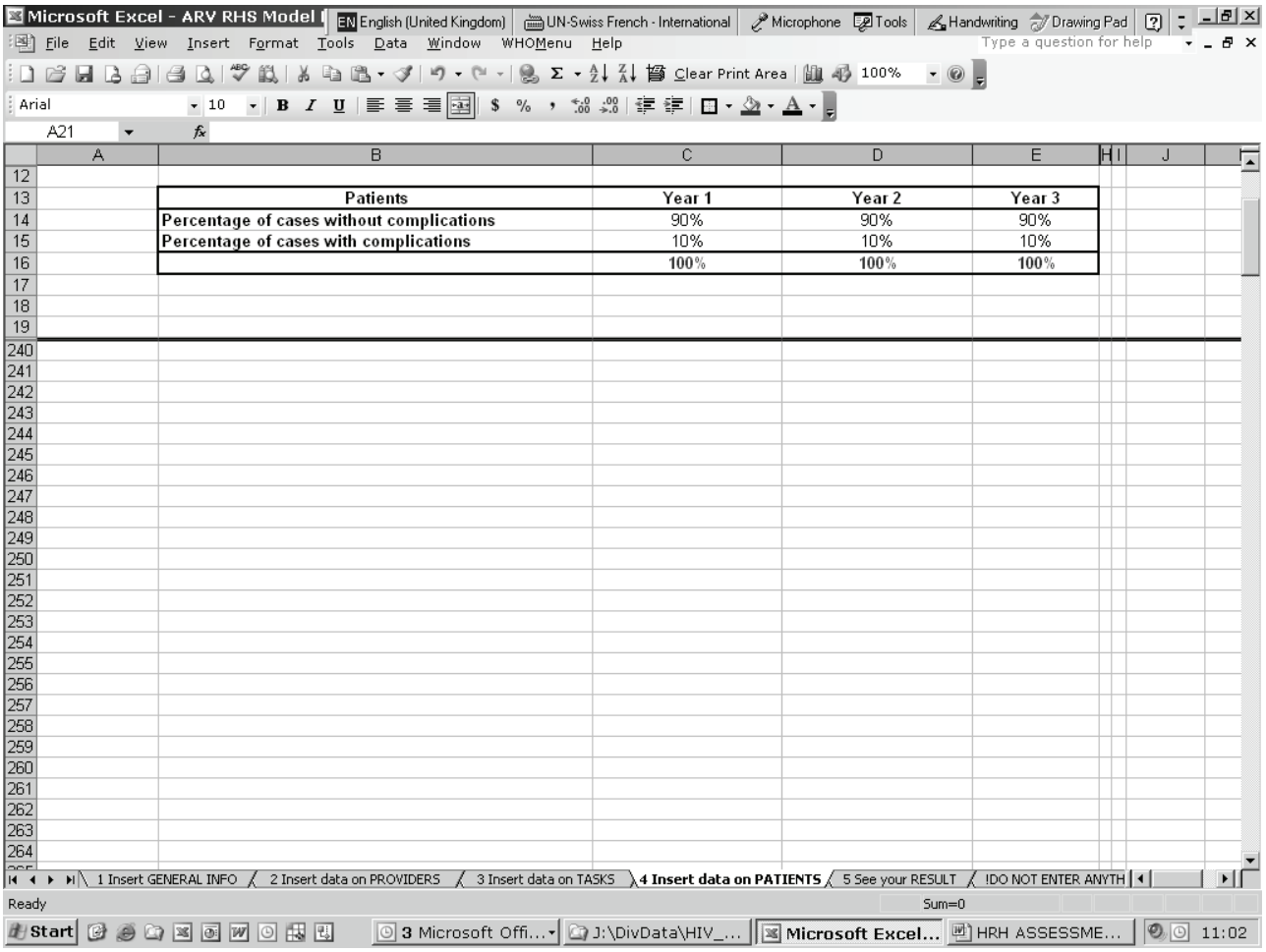
FIGURE 3.9. **Number of Patients under Treatment**



PATIENTS WITH AND WITHOUT COMPLICATIONS

Among the patients treated, some will develop complications, which will require specific care. Therefore, it is important for human resources assessment needs to evaluate the proportion of patients who will develop complications, for each of the year, as illustrated in Figure 3.10.

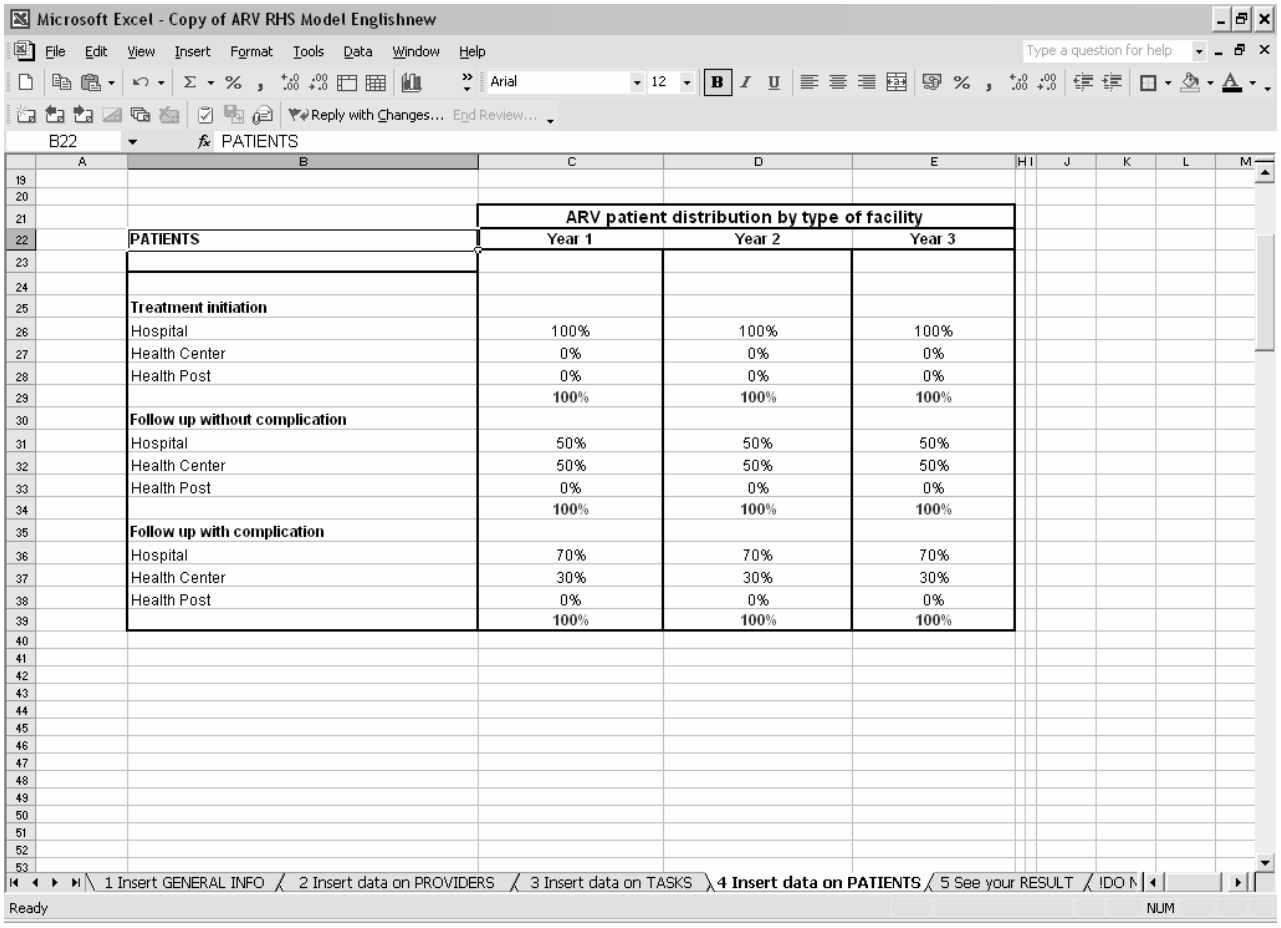
FIGURE 3.10. **Proportion of Patients with and without Complications**



Distribution of Patients among Types of Facilities

The distribution of ARV patients among the various facility levels is an important determinant of human resource requirements. For example, if the initial diagnosis and treatment plan are established only at the district hospital, it must have sufficient staff. If patients who are stable on ARVs are then transferred to the health center, sufficiently trained staff for follow-up and with referral skills need to be placed there, so that quality of care can be maintained with this shared patient care arrangement. In Figure 3.11, the ARV patient distribution is defined according to the type of cycle of care (treatment initiation, follow-up with complications, follow-up without complications) and the period (year 1, year 2, and year 3).

Figure 3.11. ARV Patient Distribution by Type of Facility



Microsoft Excel - Copy of ARV RHS Model Englishnew

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B22 PATIENTS

PATIENTS	ARV patient distribution by type of facility Year 1	Year 2	Year 3
Treatment initiation			
Hospital	100%	100%	100%
Health Center	0%	0%	0%
Health Post	0%	0%	0%
	100%	100%	100%
Follow up without complication			
Hospital	50%	50%	50%
Health Center	50%	50%	50%
Health Post	0%	0%	0%
	100%	100%	100%
Follow up with complication			
Hospital	70%	70%	70%
Health Center	30%	30%	30%
Health Post	0%	0%	0%
	100%	100%	100%

1 Insert GENERAL INFO | 2 Insert data on PROVIDERS | 3 Insert data on TASKS | 4 Insert data on PATIENTS | 5 See your RESULT | !DO N

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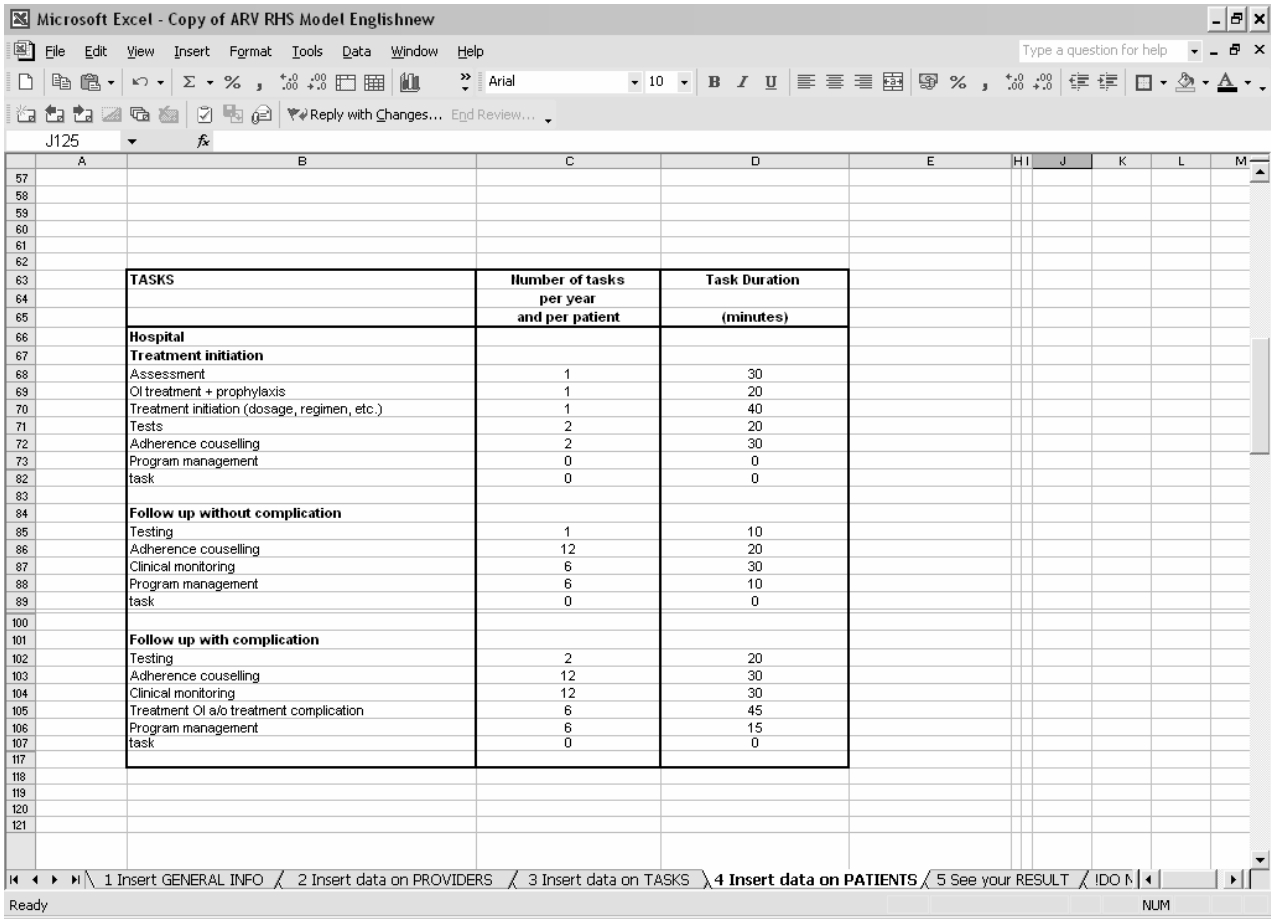
Duration and Number of Tasks Performed

Finally, for every facility in the care cycle, the amount of time which will be needed for various tasks needs to be established so that an adequate staffing number can be calculated for every facility type. Therefore, for each task performed, you should define the number of times it will be performed over one year, and how long it takes to perform. This is illustrated in Figure 3.12, where the tasks are grouped under treatment initiation, follow-up without complications, and follow-up with complications. This information should be provided for each facility level, that is, in our example, hospital (see Figure 3.11), health center, and health post.

FIGURE 3.12. **Duration and Number of Tasks Performed**



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TASKS	Number of tasks per year and per patient	Task Duration (minutes)
Hospital		
Treatment initiation		
Assessment	1	30
OI treatment + prophylaxis	1	20
Treatment initiation (dosage, regimen, etc.)	1	40
Tests	2	20
Adherence couselling	2	30
Program management	0	0
task	0	0
Follow up without complication		
Testing	1	10
Adherence couselling	12	20
Clinical monitoring	6	30
Program management	6	10
task	0	0
Follow up with complication		
Testing	2	20
Adherence couselling	12	30
Clinical monitoring	12	30
Treatment OI a/o treatment complication	6	45
Program management	6	15
task	0	0

Worksheet 5: See Your Results

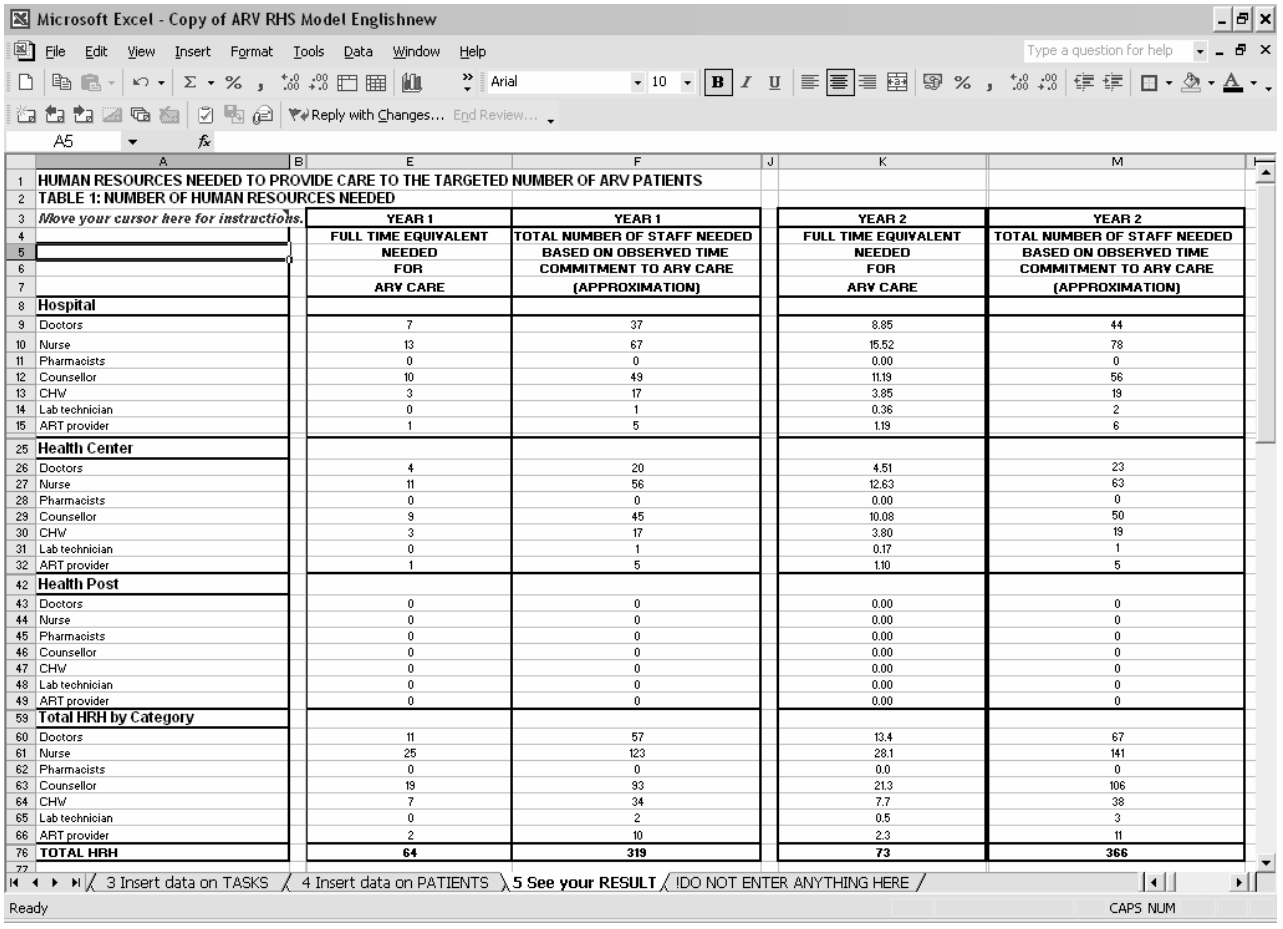
This worksheet provides the results of the calculations performed on the data you provided.

There are two tables of results. The first one indicates the number of each health provider category that is needed to provide care to the number of patients you have defined. The second one evaluates if the available health workforce for treating ARV patients is sufficient or not.

Health Workforce Needed to Provide Care

The results for the number of providers needed to provide care to the targeted number of patients are displayed in Figure 3.13 by type of facility and by year. For each year, two results are presented, that is the full-time equivalent of providers needed and the number of providers needed adjusted to the actual amount of time that providers spend in ARV care. The latter figure shows the number of staff who will actually be needed with the given distribution of time (remember, staff may be devoting only some of their time to ART).

Figure 3.13. Number of Human Resources Needed to Provide Care to the Targeted Number of Patients



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	A	E	F	K	M
1	HUMAN RESOURCES NEEDED TO PROVIDE CARE TO THE TARGETED NUMBER OF ARV PATIENTS				
2	TABLE 1: NUMBER OF HUMAN RESOURCES NEEDED				
3	*Move your cursor here for instructions.*	YEAR 1	YEAR 1	YEAR 2	YEAR 2
4		FULL TIME EQUIVALENT	TOTAL NUMBER OF STAFF NEEDED	FULL TIME EQUIVALENT	TOTAL NUMBER OF STAFF NEEDED
5		NEEDED	BASED ON OBSERVED TIME	NEEDED	BASED ON OBSERVED TIME
6		FOR	COMMITMENT TO ARV CARE	FOR	COMMITMENT TO ARV CARE
7		ARV CARE	(APPROXIMATION)	ARV CARE	(APPROXIMATION)
8	**Hospital**				
9	Doctors	7	37	8.85	44
10	Nurse	13	67	15.52	78
11	Pharmacists	0	0	0.00	0
12	Counsellor	10	49	11.19	56
13	CHW	3	17	3.85	19
14	Lab technician	0	1	0.36	2
15	ART provider	1	5	1.19	6
25	**Health Center**				
26	Doctors	4	20	4.51	23
27	Nurse	11	56	12.63	63
28	Pharmacists	0	0	0.00	0
29	Counsellor	9	45	10.08	50
30	CHW	3	17	3.80	19
31	Lab technician	0	1	0.17	1
32	ART provider	1	5	1.10	5
42	**Health Post**				
43	Doctors	0	0	0.00	0
44	Nurse	0	0	0.00	0
45	Pharmacists	0	0	0.00	0
46	Counsellor	0	0	0.00	0
47	CHW	0	0	0.00	0
48	Lab technician	0	0	0.00	0
49	ART provider	0	0	0.00	0
59	**Total HRH by Category**				
60	Doctors	11	57	13.4	67
61	Nurse	25	123	28.1	141
62	Pharmacists	0	0	0.0	0
63	Counsellor	19	93	21.3	106
64	CHW	7	34	7.7	38
65	Lab technician	0	2	0.5	3
66	ART provider	2	10	2.3	11
76	**TOTAL HRH**	**64**	**319**	**73**	**366**

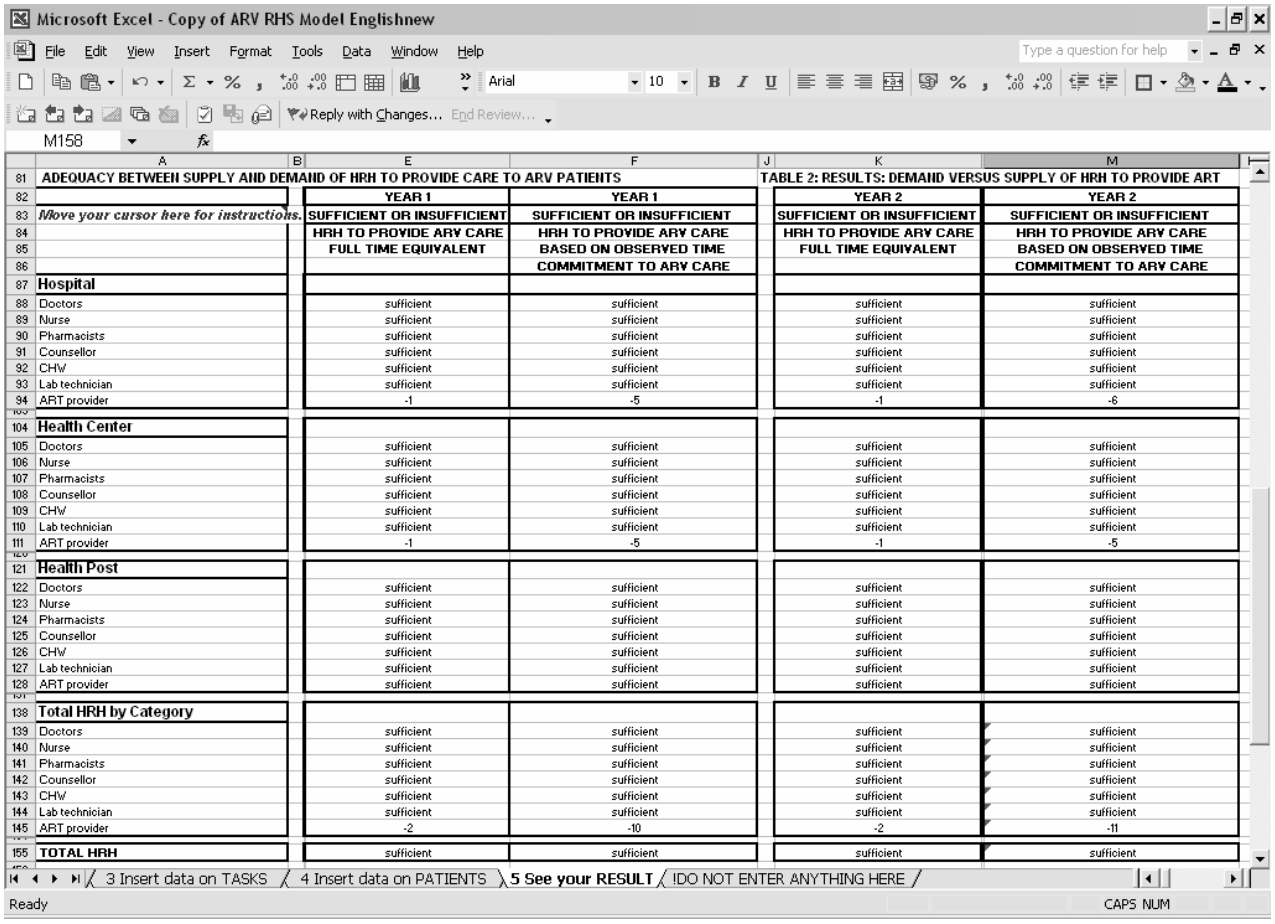
3 Insert data on TASKS / 4 Insert data on PATIENTS / 5 See your RESULT / !DO NOT ENTER ANYTHING HERE /

Ready CAPS NUM

Adequacy of Supply in the Health Workforce

The results presented in Figure 3.14 indicate whether or not there is a sufficient health workforce to provide care to the targeted number of patients. The result is "sufficient" if there are enough health workers; if not, the actual required number is indicated. As in Figure 3.13, full-time equivalents and the number of health workers adjusted for actual time spent on ART are presented.

FIGURE 3.14. **Adequacy of Supply in the Health Workforce**



	A	E	F	K	M
81	ADEQUACY BETWEEN SUPPLY AND DEMAND OF HRH TO PROVIDE CARE TO ARV PATIENTS			TABLE 2: RESULTS: DEMAND VERSUS SUPPLY OF HRH TO PROVIDE ART	
82		YEAR 1	YEAR 1	YEAR 2	YEAR 2
83	*Move your cursor here for instructions.*	SUFFICIENT OR INSUFFICIENT	SUFFICIENT OR INSUFFICIENT	SUFFICIENT OR INSUFFICIENT	SUFFICIENT OR INSUFFICIENT
84		HRH TO PROVIDE ARV CARE	HRH TO PROVIDE ARV CARE	HRH TO PROVIDE ARV CARE	HRH TO PROVIDE ARV CARE
85		FULL TIME EQUIVALENT	BASED ON OBSERVED TIME	FULL TIME EQUIVALENT	BASED ON OBSERVED TIME
86			COMMITMENT TO ARV CARE		COMMITMENT TO ARV CARE
87	**Hospital**				
88	Doctors	sufficient	sufficient	sufficient	sufficient
89	Nurse	sufficient	sufficient	sufficient	sufficient
90	Pharmacists	sufficient	sufficient	sufficient	sufficient
91	Counsellor	sufficient	sufficient	sufficient	sufficient
92	CHW	sufficient	sufficient	sufficient	sufficient
93	Lab technician	sufficient	sufficient	sufficient	sufficient
94	ART provider	-1	-5	-1	-6
104	**Health Center**				
105	Doctors	sufficient	sufficient	sufficient	sufficient
106	Nurse	sufficient	sufficient	sufficient	sufficient
107	Pharmacists	sufficient	sufficient	sufficient	sufficient
108	Counsellor	sufficient	sufficient	sufficient	sufficient
109	CHW	sufficient	sufficient	sufficient	sufficient
110	Lab technician	sufficient	sufficient	sufficient	sufficient
111	ART provider	-1	-5	-1	-5
121	**Health Post**				
122	Doctors	sufficient	sufficient	sufficient	sufficient
123	Nurse	sufficient	sufficient	sufficient	sufficient
124	Pharmacists	sufficient	sufficient	sufficient	sufficient
125	Counsellor	sufficient	sufficient	sufficient	sufficient
126	CHW	sufficient	sufficient	sufficient	sufficient
127	Lab technician	sufficient	sufficient	sufficient	sufficient
128	ART provider	sufficient	sufficient	sufficient	sufficient
138	**Total HRH by Category**				
139	Doctors	sufficient	sufficient	sufficient	sufficient
140	Nurse	sufficient	sufficient	sufficient	sufficient
141	Pharmacists	sufficient	sufficient	sufficient	sufficient
142	Counsellor	sufficient	sufficient	sufficient	sufficient
143	CHW	sufficient	sufficient	sufficient	sufficient
144	Lab technician	sufficient	sufficient	sufficient	sufficient
145	ART provider	-2	-10	-2	-11
155	**TOTAL HRH**	sufficient	sufficient	sufficient	sufficient

Do Not Enter Anything Here

Do not change this worksheet, because it performs the calculations based on the data provided in the previous worksheets.

4 Updating Health Workforce Policy

Policy can be described as a principle of action adopted or proposed by a government, party, organization, or individual. Such principles guide the direction of actions that have been decided upon. They answer questions such as: What are service providers allowed to do? A central issue in reviewing health workforce policy is considering how the scarce funding available can yield the best results. Since human resources consume the highest proportion of the recurrent budget in salaries (60–80%) and directly affect the success of health service delivery, it is important to address health workforce policy appropriately.

Human resource policy cannot be separate from overall health policy development. Within the context of overall health policy development, human resource policies must address all the essential elements of human resource development. Finally, developing policies without considering how they can be implemented can result in lack of success in implementation.

In reviewing and developing policies related to HIV/AIDS, policymakers must grapple with an increase in patients and a decrease in providers, and consider the need to provide integrated services. They must update policies to take stigma and prevention of HIV transmission into account. Sometimes—when HIV/AIDS services receive the lion's share of resources—the resulting imbalance in funding can undermine primary health care.

Purpose. The Health Workforce Policy Audit presented in this chapter is a tool for updating policy to address obstacles in planning, managing, and developing an effective and motivated workforce.

Audience. Policymakers in ministries of health, public service, education, and finance; directors and managers of health facilities

Process. A policy team can use the Health Workforce Policy Audit to review the effectiveness of various human resource policies and prioritize those that need to be addressed. This audit helps to identify issues and constraints to achieving an integrated strategy for human capacity development.

Adapted from World Health Organization, *Guide to Health Workforce Development in Post-Conflict Environments* (Geneva: World Health Organization, 2005), pp. 33–43, http://whqlibdoc.who.int/publications/2005/9241593288.pdf. This chapter was written by Joyce H. Smith for the World Health Organization as a collaborative effort of the Departments of Health Action in Crises and Human Resources for Health.

What Information Is Required?

An audit of policies that affect human resources should be based on information that is as detailed as possible. Such information may not easily be available. Potential sources to be explored include national civil service rules, government policies on the structure of human resources for health, salary structures, and labor laws.

Previous Health Policies

- When were they developed?
- How relevant are they to current health systems and services development?
- Which are the most relevant human resource elements to be included in the development of new health policy?

Detailed Data on Human Resources for Health

- What are the potential sources of information on the current and future workforce?
- How reliable is available information? If it is unreliable, what are the opportunities to collect and collate reliable data?

Demographic Data

- What demographic data are available?
- How reliable are the available data? What are the opportunities to obtain reliable data? Are labor surveys and census data available?

Economic Data

- What funding is available or is pledged by donor agencies?
- What are the possibilities of funding to sustain services after external program funding ceases?

Examples of human resource development policies from other countries

- What are the opportunities to obtain examples of health policies generally, and human resource development policies specifically, from other countries? These could be neighboring countries or countries that have reformed their health systems or adapted policies to meet human resource problems stemming from HIV/AIDS, migration, or conflict.
- How can these examples be obtained (e.g., via agencies such as WHO)?
- How can examples of policies from other countries be used to stimulate discussion and ideas for policy development in your own country?

Who Should Be Involved in Developing Policy for Human Resource Development?

To ensure that the policy improvement process is practicable and manageable, while at the same time involving as many interested parties as possible, it is useful to identify all the relevant actors and how they can be involved in the process (see Box 4.1). They can be involved directly, as regular members of the policy working group, or indirectly, through a formal mechanism to permit forwarding of proposals for policy, relevant information, and feedback on draft policy documents.

Box 4.1. Possible Stakeholders in Human Resource Policy Development

Internal

Senior officials of the Ministry of Health, Ministry of Public Service, Ministry of Education, Ministry of Finance, NGOs

Representatives of hospital and health facility management

Medical and nursing associations

Faith-based organizations

Labor unions

Community health management committees

External

Multilateral agencies (International Monetary Fund, World Health Organization, World Bank, etc.)

Bilateral agencies, international NGOs

Table 4.1 lists suggested key steps in updating or developing human resource policy.

Table 4.1. Key Steps in Developing Human Resource Policy

Key Steps	Related Questions
Identification of policy development or revision process	Who should be involved? ■ directly? ■ indirectly? Who can be involved? ■ directly? ■ indirectly? How can the process be organized? What is the timeframe for the policy development or revision process?
Analysis of the current status of human resource policy	Is there any existing human resource policy? When was it developed? Is it still relevant? Does it contain gaps or contradictions? What are its strengths and weaknesses? Does it require revision or complete redevelopment? Is it a broad statement, or does it contain more detailed operational policies?
Collection and analysis of required information	What information is required to support the human resource policymaking process? How can the information be collected? How will the data be used?
Identification of the key human resource areas to be addressed for policy development	What process is needed to identify the key policy areas that link to the HCD strategy? What support or assistance is required for this process?
Prioritization of the key areas	What process can be used to prioritize the key areas?
Identification of assistance required	What assistance is available? Who can provide assistance? How should this assistance be used?
Development of key human resource policies	How will policymakers ensure that human resource policies are complementary and linked to other health policy development? How will the likely impact of potential policies be assessed?

There are policy research institutes in many countries that can assist in some of these steps, such as studying the impact of policies before and after they are implemented. Institutes with expertise in policy research, including human resource policy, include the Center for Policy and Implementation Studies in Indonesia, the Korea Development Institute, the Thailand Development Research Institute (including its Human Resources and Social Development Program), and UDAPE (Unidad de Análisis de Políticas Sociales y Económicas) in Bolivia. Such interdisciplinary institutes bring a multisectoral perspective to policy.

Table 4.2 provides questions a policy development team can use in carrying out a human resource policy audit. The audit allows the team to rank policy issues in relation to the HCD framework. The questions are organized for each area that will require policy decisions. Comments or suggestions in italics are intended to aid discussion or clarify some questions.

Policies should address high-priority decisions, leaving less urgent matters to be addressed later; consider the stage of development of the country. The column on the left

indicates a priority ranking from 1 to 3, with 1 indicating the highest priority. In view of the number of questions that require policy decisions in relation to human resource development, the policy group should first decide and mark which questions are the highest priority, which are second priority, and which are third priority. This ranking will help the group to work in a focused way.

TABLE 4.2. Question Framework for Human Resource Policy Audit

Priority Ranking			Policy Questions
Health workforce planning			
1	2	3	Who will have the main responsibility for all aspects of national workforce planning, including monitoring and evaluating the ability of the workforce to meet the specific health service needs (including public and private)? Consider the role of the de facto health authority in relation to civil service commission or national planning agency
1	2	3	Who makes decisions on staffing levels, and mix and level of health workers, at each level of health services?
1	2	3	What are the criteria to ensure a safe level of practice of all health professionals in both public and private health services? e.g., setting minimum standards of practice, fully qualified health professionals
1	2	3	How can the human resource database in the health authority link with civil service databases for national workforce planning purposes?
1	2	3	What changes need to be made to the core functions of some categories of staff to extend professional roles to meet service needs? e.g., nurses at health center level to nurse practitioner level
1	2	3	What approaches can the health authority take to the utilization of medical students who have been unable to maintain the academic level required to graduate as doctors, while maintaining standards of patient safety?
1	2	3	What system of health professional registration and certification of all health workers is in place and is this system effective?
1	2	3	How can human resource development and the health information system work together to support health workforce planning? e.g., Human resource planning is not done in isolation but is related to providing adequate numbers and quality of health workers to meet service needs.
1	2	3	What approaches can be developed for flexible staffing plans to minimize the impact of HIV/AIDS on the workforce?
Financing human resource development			
1	2	3	What changes can be made to the standard health benefits program as an incentive to retain staff who are HIV/AIDS positive?
1	2	3	What financial envelope is likely to be available for funding all the essential elements of human resources? e.g., management systems and information systems, salaries and benefits, pre-service training, in-service training
1	2	3	What are the requirements for capital investment in human resources? e.g., for preservice training institutions: curriculum development and adaptation; training capacity and student subsidies for designated service cadres; for in-service training: continuing education for designated service cadres
1	2	3	What are the requirements for the recurrent human resource budget, apart from salaries? e.g., benefits, essential supplies and equipment, supervision (requires staff, process/materials, transport, etc.)
Management of human resources			
1	2	3	Who makes decisions on regulations for training, recruitment, and deployment of health staff? Ministry of Health, health authority/education authority/national planning agencies/university?
1	2	3	How can it be ensured that experienced, human resource professionals are managing human resources at all levels?
1	2	3	How can the system for approving posts and filling jobs (recruitment, hiring, promotion, termination) be improved? It should not discriminate on the basis of HIV/AIDS.
1	2	3	How will an HIV/AIDS workplace prevention program that limits the risk of infection and educates employees be put in place throughout the health system?
1	2	3	Is there HIV/AIDS workforce policy on discrimination and benefits, and is it included in the employee manual?
1	2	3	Are managers and supervisors trained on HIV/AIDS policy and sensitized to issues of stigma among health staff?
1	2	3	How can clear roles and career structures in all areas of health services be established?

continued on next page

Priority Ranking			Policy Questions
1	2	3	How will all health workers be provided with clear job descriptions, based on national health policies and plans, that clearly define their place within the health service structure?
1	2	3	How will health workers be made aware of possibilities for career advancement?
1	2	3	How will incentives to motivate and retain competent health workers be developed? e.g., credits for successful completion of national continuing education training modules counting toward upgrading from assistant level to registered level, or credits plus staff appraisal counting toward promotion or salary increments (see questions on continuing education)
1	2	3	What system of disciplinary measures is in place and is it effective? Do civil service commission regulations need to be adapted for the health service situation? e.g., It is more serious if a nurse or doctor does not come to work than if a secretary or driver does not.
1	2	3	How can supervisors and managers provide effective supportive supervision as part of capacity building and management of health services?
1	2	3	How will access by all health workers to regular continuing education be guaranteed, to maintain their levels of competence?
			Human resource development training
1	2	3	How will all health workers be provided with training and updating to ensure maintenance of minimum levels of professional competence, including VCT and ART?
1	2	3	Will training be linked to or based on national training plans, including the national HIV/AIDS strategy?
1	2	3	Should there be a bonding period to ensure that health workers who undergo basic or postgraduate training work for a public health authority, if required, on completion of training?
			Training institutions
1	2	3	What will be the role of the national training institutions?
1	2	3	How will those institutions relate to other universities?
1	2	3	Do the training curricula meet the needs of the system?
1	2	3	What is the impact of HIV/AIDS on teaching staff?
			Basic training
1	2	3	Will future basic training needs be linked to workforce plans and projections?
1	2	3	Will medical students continue to be trained in country or overseas? How will students be selected? Who will fund basic training?
1	2	3	What happens if students do not meet the required academic and competence levels during training? e.g., not allowed to continue training after initial probationary period?
			Postgraduate training
1	2	3	How will postgraduate training needs be identified? Will they be donor-driven or service-driven needs? Will postgraduate training be related to national workforce and training plans?
1	2	3	How will decisions be made on overseas versus local training to foster cost-effectiveness while maintaining standards?
1	2	3	What are the processes and criteria for selection of candidates to study overseas or to undertake postgraduate training?
1	2	3	Will there be a process of bonding, to serve the health authority, for health workers in receipt of overseas scholarships for health training?
1	2	3	How will health workers be utilized after completion of postgraduate training?
1	2	3	Should health workers who complete a postgraduate degree course receive a small allowance for academic qualifications, regardless of the posts they hold? *There is frequently dissatisfaction among staff who have degrees but who are in a post of a certain level, e.g., they demand that the civil service post be upgraded because of their qualification. Civil service post levels are designed according to service needs, not designed around the individual professional in the post.*
			Continuing education for high-quality health services
1	2	3	Will all continuing education be based on health service needs, be competence based, and follow health authority guidelines on development, implementation, and evaluation of training programs, so that competence can be measured and future accreditation facilitated?

Priority Ranking			Policy Questions
1	2	3	What happens if a health worker fails to achieve the level of competence required during the training course? *Real examples: Two midwives failed to achieve competence in safe delivery training, and they failed to achieve competence after repeating the training. Some laboratory technicians failed to achieve competence, and it is suspected that they are color blind.*
1	2	3	Is certification based on successful achievement of the required competence level and not on attendance at training courses?
1	2	3	Should standardized continuing education courses (e.g., IMCI, safe delivery) be accredited? Should credits for successful completion count toward upgrading? Refer to questions on the management of human resource development.
1	2	3	How will supportive supervision be provided after training to develop the capacity of health workers?
1	2	3	How can linkages be made between national training institutions and monitoring and evaluation of district health services, to assess the impact of training on service delivery?
Coordination and quality enhancement of training			
1	2	3	Who has overall responsibility for coordinating, monitoring, and evaluating health workers' training?
1	2	3	Who sets the minimum standards for training of health professionals in the country?
1	2	3	Who provides accreditation and certification for all basic and continuing education? The health authority may wish to collaborate with the university in the future.

5 Human Resource Management Rapid Assessment Tool for HIV/AIDS Environments: A Guide for Strengthening HRM Systems

The HRM-HIV Tool is a process that helps an organization to quickly assess the performance of its human resource management (HRM) system and develop an action plan for making necessary improvements. A strong HRM system is critical to support the delivery of health services and provide the key human resources needed to deliver HIV-related services.

Purpose. The HRM-HIV Tool provides organizations with a participatory, rapid assessment method for identifying an organization's human resource management status and making concrete plans for improvements. Health service organizations whose human capacity is affected by HIV/AIDS will find this tool useful as they seek management solutions to help sustain their organizations in the face of the pandemic.

Audience. Directors and human resource managers of public and private organizations

Process. The instrument includes 21 HRM components grouped into the five broad areas of HRM; four stages of development for each HRM component; characteristics that describe each HRM component at each stage of development; and spaces for users to describe how the organization fits a particular stage of development.

Reprinted from the *Human Resource Management Rapid Assessment Tool for HIV/AIDS Environments: A Guide for Strengthening Health Systems* (Boston: Management Sciences for Health, 2003). The HRM-HIV Tool was developed by Mary O'Neil and Sarah Johnson and extensively reviewed and refined by Amy-Simone Erard, Saul Helfenbein, Douglas Huber, Elke Konings, John Pollock, and Cecilia Serenata.

An Introduction to the HRM-HIV Tool

When HIV/AIDS epidemics become generalized, all organizations suffer from rising employee attrition, increasing absenteeism, declining morale, and low productivity. Health managers need to help minimize the effect of HIV/AIDS on their organization's or program's own workforce, even as they must prepare to meet growing demand for HIV-related health services. If they are working in countries that are decentralizing their health systems, these managers are also learning new roles and responsibilities to better serve local populations. All these factors require that health policymakers and managers plan well to maintain adequate numbers of staff and to develop staff skills to meet the challenge of HIV/AIDS while delivering other essential health services.

HRM managers can play a key role in developing an organizational response to HIV/AIDS. Because they are responsible for recruiting, retaining, and developing staff, it is essential that they secure executive commitment to assess, improve, and sustain these HRM functions over time. In a high-prevalence HIV/AIDS environment, HRM investments may require some hard choices. HRM managers need to recognize this and convey to others that any investment in strengthening the human resource capacity of an organization is an investment in the people who will make the difference between success or failure in the fight against HIV/AIDS. If they advocate strongly for HRM in their organization and thoroughly implement action plans resulting from HRM assessments, they can make an important difference in how well their organization responds to HIV/AIDS in their communities and contributes to their country's HIV/AIDS strategy.

What Is the HRM-HIV Tool?

Health managers can use the HRM-HIV Tool to assess both their organization's HRM system in general and their HRM policy and practice in response to the impact of HIV/AIDS on their workforce. In particular, they can strengthen their capacity to:

- develop adequate human resource plans;
- strengthen retention and recruitment of staff;
- minimize the rate of infection among health care workers;
- improve overall organizational morale and performance;
- adapt human resource strategies to changing service delivery needs.

Who Should Use This Tool?

The HRM-HIV Tool is useful for organizations in countries with a high prevalence of HIV/AIDS as well as in countries that do not yet fall into that category. It was developed for health organizations; however, it can be effectively used by other social service organizations, whether in the public or private sector. Both large multi-site organiza-

tions and small, single-site organizations can apply this tool. By taking steps now to strengthen their overall HRM system, these organizations can help to minimize the potential impact of HIV/AIDS on their workforce.

The HRM-HIV Tool can serve as a basis for focusing discussions, brainstorming, and strategic planning about the areas in which organizations need to provide support for their workforce. For newly formed organizations, it can help to guide the development of an optimal HRM system. For established organizations facing changes such as contracting out services, decentralization, attrition, or expansion, the tool can serve as a reference for the types of HRM issues that must be addressed at every organizational level in order to better plan, staff, and implement HIV/AIDS programs. For optimal benefit to an organization, the use of this tool needs the full support of the organization's leadership.

What Is Included in This Tool?

The HRM-HIV Tool includes instructions for conducting an assessment and interpreting its results, an assessment instrument, and guidelines for determining priorities and developing an action plan based on the assessment. The guide suggests some strategies that action plans may include for addressing performance issues in HRM systems. The best approaches to these issues, however, involve creative thinking about ways to reduce the factors underlying the issues. Users of this tool will be able to identify both low-cost improvement strategies (e.g., training for HRM managers, a workplace policy for HIV/AIDS, work climate improvements, or flexible hours for some staff); and high-cost strategies (e.g., increased salaries, inclusion of antiretroviral therapy (ART) in the staff benefits program, investment in employee data systems, or transport for supervisors). The guidelines for determining priorities can help users choose among their strategies those that will be most feasible and helpful for their organization.

Developing an Effective HRM System in the Context of HIV/AIDS

Good human resource management is essential to maintaining the necessary supply of qualified staff and a high overall level of performance within an organization. HRM is one of the key building blocks of a comprehensive human resources for health (HRH) strategy. HRH is a broad strategy that has been designed to develop the will, skills, abilities and HRM systems to enable people to respond effectively to HIV/AIDS. Its goal is to strengthen the ability of the workforce to lead, plan, implement, monitor, and evaluate expanded HIV/AIDS prevention, care, and treatment programs (see Box 5.1). The other components of an HRH strategy include:

- national civil service and labor policy;
- visionary leadership among the most senior managers;
- leadership development at all organizational levels;
- partnerships.

Box 5.1. Benefits of an Effective HRM System

An organization with an effective HRM system can:

- plan systematically for the staff needed to carry out the organizational mission;
- provide a clear definition of each employee's responsibilities and link them to the organization's mission and strategies;
- encourage greater equity between staff compensation and level of responsibility;
- define levels of supervision and management support;
- increase staff morale and improve staff performance;
- increase cost savings through improved efficiency and productivity;
- increase the organization's ability to manage change.

In the context of HIV/AIDS, a strong HRM system can help an organization to:

- plan for changing numbers of staff, based on projections of employee attrition;
- redefine job descriptions to reflect responsibilities for HIV-related services and to redistribute work loads after losing or gaining staff;
- minimize the rate of infection among staff through a workplace prevention program;
- minimize the impact of HIV/AIDS on the health workforce through policies designed to attract and retain staff, nondiscriminatory policies, responsive supervision, improved work climate, and training.

The HRM-HIV Rapid Assessment Instrument

The HRM-HIV Tool provides users with a process for rapidly assessing the characteristics and capacity of their organization's HRM system. Before you begin an assessment, it is important for you to understand how HRM is defined (see Box 5.2) and how the assessment instrument reflects this definition.

Box 5.2. Human Resource Management

Human resource management is defined as the integrated use of procedures, policies, and management practices to plan for necessary staff, and to recruit, motivate, develop, and retain staff so that the organization can meet its desired goals. This organizational management system includes five broad areas:

- HRM capacity (staffing, budget, and planning)
- personnel policy and practice
- performance management
- training
- HRM data

HRM Components

The 21 HRM components represent the core functions of an effective HRM system (see Box 5.3). The tool provides a systematic process through which an organization can assess how well each of its 21 components is functioning. An organization identifies the stage of development of each component based on the characteristics described in the tool. The organization can then determine what steps it can take to function more effectively.

Box 5.3. Human Resource Management Components Assessed by the HRM-HIV Tool

HRM Capacity
HRM budget
HRM staff
Human resource planning

Personnel Policy and Practice
Compensation system
Benefits program
Staff retention
Recruitment, hiring, transfer, and promotion
Orientation program
HIV/AIDS workplace prevention program
Employee manual
Discipline, grievance, and termination procedures
Relationship with unions
Labor law compliance

Performance Management
Job descriptions
Staff supervision
Work planning and performance review

Training
Staff training
Management and leadership development programs
Links to external pre-service training

HRM Data
Employee tracking system
Personnel files

Stages of Organizational Development

As organizations grow, strengthen, and mature, they evolve through several stages of development. Most organizations are at different stages of development for different HRM components at any given time, because the components have received different levels of attention during the organization's development. The numbers at the top of the HRM Instrument refer to these four stages of development, with "1" being the least developed stage and "4" being the highest stage of development.

HRM Characteristics and HIV/AIDS

For each HRM component, the instrument provides a statement that describes the common characteristics of organizations at each stage of development. These characteristics build on the characteristics of the previous stage(s). At the first stage, the characteristics describe an organization that is just beginning to develop this component. At the fourth stage, the characteristics describe an organization that appears to have an effective com-

ponent and may need to direct its energies to components that are at lower stages of development.

The HRM components in this tool also focus on HIV/AIDS issues that can be addressed through responsive, effective human resource management. Strategies for addressing these issues will vary from organization to organization. Characteristics of HRM policy and practice that are helpful for an organization to consider when responding to the impact of HIV/AIDS are included in each of the five broad areas. These policies and practices include:

- a budget to support HIV/AIDS workplace strategies;
- HRM staff training in HIV/AIDS issues;
- benefits programs adjusted to maximize staff retention in the face of attrition;
- nondiscriminatory policies in recruitment, hiring, and promotion;
- workplace prevention programs;
- supervision responsive to HIV/AIDS issues;
- a training plan to adjust for staff turnover and skills needed to address HIV/AIDS.

The HRM-HIV Rapid Assessment Instrument

Instructions. For each of the HRM components in the matrix below, you will fill in the columns labeled "Current Stage" and "Evidence." In the blank box under "Current Stage," enter the number of the stage (1–4) with the statement that best applies to the current stage of your organization. If only part of the statement applies, enter the number for the previous stage. In the blank box under "Evidence," please record the reasons that led you to select this box and any additional key information related to this component. Please refer to the glossary on page 96 for definitions of key terms used in the matrix.

HRM Component	Stages of Human Resource Management and Their Characteristics				Current Stage	Evidence
	1	2	3	4		
HRM Capacity						
HRM Budget	Outside of the personnel budget, there is no money allocated for addressing ongoing HRM activities (e.g., recruitment and training), including those needed to support HIV/AIDS strategies.	There is a budget to support ongoing HRM activities (e.g., recruitment and training), but no additional funds for activities to support HIV/AIDS strategies (e.g., a workplace prevention program, drugs, benefits).	Funds are allocated for ongoing HRM activities and also for HRM activities needed to support HIV/AID strategies, but the allocation is irregular and cannot be relied on for useful long-range planning.	Funds are allocated for ongoing HRM activities and also to sustain HRM activities needed to support HIV/AIDS strategies. These funds represent a permanent budget item, reviewed annually and adjusted as needed.		
HRM Staff	There are no staff specifically charged with responsibility for HRM functions.	There are adequate HRM staff in the organization trained in maintaining basic procedures and record-keeping functions, but they do not have a leadership role in developing human resource plans or policies and are not trained to deal with HRM issues related to HIV/AIDS.	There are adequate HRM staff in the organization who maintain basic functions and also develop HRM policy, but they do not address HIV/AIDS issues.	There is an adequate number of experienced HRM staff in the organization who maintain HRM functions, develop policy, and participate in long-range strategic planning on the organization's response to the impact of HIV/AIDS on human resources.		

HRM Component	Stages of Human Resource Management and Their Characteristics				Current Stage	Evidence
	1	2	3	4		
Human Resource Planning	There is no capacity to develop human resource staffing plans for the organization.	There is capacity to develop human resource staffing plans, but it is not based on data on the number and cadres of existing employees or the long-term impact of HIV/AIDS on staff. (This is critical in high-prevalence settings.)	A human resource staffing plan exists, based on organizational goals, staffing needs, training, and employee data. It is adjusted to include strategies to minimize the impact of HIV/AIDS, but there are no clear strategies or resources to support the staffing plan's implementation.	A human resource staffing plan exists, based on organizational goals, staffing needs, training, employee data, and the impact of HIV/AIDS. It is funded for implementation and monitored and evaluated for impact.		
Personnel Policy and Practice						
Compensation System	No formal system exists for determining the salary scale for each job category.	A formal system exists for determining the salary scale for each job category, but it is not routinely used.	A formal system exists, is understood by all employees and is consistently used to establish salary upon entry to the organization, so that qualified staff who are willing to work full days can be attracted.	A formal system exists and is used to establish starting salary, and also is fairly used to establish merit awards and salary upgrades.		
Benefits Program	No benefits program is in place.	A standard benefits program is in place, but it is not assessed for its effectiveness in supporting the retention of HIV/AIDS infected staff (e.g., expanded sick leave, funeral benefits, and free drugs).	A standard benefits program is in place. It is assessed for its effectiveness in supporting the retention of HIV-infected staff. No action is taken based on the assessment data.	A standard benefits program is in place and adjusted as appropriate to support the retention of HIV-infected staff. Its effectiveness in helping to retain staff is monitored regularly.		
Staff Retention	There are no data available on staff retention rates and the factors contributing to declining rates (e.g., how much are declining rates due to HIV/AIDS, and how much are due to out-migration, retirement, or other factors).	Data on staff retention rates are available, but no analysis has been done to determine the contributing factors.	Data on staff retention rates are available. An analysis has been done to determine the contributing factors, but no strategy has been developed to address these factors.	A strategy is in place to improve the staff retention rate. It is based on data and a realistic analysis of the available pool of qualified employees.		

HRM Component	Stages of Human Resource Management and Their Characteristics				Current Stage	Evidence
	1	2	3	4		
Recruitment, Hiring, Transfer, and Promotion	No formal process exists for recruiting, hiring, transferring, and promoting staff. There is no policy of nondiscrimination on the basis of HIV/AIDS.	There are formal procedures for recruiting, hiring, transferring, and promoting staff, but they are not followed consistently. A policy exists for nondiscrimination on the basis of HIV/AIDS, but it is ignored.	Formal procedures for recruiting, hiring, transferring, and promoting staff are used consistently, but the policy of nondiscrimination on the basis of HIV/AIDS is not consistently applied.	Formal procedures are consistently used for recruiting, hiring, transferring, and promoting staff, and the policy of nondiscrimination on the basis of HIV/AIDS is followed.		
Orientation Program	No formal orientation program exists for new employees.	An orientation program exists, but it is not implemented on a regular basis and lacks a component about the organization's HIV/AIDS policies.	Orientation is routinely offered but does not emphasize the mission, the goals, and the performance expected by the organization, especially as they relate to HIV/AIDS.	Orientation is offered to all new employees. It emphasizes the mission, goals, and performance expected, and makes people feel welcomed and valued, as well protected from stigma if they are affected or infected by HIV/AIDS.		
HIV/AIDS Workplace Prevention Program	No HIV/AIDS workplace prevention program is in place to develop awareness and protocols to prevent HIV/AIDS infection (e.g., proper handling of needles, peer education program, distribution of condoms).	An HIV/AIDS workplace program has been developed, but no resources are available to implement it.	An HIV/AIDS program is in place. It focuses on using appropriate protocols to limit the risk of infection as well as education about the HIV/AIDS virus, but only some staff have participated in the program.	An HIV/AIDS program is in place. It focuses on using appropriate protocols to limit the risk of infection as well as education about the HIV/AIDS virus. All staff participate, and it is monitored for effectiveness in increasing staff knowledge and use of protocols.		
Employee Manual (e.g., organizational chart, work hours, health insurance, sick leave, grievances, and travel)	No overall employee manual exists, and no policy is communicated about how people (staff and clients) living with HIV/AIDS are to be treated.	An employee manual exists but is out of date. It includes neither all the relevant information nor any information on HIV/AIDS policy.	A current employee manual exists and includes policies on how staff and clients living with HIV/AIDS are to be treated, but it is not available to all employees and is not always used as a basis for personnel decisions.	An updated employee manual exists and includes policies that specifically refer to HIV/AIDS. It is available to all employees and is used as a guide for all questions about employment in the organization. It is reviewed and updated regularly.		

HRM Component	Stages of Human Resource Management and Their Characteristics				Current Stage	Evidence
	1	2	3	4		
Discipline, Grievance, and Termination Procedures	No formal procedures for discipline, grievances, or termination exist.	Formal procedures for discipline, grievances, and termination exist, but they are not practiced and do not include protection against discrimination on the basis of HIV status.	Formal procedures for discipline, grievances, and termination exist and are practiced. The procedures include protection against discrimination on the basis of HIV status, but these are not adhered to.	Formal procedures for discipline, grievances, and termination exist, including nondiscrimination on the basis of HIV status. These procedures are followed.		
Relationship with Unions (if applicable)	There is no link between HRM, management, and the union(s).	Links exist between HRM, management, and the union(s), but roles are not clear.	Management involves HRM in union issues, but not on a regular basis.	Management, HRM, and the union(s) work together to resolve issues and prevent problems, including those related to HIV/AIDS.		
Labor Law Compliance (if applicable)	No review of HRM policies occurs to ensure compliance with the letter and spirit of local and/or national labor law, including HIV/AIDS regulations, if they exist.	There is some effort to review labor law, but it is not done regularly.	A review of labor law is done regularly as a formal part of the HRM function, but policy is not always adjusted to ensure compliance, including compliance with HIV/AIDS regulations.	HRM policy and practice is adjusted to comply with local and/or national labor law, including any HIV/AIDS regulations.		
Performance Management						
Job Descriptions (e.g., job title, qualifications, job responsibilities, and supervisor)	No job descriptions are developed. Jobs are not reviewed in light of organizational strategies for HIV/AIDS prevention, care and/or treatment for clients, or when tasks need to be redistributed.	Some staff have job descriptions, but they are neither always up-to-date nor adjusted to include responsibilities for HIV/AIDS prevention, care and/or treatment for clients, or to redistribute tasks, when needed.	All staff have job descriptions, but they are not adjusted to include responsibilities for HIV/AIDS prevention, care and/or treatment for clients, or to redistribute tasks, when needed.	All staff have job descriptions adjusted to include responsibilities for HIV/AIDS prevention, care and/or treatment for clients, or to redistribute tasks, when needed.		
Staff Supervision	There is no clear system of supervision. Lines of authority are unclear. Supervisors do not meet regularly with their staff, nor do they receive training on supervision skills or HIV/AIDS issues related to staff.	There are established lines of supervision, but supervisors' roles and functions are not understood, and little supervision takes place. Supervisors do not receive training of any kind.	There are established lines of supervision, and supervisors understand their roles and functions. Supervisors are trained in general supervisory skills but not in HIV/AIDS policies and sensitivity to HIV-related staff issues.	Supervision is well institutionalized within the organization. Supervisors are trained in general supervisory skills as well as in HIV/AIDS policies and sensitivity to HIV-related staff issues.		

HRM Component	Stages of Human Resource Management and Their Characteristics				Current Stage	Evidence
	1	2	3	4		
Work Planning and Performance Review	No individual work planning and performance review system is in place.	A work planning and performance review system is in place for individuals, but it is informal and does not include individual work plans or performance criteria developed jointly by supervisors and supervisees.	A formal system for work planning and performance review is in place for individuals. Supervisors are required to develop individual work plans and performance criteria with each supervisee and to review past performance, but this is not done consistently.	Supervisors and supervisees jointly develop individual work plans and performance criteria. These are used to conduct reviews of past performance at least once a year.		
Training						
Staff Training	There is no organizational staff training plan or ongoing assessment of individual staff's development needs, especially in light of new HIV/AIDS protocols, a reallocation of responsibilities, and the need for HIV-related sensitivity.	Training is offered on an ad hoc basis but is neither based on staff needs, nor linked to the organization's key priorities, including HIV/AIDS strategies. It is not implemented to reduce staff absence from their posts during training.	Training is a formal component of the organization and is linked to staff and organizational needs, including HIV/AIDS issues; however, it is not implemented to reduce staff absence from their posts during training.	Training is a valued part of the organization, and opportunities are developed for staff, based on their needs and on the needs of the organization, including HIV/AIDS issues. It is implemented to reduce staff absence from their posts during training.		
Management and Leadership Development Programs	No programs have been developed to increase management and leadership capacity at all levels of the organization.	An emphasis on developing management and leadership capacity exists, but development is done on an ad hoc basis and not linked to addressing the challenges facing the organization, such as focusing on HIV/AIDS and helping to implement the national HIV/AIDS strategy.	Management and leadership development opportunities are available on a regular basis, but they target senior-level staff and are not directly linked to addressing the challenges facing the organization, such as focusing on HIV/AIDS and helping to implement the national HIV/AIDS strategy.	A management and leadership development program is in place for staff at all levels, and everyone has an opportunity to participate based on performance and other established criteria. The program focuses on addressing challenges facing the organization, such as focusing on HIV/AIDS and helping to implement the national HIV/AIDS strategy.		

HRM Component	Stages of Human Resource Management and Their Characteristics				Current Stage	Evidence
	1	2	3	4		
Links to External Pre-Service Training	No formal link exists with the pre-service training institutions that prepare employees for the health sector, or with the accreditation organizations that approve their curricula.	A loose relationship exists between the organization and pre-service training institutions, but they do not use the relationship to formally update their curricula to meet the growing need for management capacity within the health sector nor to prepare people to work in HIV/AIDS prevention and/or treatment programs.	The organization and pre-service training institutions work together to ensure that their curricula focus on developing skills, knowledge, and attitudes required by the health sector, including management and other skills for working in HIV/AIDS prevention, care, and/or treatment programs.	The organization and pre-service training institutions offer regular in-service training for staff in the workplace to upgrade staff skills and knowledge (e.g., management training, HIV/AIDS issues, change management, and partnerships).		
HRM Data						
Employee Tracking System (e.g., data on the number of staff, position, location, gender, age, year of hire, salary level, projected HIV/AIDS prevalence, rate of attrition, and absenteeism by cadre)	None of these data are collected in any kind of systematic way.	Although most of these data are collected, there is no system to maintain them or keep them up to date. They are not used to generate reports on attrition, absenteeism, or staff turnover.	All of these data are available and up to date. They are used to generate reports on attrition, absenteeism, and staff turnover, but are not formally used in human resource planning.	All of these data are available and up to date. Data collection and reporting systems are in place. Data are formally used in human resource planning.		
Personnel Files (e.g., individual employee records that track performance, promotion, and salary history)	No individual employee records exist.	Limited employee personnel files are maintained, but not regularly updated.	Personnel files for all employees are maintained and kept up to date, but there is no policy for employee access to or use of these data.	Both updated personnel files for all employees and policies for appropriate use (e.g., confidentiality, employee access) exist.		

Using the HRM-HIV Assessment Instrument

The HRM Assessment is a one-day process that has two phases:

- assessment of the current HRM system;
- discussion of findings and action planning.

This instrument is best applied by a diverse group of no more than 15 staff within the organization, such as the Executive Director and representatives, both inside and outside of the HRM department, from senior and mid-level management and from clinics. It is often useful for an external consultant to facilitate the process of conducting the assessment and developing the action plan.

Completing Individual Assessments

First, each person in the group should individually assess the HRM components in the matrix by reviewing the characteristics of every component at each stage of development. There is no scoring involved. For each component, you should write in the number for the stage that you believe best represents the current status of your organization's HRM system. If only part of the statement applies to your HRM system, you should write in the number of the previous stage. In the blank box in the right hand column, in the row marked "Evidence," write one or two specific observations (see Box 5.4) that provide support for the stage you have marked.

Box 5.4. Evidence

Evidence is a fact or concrete observation that supports the condition or stage of development. It answers the question: "What can we see or hear that tells us our assessment is accurate?"

For example, a participant who places her organization in Stage 2 for a workplace prevention program for HIV/AIDS can point to a program that was developed but has not yet been implemented.

Reaching Group Agreement on the Assessment Results

After this individual exercise, group members work together to reach agreement on the appropriate stage of each component for their organization at the current time. To do this, they share their assessment of each component and discuss their evidence or reasons. It is important for individual opinions to be respected because people in organizations frequently experience HRM in different ways depending on their role and responsibilities in the organization. A review of documents will help to inform this discussion and subsequent interpretation of the results; please see Box 5.5.

Box 5.5. Complementing the Assessment with a Review of Documents

In each case, the assessment work should be complemented by a review of all relevant HRM and personnel documents. The facilitator should review them prior to the assessment and use them as references to inform the discussion. The following documents are recommended for review:

Personnel files and reviews	Employee manual
Job descriptions and work plans	Organizational mission statement
Financial/payroll records	Strategic plans
Labor law	HIV/AIDS policies

Interpreting the Results and Taking Action

When the group has completed its assessment, it will need to interpret the results and take action to address the issues revealed in its findings. First, the group needs to discuss their results and reach an understanding about why their organization is at a particular stage of development for each component that they have found has especially disappointing results. To identify the reasons underlying the results, ask the question: "Why does this situation exist?" It may well be that the main factor influencing the situation lies outside the organization and will require advocacy to change. In other cases, the HRM system may be fine, but the problem may be in the way the issue is perceived within the organization.

In HIV/AIDS contexts, it is also critical that you have some understanding about the stage of the epidemic in your area and how it is affecting the organization.

HRM Priority Areas

Once the group understands the factors underlying their assessment results, they can begin to propose solutions. They should first focus on specific HRM components and the performance weaknesses identified within them. Typically, the order of importance for improving HRM functions is as follows:

HRM capacity. It is critical that you address the components of this area first. If your assessment for HRM Capacity (budget, staff, human resource planning) is at Stage 1 or 2—there are no qualified staff charged with HRM responsibility and no HRM budget or human resource planning—then your organization cannot address the other HRM components described here.

Personnel policy and practice. All of the components included in personnel policy and practice provide an essential framework for defining the terms and conditions of work and need to be in place before effective performance management and supervision systems can be implemented.

Performance management. Performance management and supervision systems define how people will interact with each other and how the work that they do will support the goals of the institution or organization.

Training. Training is essential to an effective HRM system, but it is most effective when it is managed and integrated into human resource planning, HRM policy, and performance management.

Data. HRM data supports all the other components. Improvements in this area need to be integrated with other changes. All organizations require some means of gathering data about the people who work for them. They need employee data to accurately project employment needs.

Reaching Consensus on Priority Strategies

Within the priority areas, the group probably will have identified several performance weaknesses that undermine the HRM system. It will also have pinpointed some challenges that HIV/AIDS has introduced into maintaining an adequate supply of human resources. The group needs to decide which weaknesses they will address and how. Some weaknesses are more serious than others and may need to be addressed first. Solutions for a weakness in one component may require an integrated response from various components. *In the case of HIV/AIDS, for example, if an organization does not have adequate numbers of staff, then identifying strategies that focus on retention, recruitment, and links with pre-service institutions becomes more of a priority. If these measures do not yield the desired results, then strategies for redefining the job descriptions of current staff and providing them with HIV/AIDS training may be needed. If low morale from HIV/AIDS is the major issue, then strategies focusing on supervision and management are appropriate.*

Within each HRM component, the characteristics described in each stage of development provide information that is useful in developing possible actions for addressing the high priority areas. Strategies required for making improvements are not necessarily costly, but if resources are limited, you will need to think strategically. You will want to identify strategies that:

- can be accomplished quickly and require few resources;
- will have the biggest impact on organizational goals, even if they take longer to accomplish;
- will provide a basis for many other activities.

For example, implementing a workplace prevention program can have the immediate effect of limiting the spread of infection among staff and also increase knowledge and awareness that can improve the delivery of HIV-related services. Leadership development can improve the work climate and motivation in work groups and help your organization more effectively utilize limited resources.

While it is necessary to focus at first on a manageable number of components, it is also important to remember that the long-term effectiveness of HRM is achieved only when all of the components described in this tool are addressed in an integrated man-

ner. For example, a focus on in-service training is unsustainable if not linked to an overall organizational strategy and to the curricula in pre-service training institutions. Whatever the amount of time and resources required, your organization will reap many benefits from investing in HRM.

Developing and Implementing an HRM Action Plan

Once the priority areas and strategies are agreed on, the group should develop an action plan (see the Sample HRM-HIV Action Plan on page 93). The group needs to ground the action plan in good social policy and gain commitment from all stakeholders for implementing it.

By looking at the characteristics of the next higher stage for each HRM component, you can formulate targets for desired performance and define tasks for your action plan. While it may not be possible to immediately reach a performance goal, defining optimal performance will help to establish an interim step an action plan can address. Successful, lasting change is a gradual process, so it is better to set realistic goals and try to move from one stage to the next in logical steps. Your action plan should specify activities and time lines and identify the persons responsible. Other elements you need to consider for your action plan include:

- **securing the commitment of leadership:** The leadership of your organization should participate in action planning and guide the implementation of the resulting plan. It needs to actively support your activities, especially those that involve difficult decisions regarding the use of human and financial resources.
- **allowing sufficient time:** Realistic expectations are often the key to success. improvements that are incremental and cumulative build to sustainable change.
- **managing change:** Organizational change is often met with resistance. By involving people in the process, you can reduce resistance and/or focus on areas where there is the most agreement.

Sample HRM-HIV Action Plan

HRM Component for Improvement	Proposed Activities	Time Line	Person(s) Responsible	Resources Needed	Indicators
Performance Management					
Staff Retention	Analyze data about the retention of staff over the years to determine whether rates are declining and what the contributing factors are.	Within 30 days (from date of this plan)	Human Resources Manager, Consultant	Staff time and assistance, 10 days for consultant	A report is written describing patterns of staff retention rates and the main factors contributing to retention rates. It recommends actions to retain staff.
HIV/AIDS Workplace Prevention Program	Conduct a needs assessment to determine what issues the program should address, based on the key issues in the epidemic afflicting the communities served and the issues that employees want a workplace prevention program to address. Develop the program.	Within 45 days Within 3 months	HRM Director	Staff time, Budget	The workplace prevention program is in place.
Work Planning and Performance Review	Revise existing system to include a process of joint work planning between the employee and the supervisor, based on the employee's job description and linked to organizational goals.	Two months to review and develop a process and six months to train staff and implement it	Staff responsible for HRM and Director of Training, with a working committee representative of all levels of the organization	External consultant to assist in training all staff	A revised performance evaluation system is in place. Staff are trained and a system has been developed to monitor implementation.

Reducing the Impact of HIV/AIDS on the Workforce

Over time the improvements you make will strengthen your HRM system so that can help to reduce the impact of HIV/AIDS on your organization's workforce. A strong HRM system can address HIV/AIDS by taking steps to:

- budget funds to support human resource strategies that address HIV/AIDS in the workforce and the community;
- plan for minimizing the impact of HIV/AIDS through such strategies as flexible staffing, training, collecting employee data, and developing sick leave policies;
- extend its benefits program to maximize staff retention;
- develop and enforce policies that do not discriminate against people with HIV/AIDS in hiring, transfer, promotion, and discipline;
- develop an orientation program that helps new employees feel supported with respect to HIV/AIDS issues;
- implement an HIV/AIDS workplace prevention program that limits the risk of infection and educates employees;
- include an HIV/AIDS policy in the employee manual;
- provide training for all staff in HIV/AIDS-related issues;
- generate reports on attrition, absenteeism, and staff turnover, and contributing factors to assist in planning and forecasting staffing needs.

The organization should provide the training on a routine basis and include instruction for:

- HRM staff in HRM issues related to HIV/AIDS and the human rights of infected persons;
- supervisors in HIV/AIDS policies and in maximizing employee performance;
- staff in the implementation of HIV/AIDS strategies;
- managers and emerging leaders at all levels in addressing the challenge of HIV/AIDS faced by the organization and the country;
- staff working in HIV/AIDS programs on prevention, care, and treatment, through links with pre-service training institutions.

The Importance of HRM Components to the Organization

Table 5.1 provides a summary of how each HRM component fits into the overall management of the organization and its particular relevance to the HRM system.

TABLE 5.1. Human Resource Management Components and Their Importance in the HRM System

HRM Component	Importance
Area: HRM Capacity	
HRM budget	Allows for consistent human resource planning and for linking costs to results
HRM staff	Experienced HRM staff contribute higher levels of individual and organizational performance and assume leadership in HRM issues, particularly those related to HIV/AIDS' impact on the workforce
Human resource planning	Allows HRM resources to be used efficiently in support of organizational goals
Area: Personnel Policy and Practice	
Compensation system	Allows for equity in employee salary and benefits and is tied to local economy, so organizations can compete for scarce skills
Benefits program and staff retention	Provides competitive and equitable benefits and added incentives for ensuring staff retention, based on staff retention data
Recruitment, hiring, transfer, and promotion	Assures fair and open process based on candidates' job qualifications
Orientation program	Helps new employees to identify with the organization and its goals/values
HIV/AIDS workplace prevention programs	Assures that all staff understand the systems in place and the knowledge required to prevent the spread of HIV/AIDS
Employee manual	Provides rules and regulations that govern how employees work and what to expect
Discipline, grievance, and termination procedures	Provides fair and consistent guidelines for addressing performance problems
Relationship with unions and labor law compliance	Promotes understanding of common goals, and decreases adversarial behaviors and litigation
Area: Performance Management	
Job descriptions	Defines what people do and how they work together
Staff supervision	Provides a system to develop work plans and monitor performance
Work planning and performance review	Provides information to staff about job duties and level of performance
Area: Training	
Staff training	Offers a cost-effective way to develop staff and organizational capacity
Management and leadership development	Are keys to efficiency, effectiveness, and sustainability
Links to external pre-service training	Ensures cost-effective development of staff by incorporating the skills needed in the workplace into pre-service training
Area: HRM Data	
Employee tracking system	Allows for appropriate allocation and training of staff as well as tracking of personnel costs
Personnel files	Provides essential data on each employee's work history in the organization

Glossary of HRM Terms

compensation and benefits: The annual base salary paid to the employee for a particular job, including the added benefits that are customarily allowed (e.g., health, vacation, housing, loans).

discrimination: The act of treating a person differently than others in a similar situation, because of gender, physical condition, ethnicity, etc.

human resource management (HRM): The integrated use of systems, policies, and practices to plan for necessary staff and to recruit, motivate, develop, and maintain employees in order for the organization to meet its desired goals.

human resource plan: The document that results from annual (or longer-term) planning, describing the goals and priorities for staffing, training, and other HRM activities, and how they are related to the organization's mission. It includes a budget for achieving these goals.

incentives: Rewards, generally monetary, that are used to compensate staff for good performance and the achievement of objectives, and/or to motivate employees to improve program quality. Incentives, in addition to salary and benefits, can be a planned part of total compensation.

job description: A document that states the job title, describes the responsibilities of the position, the direct supervisory relationships with other staff, and the skills and qualifications required for the position.

performance management: The system, policies, and procedures used by an organization to define and monitor the work that people do, and to ensure that the tasks and priorities of employees support the mission and goals of the organization.

performance review: A review of the employee's performance by the supervisor and employee, and based on jointly established work plans and performance objectives.

stigma: A sign of shame towards, disapproval of, or rejection by others.

recruitment: Activities undertaken by the organization to attract well qualified job candidates.

work planning: The process used by supervisors with individual employees to jointly plan the performance objectives and specific activities an individual employee is expected to perform within a specific time period. This process differs from the work planning of organizational units.

6 Leading Change for Human Resources for Health

Any country or program that is facing challenges such as the HIV/AIDS crisis, protecting family planning programs in light of competing demands for resources, dealing with infectious diseases, undergoing health sector reform, or responding to reduction or growth in funding for health is experiencing challenges that require leading change. To face the enormous challenges of improving the health of clients, managers have to initiate and carry out many types of changes. They need to be clear about what they are changing, at what level the changes need to take place, and how to navigate through the change process. They have to know how to create a climate that encourages change, how to address resistance to chance, and how to develop management systems that support change. Finally, scaling up changes is crucial in the fight against HIV/AIDS.

Purpose. To make significant improvements in human resources for health and in the health of populations—improvements that will last over time—managers need to know how to lead and how to influence change within and outside their organizations.

Audience. This tool can be used by directors of public or private social service organizations and by human resource managers and facility managers.

Process. The material in this chapter shows managers how to be more effective in leading change by:

- framing their principal challenge and defining its scope and complexity;
- leading organizational change;
- creating a climate that encourages change;
- supporting change with management systems;
- scaling up changes within and beyond their organizations.

Adapted from *Managers Who Lead: A Handbook for Improving Health Services* (Boston: Management Sciences for Health, 2005), pp. 149–71.

Defining the Challenge of Leading Change

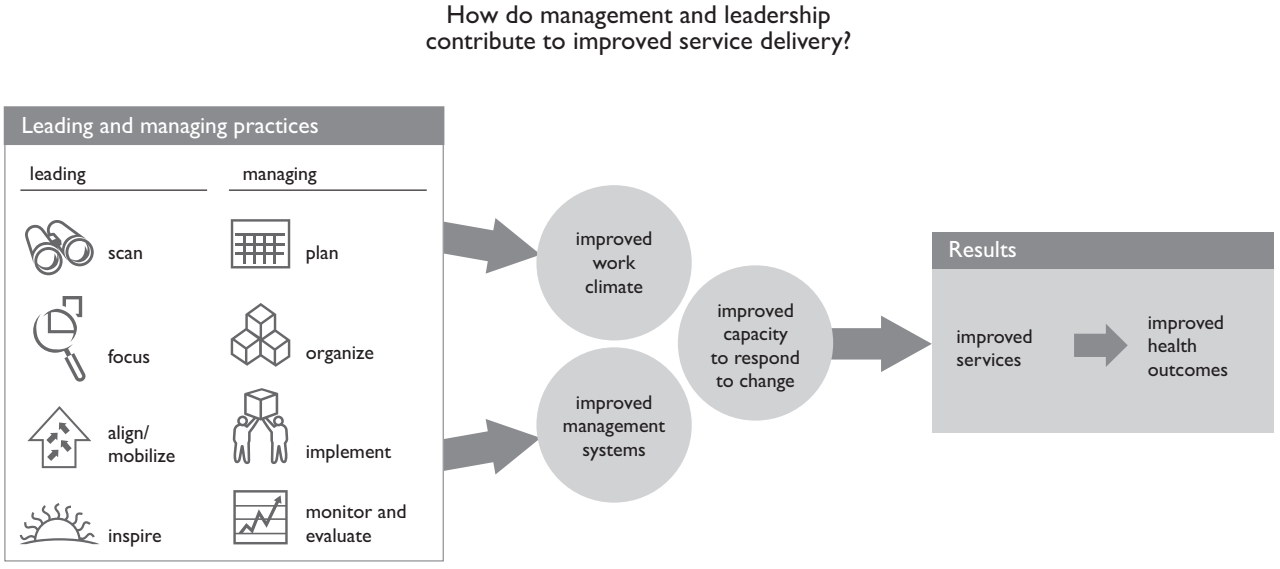
To face the enormous challenge of addressing the human resource crisis, you will need to be clear about what you are changing, at what level the changes need to take place, and how to navigate through the change process. Depending on the scope and complexity of the challenges you are facing, you may need to lead changes in some or all of the following areas:

- organizational structure and human resource management systems
- national or organizational policies and strategy
- clinical or management practices.

To lead a change process, you first have to identify the types of challenges that need to be addressed. The Human Resources for Health Framework (chapter 1) provides a process for identifying the challenges that you need to address to minimize the human resource crisis. In most cases, changes will need to be made in multiple areas. By applying the leading and managing practices shown in Figure 6.1 consistently, managers can make and institutionalize improvements in human resources that allow organizations to serve clients better and realize sustainable improvements in the health of their populations.

The Leading and Managing for Results Model (Figure 6.1) illustrates how applying the leading and managing practices, fostering a positive work climate, building effective management systems, and strengthening the ability of both the staff and the organization to respond to change all contribute to achieving positive results in health. To start, it is important to understand the complexity of the challenges managers and organizations are facing.

Figure 6.1. Leading and Managing for Results Model



When applied consistently, good leading and managing practices strengthen organizational capacity and result in higher-quality services and sustained improvements in health.

Distinguish between Routine Problems and Complex Conditions

Leadership means "enabling others to face challenges and achieve results under complex conditions." What do we mean by complex? A complex condition is one that is constantly changing or unpredictable (see Table 6.1). In these situations, we cannot apply a prescribed set of steps and count on a predefined outcome. Instead, as conditions in the environment evolve, we must change the way we think and respond. This type of change requires that we learn from day-to-day experience and adapt by applying new values, new ways of thinking, and new practices. There are no easy answers.

Table 6.1. Distinguishing between Routine and Complex

Routine Problems	Complex Conditions
The problem is well defined and the solution is known.	The situation must be analyzed and the immediate solution is not known.
The problem can be solved with existing knowledge and practices.	People need to adjust their values, ways of thinking, and practices to address the condition effectively.
A prescribed process can be implemented to solve the problem.	Implementation requires learning new approaches and practices and being flexible as new conditions emerge.
The solution can be applied by a single person or group.	Collaborative work by several stakeholders is required to achieve the solution.

Source: Adapted from R. Heifetz, J. Kania, and M. Kramer, "Leading Boldly," *Stanford Social Innovation Review* vol. 2, no. 3, 2004:20–31.

Leading Organizational Change

All successful change efforts require a champion—a person or group of people committed to leading the change process over time and working to overcome the obstacles along the way. The members of this leadership team first need to clarify their own commitment to the change and believe strongly that the new practice, process, or system is needed to address the challenge the organization is facing. They may be inspired by the words of Anne Frank: "How wonderful it is that nobody need wait a single moment before starting to improve the world."

The leadership team will also need to communicate a compelling case for the proposed change. As part of a strategy for aligning senior management and key stakeholders and gaining their commitment, the team needs to show that the proposed change is consistent with organizational values and priorities, and explain how the changes can be implemented without seriously disrupting other important organizational activities. Gaining this critical commitment from other stakeholders will help ensure that necessary resources will be made available to support the change effort. At the same time, the leadership team must regularly monitor and report on the progress of the effort, and those involved in implementing the changes must be responsible and accountable for using resources appropriately.

Lead the Change Process

Once you are certain that a change is needed and have identified the types of challenges you are facing, your job is to initiate and lead the change process. This is especially important in leading change in human resources, which will require action on multiple fronts over several years. Effective action requires knowing and incorporating the critical success factors in your change effort.

Many change efforts fail because they are not led and managed well. Such efforts waste precious organizational resources and create pessimism about the organization's ability to change.

The eight factors shown in Table 6.2 largely determine whether a change effort will be successful. The lessons are drawn from John Kotter's research on thousands of organizations undergoing organizational change. They also draw on MSH's approach to developing managers who lead at all levels of an organization. These lessons can serve as guidelines for managers leading a change process.

Table 6.2. Key Factors in Leading Organizational Change

Success Factor	Consequences of Not Taking This Step
Communicate urgency by framing the challenge clearly	**Complacency.** People will not be mobilized to change if they think everything is fine the way it is. They need to understand the challenge they are facing and how it affects their work and their organization.
Build the core team	**Going it alone.** If there is not a group of "early adopters" who are committed to the change, it will falter in the face of opposition. Include key stakeholders and authority figures on the change team in order to get organizational buy-in.
Create a shared vision	**Lack of commitment.** If the vision is not created together with all of the stakeholders, there is no clear picture of and path toward a desired future, and energy and commitment will be dispersed. Be inclusive in creating the vision.
Include others in planning and implementation	**Lack of involvement.** If the vision is not communicated clearly and regularly and used as a guide for shared planning, it will not have an impact on organizational activities. Engage others in creating the implementation plan.
Overcome obstacles together	**Demoralization.** When obstacles remain in place, and little or no effort is made to remove them, people will not be able to sustain the energy to continue. Work together to identify the root causes of obstacles and overcome them.
Focus on results and create short-term wins	**Lack of sustained effort.** When people do not see any positive results in the short term, it is hard to keep them engaged. Focus on results and how to achieve them.
Maintain support for facing ongoing challenges	**Shifts in attention.** While the first positive results may be encouraging, they are not a substitute for lasting change. The risk of declaring victory too soon is that people's attention shifts to something else, and the effort to keep the change moving is lost. Continue to frame the new challenges.
Make change stick in organizational systems and culture	**Changes that don't last.** If the changes do not become part of the organization's systems and culture, it is unlikely that the changes will last. Incorporate new values, behaviors, and processes into routine organizational systems.

Source: Adapted from John P. Kotter, "Leading Change: Why Transformation Efforts Fail," *Harvard Business Review,* March–April 1995, p. 61.

To be successful in implementing these success factors, managers need to create an environment that supports and encourages change. This means creating a work climate that rewards staff for trying new ways of doing things and acknowledges them for their efforts and commitment while also holding staff accountable for their work.

Creating a Climate That Encourages Change

John Welwood wrote that "The most powerful agent of growth and transformation is something much more basic than any technique: a change of heart." Any successful change process—whether it is a single practice or an organization-wide system—relies foremost on a manager's desire to make changes. The manager needs to be willing to reflect on his or her own values and behaviors. This proactive attitude is a prerequisite to leading any change effort. Indeed no significant changes are made that don't begin with a change in oneself. Change requires that you think about and be willing to question long-held beliefs, since often our beliefs are the biggest obstacles to change.

Managers also need to help staff examine their own attitudes and behaviors so that they can respond appropriately to changing conditions. Change is a learning process and requires that you have the ability to question assumptions and test new ways of acting. You will be much more credible as a leader of change if you show in your daily life that you are also making the changes you request of others.

Address Resistance to Change

Resistance is a common response to change. People usually resist change because they view it as losing something that is important to them. They may oppose changes and seek to sabotage them because they weren't included in the decision-making that led to the changes. People also resist change if the proposed changes strongly contradict their ideas or appear to threaten their survival.

When you run into resistance, allow people to express their fears and feelings of loss. Don't rush them into seeing things your way, but consider how the change appears to them.

Scan to understand who is resisting and why. Different people or groups may resist a change for different reasons. Find out what people think they stand to lose. Look for examples elsewhere of successful change efforts that you can learn from. Sharing experiences and providing support to one another is important. Tap into networks of people who may have dealt with similar challenges.

Focus on the early adopters. Look at the causes of the resistance, not just the symptoms, and form a strategy for dealing with the resistance. One strategy is to focus on early adopters, those people who buy in and become change agents themselves early on, especially those who are already opinion leaders. Start by including them in your deliberations. It will be a small group at first, but each additional member increases your momentum.

Align and mobilize other people with your change efforts. With your core group, seek allies and the support of influential people to get political support and credibility. Mobilize the opinion of others who are in favor of the change both inside and outside your work group by connecting the benefits of the change to the expressed needs of the clients you serve.

Inspire others to work toward the vision. Appeal to a shared vision and to people's deeply held values, such as equity, justice, and fairness. This advocacy will build a com-

mon foundation with others and cause them to reflect on how they can connect what is most meaningful in their lives with the changes that are underway or being proposed.

Box 6.1 gives other strategies for dealing with resistance to change.

Box 6.1. How to Deal with Resistance

Use reason. Make the case (as in a legal argument) for the change you propose, by pointing out the pros and cons of the change, showing the consequences of not addressing it.

Debunk myths. Directly (but tactfully) challenge myths stemming from long-held beliefs, wrong or outdated ideas, or misinformation passed on by others.

Reinforce the desired new behaviors or practices. Provide resources and rewards (which may be publicity, public recognition, awards, extra resources, or opportunities for growth) to those who apply the new behaviors or practices.

Describe the vision in a variety of ways. Provide opportunities for people to "try on" the new vision for themselves.

- Tell a compelling story about the vision and show how the changes are inevitable.
- Recognize that people take in information in different ways. Some need to see numbers presented in graphs or tables. Others prefer to see pictures or hear or see quotations.
- Use movies, poetry, or visual arts to help people understand the benefits of the change.

Look at yourself. Reflect on your habitual ways of communicating, of telling the story. Maybe something you do needs to change. Your own style may be strengthening the resistance!

- Maybe you are moving too fast and are too impatient.
- Maybe you need to use a different way of communicating with people. Presenting slides from a podium may not be the right way. Consider sitting around a table and exploring the implications of the change with those whose support you need most.
- Spend less time communicating your point of view and more time listening.
- Practice what you preach. If the change involves setting and maintaining high standards, then you too should live up to those higher standards. If you tell people that treating clients with respect is your message, then show respect in every interaction, and if you made a mistake, admit it, apologize, and move on.

Expose the resisters to other people or places. Arrange meetings with other people who have been through significant changes. Take staff to visit clinics to see or talk with clients to make the impact of the change visible. These contacts will help demonstrate the (possible) positive effects of the changes you are proposing.

Address slow changers indirectly. Studies on the diffusion of innovations show that a small percentage of almost any group will lag behind in making a change. Do not focus your efforts on this group, sometimes called "slow changers," but let improved results speak for themselves. When a change in practice becomes official, changes in standards will eventually motivate these slow changers to adopt the new practice.

Learn and Share Knowledge

An important factor in supporting a climate in which people think about new ways to approach new challenges and learn from others' experience is to support systems and norms for regularly sharing and exploring what has worked (or not worked) well and why. Having a process for exchanging information, synthesizing it, and making it available to people when they need it supports an environment in which people learn from each other and find new ways to improve performance.

Knowledge management involves establishing processes and work norms that support generating knowledge (information sharing and synthesis); collecting, storing, and packaging the information for easy access, and helping people to apply the information. Create opportunities for sharing knowledge and reward people who engage in this process: see Box 6.2 for ideas.

Box 6.2. Provide Opportunities for Sharing Knowledge and Experience

Share experience in public forums. Encourage people who have completed a project, gone on a mission or field visit, or presented at or attended a conference to present what they learned to the rest of the organization.

A common practice in the United States is to conduct a "brown bag," named after the brown paper bag that people often use to carry their lunches. These presentations occur around lunch time and people are invited to eat their lunches while listening. (Because the atmosphere is informal, eating is not considered disrespectful.) In this way, the organization does not have to disrupt work schedules and the presentation is limited to one hour.

Brown bag presentations give people a chance to learn about colleagues' work (challenges and successes) and also provide an opportunity for people to practice their presentation skills. These presentations also allow those who have little direct contact with the ultimate beneficiaries of their work to see the connection between their work and the well-being of those served by the organization.

Write up and publicize your results. When a program or intervention has been underway for some time, particularly when it has yielded significant results, work with a small team to produce a flier, brochure, book, newsletter or journal article, curriculum, guide, video or photo montage, or even a conference (virtual or traditional). Creating a product compels you to distill the essential lessons from experience in a form that is accessible to others.

Evaluate progress and share lessons learned. Routine monitoring and periodic focused evaluations allow you to continuously learn from your activities. Be sure to look carefully at data and information from routine monitoring, discuss the results of evaluations, and apply what you have learned so that you can improve your organization's ability to serve your clients and communities.

Another way to discuss lessons learned is to hold an "after-action review" meeting. The after-action review brings together members of a team who have worked over a period of time to achieve an objective. The members discuss what worked well (and should be continued in another initiative) and what didn't work as well as intended (and should be done differently next time). To be effective, this process requires that the participants be honest and provide constructive feedback, be open to hearing others' perspectives, and be willing to make changes.

Supporting Change with Management Systems

Systems are the interdependent processes that support and enable an organization to do its work and reach its intended results. Good human resource management (HRM) systems support an organization's capacity to manage its human resources well and provide better health care. As the Results Model indicates, well-functioning and efficient HRM systems are essential in order for an organization to effectively address its human resource challenges.

You have to make sure that your HRM system can support you, your team, and the entire organization in addressing your current challenges. Do they provide you with the critical information you need in a timely manner? Do they enable you to respond quickly to opportunities and requests? Do they help you see trends and problems, and provide warning signals in time? Can they compensate for the inevitable knowledge and experience gaps when you lose seasoned staff?

Good organizational performance is more likely if you have appropriate staffing levels and (at a minimum) people who perform their jobs according to established job standards. If you do not have enough staff who are performing to these standards, all your other management systems will be compromised. To sustain strong performance, your human resource management system needs to support:

- planning of human resource needs
- deployment of staff in response to changing work requirements
- creation of a resilient and motivated workforce
- a culture of shared learning and teamwork.

Work with Multiple Stakeholders to Scale Up Changes

The challenge of scaling up changes in human capacity development is particularly relevant in the fight against HIV/AIDS. The urgency of addressing the pandemic and dealing with its consequences calls for concerted, large-scale action to mobilize human resources. Large global and multidonor funding arrangements (such as those used to support initiatives focused on eradicating a specific disease), sectorwide funding strategies, and basket funding mechanisms often carry an imperative to create partnerships among sectors and stakeholder groups in order to use the funds to scale up national programs effectively.

Coordination across sectors is absolutely necessary to address most public health crises. When many organizations operate in the same general area, they must coordinate activities to serve the needs of their client populations. Whether it is human capacity development, HIV/AIDS, education of women and girls, family planning, or the elimination of harmful practices, coordination requires planning with key stakeholders.

Coordination efforts usually illuminate common hopes and dreams, along with potential conflicting agendas.

Define Roles and Rules of Collaboration

When coordinating with other stakeholders, a group composed of representatives of each organization needs to develop a shared vision, find common ground, and establish a common language. In doing so, they make visible the intricate interdependencies among the various partners. If it is done well, each stakeholder group will understand how it can contribute its unique strengths, expertise, experience, and position to support a successful scale-up. If it is done poorly, it will create cynicism, waste resources, and compromise the most precious resource we have: people's energy and their commitment to a common cause.

Because the professional and organizational cultures of the various stakeholder groups will vary, it is important to be clear about how you will work with other stakeholders so that together you can realize the greatest benefit from your collective interests, experience, and capabilities. To engage effectively with other stakeholders, you will need to know:

- how decisions will be made (Will the leader make the final decisions? Will you vote? Will you seek consensus?);
- what the criteria will be for accepting or rejecting plans, or modifying them when circumstances change (Are you looking at time, cost, scope, impact?);
- who will need to agree on which kinds of decisions (Will consultative groups need to agree only on broad strategy but not on the details of implementation?).

Deciding together on the process and structure of your collaboration will establish a strong foundation for the future. Irritations frequently arise out of mismatched expectations about how people will work together, what processes and outcomes are acceptable (and which are not), and how credit and accountability will be handled. Establishing ground rules is important because they state what people's responsibilities are for approving, implementing, and evaluating activities. By agreeing on the rules, people will know what they will be held accountable for, and what the consequences will be if they don't follow through on their responsibilities.

Taking the Lead in Scaling Up a National Response to Human Capacity Development

Coordination is an important mechanism for managing large-scale change or scaling up small successes beyond one group's pilot project. Coordination involves more than meeting periodically. To turn a coordinated effort into a true partnership you need to actively shape it. The following actions will help you lead a diverse group of partners as they prepare to scale up a practice or service on a regional or national scale in partnership with one another.

Develop a common view

- Alignment is key. Develop a common view of the central challenge that the partnership needs to address.
- Coherence provides focus. Agree on the central goal of the initiative or program. Make sure everyone agrees with "what success looks like."

Recognize opportunities and constraints and plan to address them

- Recognize that each group contributes in specific ways to addressing the common challenge and achieving the partnership's goal. Define clear roles in line with each partner's strengths.
- Acknowledge that individual groups cannot do everything even in limited geographical zones. Map out who will do what and where in order to build on each partner's strengths and geographic presence, and look for complementarities within and across regions.
- Be aware that coordinated action creates new work or tasks that may require additional resources that are not already programmed in annual plans and that pose human capacity challenges in particular. Include plans for how the additional resources will be mobilized and deployed.
- Know that when diverse groups work together, conflict is inevitable. Discuss at the outset how you will address obstacles to good coordination (such as competition, technical and style differences, resource needs and uses) and make agreements or ground rules to fulfill the potential that your diversity offers.

Help partners grow and develop

- The scope of the collective task may require individual partners to move beyond their traditional roles and geographic area. Therefore, help them to take on their new responsibilities.
- Working in partnership makes new demands on managers and leaders. Help them look at their leadership and management roles in the scale up effort and determine where they need to strengthen their capabilities to carry out their roles successfully.

In the end, change is always a process of aligning and mobilizing stakeholders. In most situations, other people have commitments, beliefs, and expectations that differ from our own. If we are really going to lead change successfully, we have to consistently seek to understand others' views and create shared visions to bring new realities into being.

7 Indicator Guide for Developing and Implementing a National Plan for Human Resources for Health

As reported in the Joint Learning Initiative report *Human Resources for Health: Overcoming the Crisis,* "Effective action, both urgent and sustained, requires solid information, reliable analyses and a firm knowledge base" (Cambridge, MA: Harvard University Press, 2004, p. 9). The matrix of indicators in this chapter contributes to this knowledge base, although global indicators for human capacity development are still being developed. The chapter also provides guidance for developing and implementing a national plan for human resources for health (HRH), as described in chapter 1.

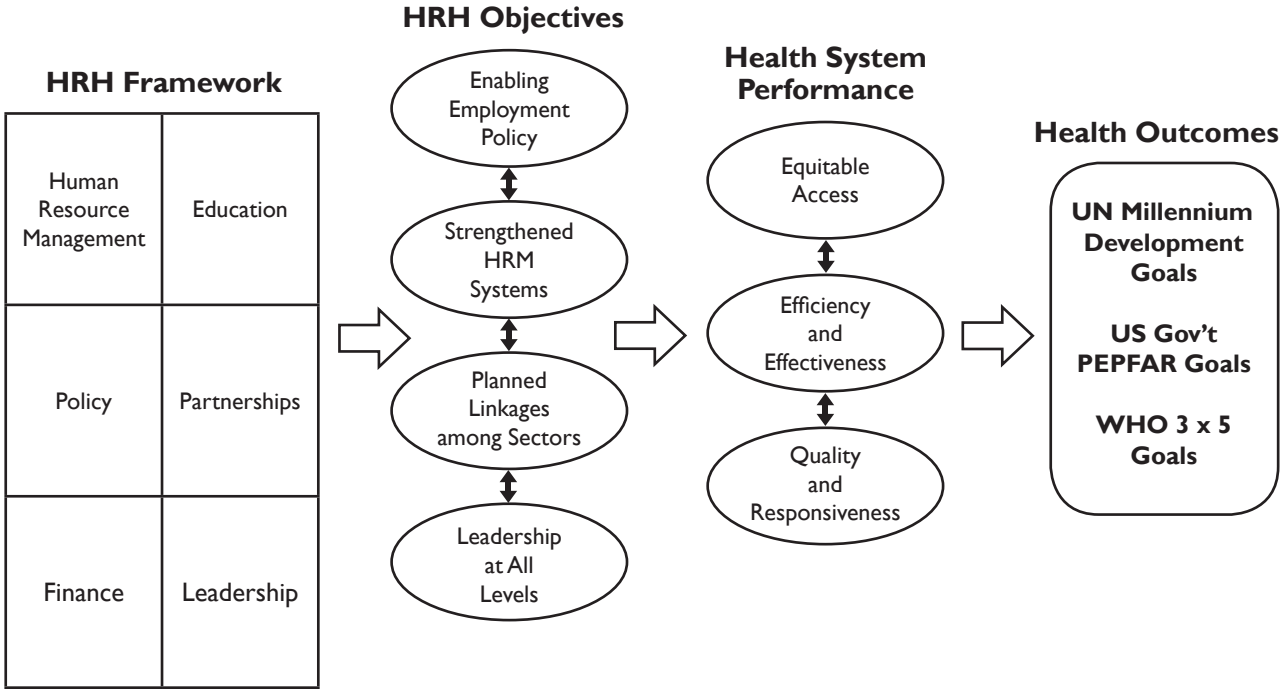
Figure 7.1 illustrates how the components of the HRH Framework contribute to health system performance and health outcomes. Because measures of health system performance and health outcome are widely available in other publications, they are not presented here. Research conducted for the Joint Learning Initiative report shows a correlation between health worker density and improved health outcomes. This correlation is universally higher than the correlation between health outcomes and income, education, or poverty. Evidence of the impact on health outcomes of comprehensive, planned HRH interventions is limited because few HRH interventions have been implemented. MSH and WHO have accumulated data from small interventions that do link improved health outcomes to the HRH interventions described in this book, but more research needs to be done. This evidence shows that carefully planned strategies to strengthen policies, human resource management systems, linkages across the health system, and leadership are necessary steps toward improved health system performance and health outcomes.

By Steve Reimann, Sarah Johnson, Riitta-Liisa Kolehmainen-Aitken, Mary O'Neil, and John Pollock, Management Sciences for Health, 2005. The authors would like to acknowledge the assistance of Alison Ellis and Cary Perry.

Purpose. This guide provides process and outcome indicators for use in developing and implementing a country-based HRH plan. The indicators are organized into a logical framework, beginning with process measures concerning the necessary structures to implement an HRH plan and the required steps to analyze challenges in human capacity development. These process indicators are followed by output measures for each of the four categories of the HRH Framework and outcome measures specific to HRH. The HRH Framework shows that a comprehensive, integrated HRH plan must include action in six categories: human resource management, policy, finance, education, partnerships, and leadership.

Audience. Policymakers, human resource planners, human resource managers, HIV/AIDS commissions and others involved in multisectoral health initiatives and public-private partnerships

Figure 7.1. **Contributions of the Human Resources for Health Framework to Improved Health Outcomes**



Process. The matrix that follows is organized in three columns. On the left, you will find illustrative process, output, and outcome indicators for the stages of developing and implementing a national HRH plan. The second column provides definitions and standards for the critical components of HRH planning and implementation, and guidance about the process and products. The last column suggests sources of data that can be used either to inform the human resource analysis or to document progress in implementing the plan.

Indicator	Definitions and Standards	Sources of Data
Stage 1: Preparation		
In-country leadership team constituted, with budget support and holding regular meetings	**Leadership Team** This team should include representatives of: ■ Ministry of Health (MOH) ■ Ministry of Education ■ Ministry of Finance ■ National AIDS Commission ■ Public Service Commission ■ professional associations ■ health training institutions ■ labor unions ■ private sector One or two local human resource experts should participate to provide technical input to strategy development. Role: ■ Gather data about human resource gaps, with a focus on scaling up HIV/AIDS services. ■ Identify root causes of gaps. ■ Using the HRH Framework, develop a comprehensive HRH strategy and implementation plan. ■ Secure short-term consultants as needed to assist with strategy development. ■ Secure a high-level advocacy team and budget to support implementation. **Administrative Team** The administrative team should include: ■ project manager(s) ■ administrative assistant(s) ■ budget analyst(s) Role: ■ Support the leadership team in: - identifying sources of current HR policy and data; - providing budget and administrative support; - drafting report on strategy.	■ Terms of reference ■ Constitution of HRH leadership team ■ Meeting minutes, policy workshop reports, research studies, etc. ■ Budget allocated to HRH strategy development ■ Interviews with leadership team members and leaders from stakeholder organizations ■ Focus group interviews

Indicator	Definitions and Standards	Sources of Data
Stage 2: Scanning and Analysis of Human Resource Challenges in the Health Sector		
Report analyzing human resource gaps and root causes produced from scanning variables that impact human resources for health	The report should describe and analyze the following five areas. **Governance** ■ Government structure for human resource management (HRM) (centralized versus decentralized authority) ■ Human resource policy (civil service rules, salary structures, and authorized scopes of practice for health cadres) ■ Health expenditure ■ Strengths and weaknesses in the HRM system and the capacity of the MOH to manage its human resources at all levels (planning, recruitment, hiring, transfer, promotion, training, human resource information systems, HIV/AIDS workplace programs) ■ Economic climate and health priorities **Numbers and types of health staff available from all sources** ■ Basic demographic data on the workforce ■ Strengths and gaps in numbers of workers needed ■ Projections of human resource needs over 10–15 years ■ Skill levels of existing health staff ■ Impact of HIV/AIDS on the workforce (illness or death from infection) ■ Public-sector–private-sector mix of health providers ■ Numbers of trained but unemployed health staff in country ■ Numbers and types of health staff being trained by professional schools **Education** ■ Capacity of training institutions to supply needed health workers (tutors, lab facilities, capacity for distance learning) **Partnerships** ■ Existing contractual arrangements between the MOH, NGOs, faith-based organization (FBOs), community-based organizations (CBOs) **Leadership** *Country level:* ■ Extent to which donors are providing HR assistance ■ Budgetary commitment to cooperative HRH efforts *Facility level:* ■ Level of employee motivation and work climate ■ Evidence of teamwork to solve problems	■ Situational analysis report ■ Research study papers ■ Meeting and conference reports

Indicator	Definitions and Standards	Sources of Data
Stage 3: Strategic Planning		
HRH implementation plan developed and budgeted	■ An HRH implementation plan is organized according to the HRH Framework. Priorities for action are informed by the HRH report (stage 2) and include short-term emergency measures and long-term sustainable goals. ■ The HRH implementation plan covers SMART objectives, activities, responsibilities for implementation, and resources needed. ■ High-level advocacy is in place to support the long-term financial commitment to implement the HRH strategy. ■ Health strategies contain budgeted human resource requirements.	■ HRH implementation plan ■ National, provincial, and district health strategies and plans ■ National health accounts and budgets ■ Interviews with national, provincial, and district health leaders
Stage 4: Implementation of the HRH Strategy ***The following indicators are illustrative. While your plan should include activities in each component of the framework, the specific indicators you select will depend on the priority actions in your HRH plan.***		
A. Outputs		
Policy and Financial Requirements		
Human resource policies in place that support HRH	Human resource policies that support HRH should include the following elements: ■ Salary structures ■ Authorized scopes of practice for health cadres ■ Recruitment targets ■ Training targets ■ Educational standards for professional training institutions ■ HIV/AIDS workplace programs ■ Leadership development and succession planning ■ Supervision practice ■ Procedures for hiring, transfer, promotion, discipline, training, etc. ■ Human resource management capacity ■ How these policies apply to NGOs, FBOs, CBOs and the private sector.	■ Labor law and Civil Service Commission policies and procedures governing the health sector ■ MOH personnel policies and procedures ■ Employee handbooks ■ Strategic plan for human resources ■ National, provincial, and district health strategies ■ Training plans ■ HIV/AIDS workplace programs ■ Interviews with human resource department and organizational leadership

Indicator	Definitions and Standards	Sources of Data
Appropriate scopes of practice defined for all cadres	■ An acceptable level of responsibility is allocated to each cadre in light of the availability of health staff and demand for health services. ■ Contractual arrangements between the MOH, NGOs, FBOs, and CBOs support these aims.	■ MOH personnel policies and procedures ■ Strategic plan for human resources ■ National, provincial, and district health strategies ■ Agreements between the MOH and partners ■ Interviews with leading staff of the MOH and partners
Amount of funding available to support the leadership team in implementing policy recommendations	■ The MOH, Ministry of Finance, and Ministry of Education have allocated adequate funds to support the implementation of all elements of the HRH strategy. ■ The mechanisms to release the funds on time are in place.	■ National health accounts and budgets ■ Financial management policies and procedures
Human Resource Management		
Percentage of hospital and administrative units at district level and up with a trained human resource professional	The human resource professional is dedicated to HRM and has experience or training in modern HRM practice, i.e., in one or more of the following functions: human resource planning, personnel policy, information systems, performance management, training, and leadership.	■ Staffing list of hospitals and administrative units ■ Resumes of human resource professionals ■ Interviews with human resource professionals
Human resource information system in place for all MOH hospitals and administrative units at the district level and up	The human resource information system has current data, including the following: ■ General employee data: number of staff by job category, their location, skills and educational level, gender, age, year of hire, salary level; ■ Personnel files for individual employees with details of their employee record. Larger organizations should have a computerized human resource system. It is not essential for smaller organizations to have a computerized system, providing comprehensive, current data are available and accessible (systematically organized and filed).	■ Human resource information systems ■ Interviews with human resource department staff
Percentage of hospitals and administrative units at the district level and up that use human resource information system for HRH planning	Hospitals and administrative units consistently use information from their human resource information systems to plan recruitment, deployment, training, retention, and partnering strategies.	■ Hospital and administrative units' long- and short-term plans ■ Minutes of management team meetings ■ Interviews with unit and human resource managers

Indicator	Definitions and Standards	Sources of Data
Percentage of hospitals and administrative units at the district level and up with procedures in place for human resource planning, policy, recruitment, hiring, deployment, performance management, training, and career paths	■ Hospitals and administrative units have policy and procedure manuals that set standards and govern practice in all the following areas of HRM: human resource planning, recruitment, hiring, deployment, performance management, training, and career development. ■ They have systems to translate policy into action. ■ They consistently use the systems to manage human resource issues.	■ Human resource policy and procedure manuals ■ Human resource management systems ■ Human resource department files ■ Interviews with hospital, administrative unit, and human resource department managers
Percentage of hospitals and administrative units at the district level and up where trained, non-physician staff provide ART	■ Hospitals and administrative units give authority to non-physician staff to administer ART by including this duty in their job descriptions. ■ Non-physician staff members receive appropriate training and supervision to administer ART.	■ Job descriptions of relevant non-physician staff ■ Interviews with non-physician staff and their supervisors ■ Supervision logs and reports ■ Training curricula and records
Percentage of hospitals and administrative units at the district level and up that have implemented a staff training plan	Hospitals and administrative units have implemented a current, comprehensive staff training plan based on: ■ an internal needs assessment ■ financial feasibility ■ worksite training ■ practical, on-the-job methodologies.	■ Training plans and curricula ■ Observation of training activities ■ Interviews with trainers and trainees
Education		
Ratio of graduates of pre-service training programs to projected demand by type of health worker	This ratio compares the number of students graduating from pre-service training institutions with the number required to meet service delivery demand for each type of health worker. It is an indicator of the capacity of pre-service training institutions.	■ HRH studies projecting demand for main health work cadres ■ Number entering and graduating from pre-service training institutions ■ Interviews with training institute and MOH directors
Number of institutions providing pre-service training by cadre and geographic location	■ Cadres include doctors, nurses, laboratory technicians, pharmacists, and community health workers. ■ Pre-service training institutions include established schools as well as programs associated with the MOH (e.g., to train community health workers). ■ There is access to these programs from all parts of the country.	■ Reports on pre-service training institutions ■ Review of other relevant training programs ■ Map showing locations of training institutions and programs
Number of certified lecturers/ tutors employed by pre-service institutions by cadre and geographic location	■ Numbers of lecturers/tutors certified in content and quality for each of the essential cadres ■ Lecturers/tutors deployed geographically	■ National database of graduates of essential health training programs and where they are posted ■ Lecturers and tutors matched to types of programs and numbers of students

Indicator	Definitions and Standards	Sources of Data
Numbers of supplies and equipment available directly within the institution or indirectly through an institution providing services	■ Numbers of supplies and equipment to train pharmacists, laboratory technicians, and cadres requiring special skills ■ Equipment and supplies available within the training institutions or by arrangement with institutions providing services.	■ Survey of equipment and supplies at training institutions and programs
Partnerships		
Agreements in place between MOH and other health providers to supplement the delivery of HIV/AIDS services	The MOH has written agreements with other public-sector institutions (ministries of Finance and Education, Public Service Commission), NGOs, CBOs, FBOs, and the private sector to allow the widest possible provision of HIV/AIDS services.	■ MOH partnership agreements with other organizations ■ HIV/AIDS service statistics ■ Interviews with senior staff of MOH and partner organizations
Leadership		
Country level: Evidence of high-level advocacy to promote the implementation of the HRH plan	National MOH leadership, other senior government officials, private-sector leadership, and donors publicly promote and support HRH initiatives. Evidence includes: ■ The HRH plan is featured on donor platforms and conferences. ■ The president speaks out in support of HRH initiatives. ■ Ministry officials make public statements in support HRH initiatives. ■ The media covers speeches.	■ Conference agendas ■ Published speeches and media coverage of government officials' statements ■ News media materials
Hospital or administrative unit level: Leadership development program established for managers at all levels	■ A leadership development program that prepares leaders at all levels has been institutionalized. ■ There is a clear leadership transition policy and plan to implement it.	■ Curricula and reports from the leadership development program ■ Human resource data on people trained ■ Interviews with organizational leaders
B. Outcomes *The following indicators allow you to determine the degree to which your HRH plan, as implemented, results in measurable outcomes.*		
Percentage of health facilities with staffing levels that meet the requirements of the HRH plan	Staffing levels at all health facilities have been compared with those recommended in the HRH plan.	■ Human resource department staffing data ■ HRH plan staffing recommendations
Employee satisfaction	Overall employee satisfaction levels have increased. You need to establish a baseline before implementing the HRH action plan. Research indicates that employees' level of satisfaction with their work stems from how they perceive five components of their work environment: 1. Employees perceive they are being treated fairly. 2. Employees understand what they are expected to do on the job. 3. Employees feel they get adequate feedback on their performance. 4. Employees feel their work is meaningful and valued by the organization. 5. Employees feel they have opportunities for career development. The MSH employee satisfaction tool provides an instrument to measure these components.	■ Employee satisfaction survey

Indicator	Definitions and Standards	Sources of Data
Staff vacancy rate	**The position vacancy rate:** This rate is based on a sum of all vacant positions for a specific type of personnel (physicians, nurses, midwives), divided by the sum of all established and budgeted positions for that type of personnel at a particular point in time. This calculation of vacancy rates is preferred for a large geographic area such as a province or region. It is simply the percentage of all budgeted positions that were vacant and for which staff were being actively recruited at a given time. **The average facility vacancy rate:** A facility vacancy rate is calculated for each facility in a geographic region. This rate is the number of vacancies for a particular facility, divided by the sum of budgeted positions for that facility. These individual values are then summed across facilities, and the sum is divided by the number of facilities represented to get the average facility vacancy rate. Average facility vacancy rates can be heavily influenced by a large hospital or a number of very small health centers in a region. A baseline should be established at the beginning of implementation. A trend of decreasing vacancy rates is the goal.	■ Human resource department data ■ Payroll records ■ Vacancy rate surveys
Staff absenteeism rate	**Absenteeism** is defined as failure of employees to report for work when they are scheduled to work. Employees who are away from work on recognized holidays or vacations are not included. Staff working at another facility may or may not be included, depending on the reliability of the report. In random unannounced surveys of health facilities, a worker is counted as absent if, at the time of the visit during facility hours, he or she was not in the health facility. There are several ways of measuring absenteeism: ■ **Lost time rate:** The total number of hours or days absent in the period, divided by the possible total hours or days in the period, multiplied by 100. ■ **Absentee frequency rate:** The average number of spells of absence in a period divided by the number of workers in the period, multiplied by 100. A baseline should be established at the beginning of implementation. A trend of decreasing staff absenteeism is the goal.	■ Staff attendance records ■ Human resource department records ■ Unannounced health facility surveys
Staff retention rate	**Separation rate:** The number of staff leaving during a period divided by the average number working, multiplied by 100. **Stability index:** The number of workers with one year's service or more divided by the number of workers one year ago, multiplied by 100. A baseline should be established at the beginning of implementation. A trend of decreasing separation rates and increasing stability index is the goal.	■ Human resource department records ■ Payroll records ■ Interviews with human resource staff and department or unit directors

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About Management Sciences for Health

Management Sciences for Health (MSH) is an international nonprofit organization, dedicated to closing the gap between what is known about the overwhelming public health challenges facing many nations and what is done to address those challenges.

Since 1971, MSH has worked in more than 100 countries with policymakers, health professionals, and health care consumers to improve the quality, availability, and affordability of health services. We work with governments, donors, nongovernmental organizations, and health agencies to respond to priority health problems such as HIV/AIDS, tuberculosis, malaria, child health, and reproductive health. Our publications and electronic products augment our assistance in these technical areas.

MSH's staff of more than 1,100 from almost 70 nations work in its Cambridge, Massachusetts, headquarters; offices in the Washington, DC, area; and more than 30 country offices. Through technical assistance, research, training, and systems development, MSH is committed to making a lasting difference in global health.

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About the World Health Organization

The World Health Organization (WHO) was founded in 1948 as a specialized agency of the United Nations. It has 192 member states, which govern the Organization through the World Health Assembly. WHO has a decentralized structure with a headquarters in Geneva, Switzerland, six regional offices (in Brazzaville, Cairo, Copenhagen, New Delhi, Manila, and Washington, DC), and WHO representatives in more than 140 countries.

WHO's mission is to promote and protect the health of all peoples. The Organization's constitution defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

WHO's programs and activities cover a very broad range of subjects that include infectious diseases, mental health, environmental issues, education and training, emergencies and disasters, epidemics and epidemiology, pharmaceuticals, community services, chronic diseases, health systems, nutrition, healthy lifestyles, gender, ethics, and human rights. WHO is also responsible for setting international standards relating to public health.

WHO's Web site is www.who.int.

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