Global Heath Workforce Alliance (GHWA)

"*Promoting Synergy Between Partners*"

Addis Ababa, Ethiopia: 10-11 January 2008.

Meeting Notes

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"Promoting Synergy Between Partners" is one of the five core areas of the Global Health Workforce Alliance (GHWA).

"The Alliance should initiate consultations with relevant partners to share experiences on perceived needs and bottlenecks, innovative strategies, and how these initiatives are impacting upon the workforce. Encouraging compliance with best practices for workforce development, selective experimentation and improvisation should be a high priority."
GHWA (2006) Strategic Plan.

The GHWA Strategic Plan (2006-15) is available for download at:

http://www.who.int/workforcealliance/GHWA_STRATEGIC%20PLAN_ENGLISH_WEB.pdf

1 Meeting Notes

This report provides a short summary of the key discussion points from a meeting in Addis Ababa, Ethiopia on the 10th and 11th of January 2008. The meeting followed on from the launch of the WHO Guidelines on Task-Shifting (8-10 Jan) and was attended by participants who are actively involved in addressing Human Resources for Health (HRH). The meeting agenda is available as Annex 1 and a list of participants as Annex 2.

Whilst the meeting was open for all participants at the Task-Shifting meeting to attend, the focus was on four countries (Ethiopia, Kenya, Mozambique and Zambia) which are included in the 'first-wave' of the International Health Partnership (IHP) support and have significant PEPFAR programmes. These are considered as the IHP/PEPFAR 'overlap countries' where partner synergy and concerted actions could add immediate value in supporting country governments to address their respective HRH issues. GHWA extends its thanks to DFID and PEPFAR staff who had provided support in organising the meeting and convening country participants.

2 Day 1 - Thursday 10th

Dr. Francis Omaswa, Executive Director, GHWA opened the meeting with a brief introduction.

Dr, Anders Nordstrum, ADG, HSS/WHO provided participants with the background and called for agreement between partners on some clear, practical actions that would address country needs in HRH.

Dr. Omaswa then provided a short overview of the work of GHWA in developing a Global Action Plan (GAP) for HRH and the objectives of the document. Questions from the floor prompted some discussion. Points for GHWA to consider as the GAP is further developed included:

- A set of 5-10 very tangible targets – to make the case for HR
- Address the barriers and have a monitoring and evaluation mechanism for tracking partnerships and how we are working together. A case of mutual learning from countries.
- Need commitments to solidarity
- Process and output indicators required
- Focus on action

Dr. Nordstrum then invited country representatives to offer the group their own perspectives on country progress and needs, and asked them to use the opportunity to inform partners on what they would like to see in the GAP.

Country presentations followed with inputs as below and discussion from the meeting participants:

Ethiopia	Wuletta Lemma, Marion Kelly
Kenya	Maurice Maina, Miriam Were, Tony Daly
Mozambique	Antonio Mussa
Zambia	Oliver Lulembo, Margaret Kaphiya, Simon Mphuka, Dyness Kasungami

The presentations were extremely useful in establishing the current scenarios, challenges and actions at the country level and prompted questions of clarification from the group in advance of the planning work scheduled on Day 2.

3 Day 2 – Friday 11th

Dr. Stewart Tyson, DFID, presented a summary of the key points arising from country presentations and discussions on the preceding afternoon. The summary reflected the key themes in the GAP that had been presented by Dr. Omaswa, drawing attention to discussion points on Leadership, Planning,

Workforce management and retention, Education & Training, Migration, Financing and Advocacy. Partnership, & Accountability. The presentation is available as Annex 3.

Minister Kebede Worku, Ethiopia added some further points of relevance on the need to 'promote synergy' between international agencies. In the case of Ethiopia there was a need to shift from in-service training initiatives, which are often not aligned or coordinated, to pre-service training which has long-term financing and can contribute to the expansion of medical education and capacity.

Dr. Neil Squires, DFID Mozambique, then presented the overview and objectives of the break-out groups. Each of the four countries represented formed a group of country stakeholders and were joined by meeting participants representing HQ staff, WHO, UNAIDS, civil society. The Chair of each group was from the country delegation.

Brief discussion notes and presentations of each country group are available as Annexes 4- 7. Participants from each country group agreed to use the points presented as a basis for further discussion with government and partners on their return, seeking to develop actions and their implementation.

Dr. Tom Kenyon, PEPFAR and **Dr. Stewart Tyson**, DFID, provided their summary perspectives on the morning discussions and presentations and how their organisations could support HRH in response to the country deliberations.

Dr. Kenyon noted that there is "very little that PEPFAR actually can't do" in support of country-led priorities and plans. In countries where supply is an issue then it may be appropriate to support pre-service education. Technical assistance can be provided for HRH interventions, linked to workforce planning for HIV/AIDS services. The next phase of PEPFAR will allow for longer term perspectives but with annual revisions. The impact of PEPFAR and other programming on country HRH strategies is reviewed regularly.

Dr Tyson noted his concerns for HRH plans being left on shelves rather than actioned. Evidence suggests that country success is premised on high-level leadership. Innovation is required. Better collaboration is required between partners to maximise resources. Development expenditure for health has increased from $6bn to $14bn in the last five years – more effective use of these resources is required, linking with all global health initiatives, foundations, multilaterals and UN agencies. Ethiopia's approach, setting specific targets for the number of HWs it will recruit and employ is a good example of country led leadership. Quick wins are possible, use what you have, make the best use of it, and then think about plans for the longer-term. DFID is available, through country offices to support this, as well as through the IHP.

Dr. Omaswa thanked the speakers, chairs and participants of the meeting for their contributions. He encouraged all to participate in the HRH Forum in Kampala and to share the best practice that had been evident in the earlier country presentations. He reminded participants that the key to making progress in HRH is country-led leadership and called upon all present to facilitate this.

Minister Kebede Worku was invited to provide the closing remarks. He took the opportunity to remind participants that the delivery of quality health services requires the human resources, the facilities and the equipment/drugs/supplies within them. Beyond this it needs the wisdom to bring the three together and the human resources to manage the interactions. Harmonisation of partners' efforts is essential to support this.

Annex 1: Meeting Agenda

Title: **Human Resources for Health (HRH): Promoting Synergy Between Partners**
Convened by: **Global Health Workforce Alliance (GHWA).**
Location: **ECA, UN Compound, Addis Ababa, Ethiopia**
Date/Time: **Thursday 10th January (PM) & Friday 11th January (AM), 2008**

The objectives of the meeting are:
1. To provide preliminary reactions from countries to the GHWA Global Action Plan
2. To agree concrete actions to improve HRH situation in a first set of countries

Date	Time	Agenda Item & Speaker		Chair
10th	14:00 – 14:10	**1**	**Welcome & Introduction**	Anders Nordstrom
	14.10 – 14.20	**2**	**The Global Action Plan for HRH** *Speaker: Francis Omaswa*	
	14:20 – 16.00	**3**	**Country responses: priorities for action**	
		3.1	Ethiopia	
		3.2	Kenya	
		3.3	Mozambique	
		3.4	Zambia	
		3.5	Other countries	
	16.00-16.15		*(Break)*	
	16.15 – 17.30	3.6	Further discussion	
		3.7	Summary of key messages & actions required	
	17.30	**4**	**Close**	Francis Omaswa
11th	09:00 – 09:10	**5**	**Opening Day 2: Key messages from Thursday** *Speaker: Francis Omaswa*	Stewart Tyson (DFID)
		6	**Linking global action plan to specific actions in four PEPFAR/IHP countries**	
	09.10 – 09.20	6.1	Introduction and purpose *Speaker: Neil Squires (DFID)*	
	09.20 – 12.00	6.2	Break-out groups to discuss country actions and responsibilities *All participate in groups*	
	11.00-11.15		*Coffee*	
	12.00 – 12.30	6.3	Report back *Speakers: from country groups*	
	12.30 -13.00	6.4	Discussion and next steps *Speaker: Tom Kenyon (PEPFAR)*	
	13.00 - 13.15	**7**	**Closing remarks** *Speaker: Francis Omaswa*	

Annex 2: Participants

	Name	Surname	Organisation	Country	Thurs 10	Fri 11
1	Pam	Barnes	Elizabeth Glaser AIDS Foundation	USA	x	x
2	Jean-Marc	Braichet	WHO	Switzerland	x	x
3	James	Browder	USAID	Ethiopia	x	
4	Jim	Campbell	GHWA	Switzerland	x	x
5	Joyce	Chung	Clinton Foundation	Ethiopia	x	
6	Tanya	Cross	DFID	UK	x	x
7	Leley-Ann	Cull	Open University			x
8	Anthony	Daly	DFID	Kenya	x	x
9	Basiro	Davey	Open University	UK		x
10	Ben	David	DFID	UK	x	x
11	Paul	Davis	Health GAP	USA	x	x
12	Manuel	Dayrit	WHO	Switzerland	x	x
13	Abdoul	Dieng	UNAIDS		x	
14	Carmen	Dolea	WHO	Switzerland	x	x
15	Francisco	Eduardo de Campos	MoH	Brazil	x	x
16	Ben	Fouquet	GHWA	Switzerland	x	
17	Seble	Frehywot	GWU	USA	x	
18	Pape	Gaye	Intrahealth	USA		x
19	Zelalem	Gizachem	Clinton Foundation	Ethiopia	x	x
20	Piya	Hanvoravongchai	AAAH	Thailand	x	x
21	Joan	Holloway	PEPFAR	USA	x	x
22	Mohammed	Hussein	MoH	Ethiopia		x
23	Jantine	Jacobi	UNAIDS	Switzerland	x	x
24	Margaret	Kapihya	MoH	Zambia	x	x
25	Dyness	Kasungami	DFID	Zambia	x	x
26	Tom	Kenyon	PEPFAR	USA	x	x
27	Marion	Kelly	DFID	Ethiopia	x	x
28	Wuleta	Lemma	University of Tulane	Ethiopia	x	x
29	Fritz	Lherisson	UNAIDS	Switzerland	x	
30	Olivier	Lulembo	USAID	Zambia	x	x
31	Louisiana	Lush	DFID	UK		x
32	Maurice	Maina	USAID	Kenya	x	
33	Elizabeth	McCarthy	Clinton Foundation	USA	x	x
34	Catherine	McKinney	CDC-PEPFAR	Mozambique	x	x
35	Hugo	Mercer	WHO	Switzerland	x	x
36	Sigrun	Mogedal	NORAD	Norway	x	x
37	Simon	Mphuka	Church Health Association	Zambia	x	x
38	Antonio	Mussa	MoH	Mozambique	x	x
39	Marjorie	Ngaunje	MoH	Malawi	x	
40	Anders	Nordstrom	WHO	Switzerland	x	
41	Francis	Omaswa	GHWA	Switzerland	x	x
42	Judith	Oulton	ICN	Switzerland	x	x
43	Asia	Russell	Health GAP	USA		x
44	Badara	Samb	WHO	Switzerland	x	
45	Imogen	Sharp	TF-SET	UK	x	x
46	Jon	Snaedal	WMA	France	x	
47	Neil	Squires	DFID	Mozambique	x	x
48	Barbara	Stillwell	Capacity Project	USA	x	x
49	Stewart	Tyson	DFID	UK	x	x
50	Miriam	Were	AMREF	Kenya	x	x
51	Kebede	Worku	MoH	Ethiopia		x
52	Isaac	Zulu	CDC-PEPFAR	Zambia	x	x

Annex 3: Summary of country discussions on Day 1

Presented by Dr. Stewart Tyson, DFID

Summary of Country Issues

- All starting from low base –poor access HW
- Production: Numbers, cadre mix
- Deployment
- Productivity
- Retention
- Outmigration
- Finance
- Performance /M+E

Leadership

- PM/President
- Skilled HR planning and management capacity
- Opportunity to use HR as indicator of sector performance

Planning

- Robust costed HR plan embedded in comprehensive health plan
- Current information who, where, unemployed
- Skilled HR planners and managers
- Systematic approach
- Targets
- X government links, education, finance
- Scenario based
  Short, medium, long term
  Low, medium, high funding level

Best use of existing workforce and retention

- Integrate targeted initiatives, IMAI
- Task shifting, cadre mix
- Deployment and distribution-housing, health infrastructure, work environment, drugs
- Focus on neglected areas
- Referral system and support
- Erosion of value of retention schemes
- Incentives-monetary, non-monetary
- Career ladders –intra, inter cadres

Best use of existing workforce and retention (2)

- Increase productivity-performance management systems
- Emergency donor funded hire conditional on future absorption into CS
- Address HIV in workforce
- Support professional associations-CPD

Scale up education and training

- Ethiopia –CHW, HExW, CO, Dr, Nurse –rapid increase HW density and mix
- Standardise basic HW (nurse) with options for future specialisation
- Curricula review
- Training infrastructure-innovation in short term
- Training policy pre/in service/coordination
- Lack tutors
- Exploit private links-contract
- Match production, retention , absorption
- Growing NGO market

Address migration

- Brain drain
- Flood the market

Financing the response

- Fragmented funding –reduce
  - Pooled funds
  - Max use of flexibilities aid
  - multi
  - Bilat- barriers to access BS, clarity in what PEPFAR can/cannot support
  - GFATM/GAVI
- Absorption capacity
- Link finance to performance
- PE/GDP ceilings

Advocacy Partnership Accountability

- Exploit commitments –WHA,EU,AU,JLI, consensus that HRH critical bottleneck
- X country learning networks FBOs
- Work with partners, change behaviour
- Plan to specify 5-10 clear output targets + process indicators
- HR info systems-integrated with other HMIS
- CSO monitor quality service delivery

Annex 4: Mozambique – discussion and presentation

The HRH plan
The HRH plan is in the making, and its finalization is planned for end of February, to be then presented during the Kampala Forum. Need to get funds for its implementation. Need commitment from all partners. Aim is to include in the plan all priorities for HRH development. Currently there is an ad-hoc approach for identifying and funding HRH initiatives/projects (ex. FIOCRUZ project for distance education)

First priority is to finalize HRH plan and conduct a robust costing of it, with scenarios for duration (short term, medium-, and long-term), and for level of financing (low, medium, or high level of financing).

Donor funding behaviour
Normally, the HR plan could be financed through the pool, but not all donors give their funds for the pooled basket. Pool can be used for anything. Priorities need to be identified and see how much of it can be funded through government, how much through the pool fund, and how much other donors.

Distortions due to funding outside the pool:
- for example, PEPFAR can fund an NGO, which will then decide on a project at a provincial level, but the province doesn't have a clear idea about their HRH situation and their needs.

Distortions due to delays in disbursement:
- GFTMA is putting 50% of the funds in the pool, but this money reach the country only in September.
- similarly with PEPFAR funds – government planning is conducted between July- September, but funds only come in March

Therefore, financial flows need to be linked/aligned to the planning cycle of the MoH. If this is not possible, need to allow flexibilities in the pool financing to buffer the fluctuations.

Priorities for financing
- Infrastructure a big problem: training facilities, as well as health facilities, and equipment. (There is flexibility for PEPFAR to fund some equipment: JICA and EU are also funding some infrastructure development.
- CHWs: there is a government decision to produce more, problems is who is paying for them. This should be part of the HRH plan, and options proposed for their salary support for the medium term.
- Curriculum revision: 50% already revised (for *technioss de medicina*, nurses, and lab technicians). PEPFAR indicated a flexibility to finance pre-service education interventions, such as curricula revision.

These priorities should all come under the HRH plan, and options for their financing presented in the plan.

Retention and incentives
- Housing for doctors in remote areas (PEPFAR cannot support building houses, only renovation of facilities (see below point on integrating HIV services into PHC programmes). Other options could be HABITAT, prefab houses.
- Installation kit for rural areas (including materials to build a house). This started last year, needs to be evaluated and incorporated into a broader incentive strategy.

- Other incentives used: lunch allowances, top-ups for specialists going at the provincial levels, and top-ups for national leaders, as well as provincial directors.

All these examples should be part of a comprehensive retention strategy, to include financial and non-financial incentive packages, pay for performance, review of the current types and scope of incentives, and identification of sources of funding for the retention strategy. Pool funds can be used for this kind of activities. As part of it, need to understand better what constitute a "good incentive" for health workers, what are some output indicators (turnover rates, vacancy rates etc).

Integration of HIV/AIDS services into the PHC programmes
In many instances, NGOs are renovating or supporting those parts of a facility that deliver HIV/AIDS services. It became clear that those clinics could or should be offering services for other diseases too, also HIV/AIDS patients require comprehensive care. There is flexibility from PEPFAR to use funds for supporting the integration of HIV/AIDS services into PHC programmes; this may mean renovating all areas of the clinic where HIV/AIDS services are provided.

Distortions of the health labour market
Donor-funded NGOs are "poaching" from the public sector, paying much higher salaries (up to 4,000 USD for a consultant). There is an internal policy for donors stipulating they can't hire from the public sector, but this is not reinforced. Other countries are discussing normative salary guidelines (Tanzania, Vietnam).

Key Actions resulting

Key action	Responsibilities	Outputs/indicators
Integrate HIV services into PHC comprehensive programmes	MoH policy Donor communication to Partners (NGOs)	Existing day hospitals integrated NGOs to fund PHC facilities rehabilitation, not only for HIV/ADIS
Finalize HRH plan and use as basis for prioritizing donor support (currently ad-hoc)	MoH - strong leadership needed Donor responsiveness MoF,	HR costed plan Resource commitment for at least medium term scenario Increased funding through the pool fund
Align donor financing to national planning cycle (buffer when not possible); develop one procedure	Donor coordination	Agreements on predictable financing with front loading from flexible pool funders Base planning on financing flows
Expand production of CHWs - salary support through increased financing through pool fund	MoH policy Increased donor financing Provincial management	Agreed salary levels and competencies for CHWs Resource needs specified and included in sector budget
Address immediate financing priorities: curriculum revision; training infrastructure; housing (to incorporate into the incentive package)	Donor response to priorities through pool fund, and earmarked	Improve training infrastructure capacity from x to y Incentive strategy/policy developed (linked to indicators for retention/ linked to labour market analysis
Address NGOs distortion of the market (salaries, incentives, code of conduct)	Government policy Donor communication Civil society cooperation Accountability framework	Accountability framework for NGOs "with teeth"

Notes prepared by Carmen Dolea (WHO)

Annex 5: Ethiopia – discussion and presentation

The HRH plan

Work on Ethiopia's HRH plan is still in progress. The main strategies are flooding (i.e. stepping up production of health workers) and improving retention.

Progress toward the target of deploying 30,000 health extension workers (HEW) is on track and over 17,500 are now at work in health posts. Accelerated training of nurses to become Health Officers (HOs) is also proceeding as planned, and a new two-year MSc in emergency obstetric and surgery for HOs will begin soon. Capacity for health worker training has been expanded with the establishment of 13 new universities, where 12,000 new doctors will need to be trained in the next 10 years to meet the country's goals for universal access to primary health care services including HIV/AIDS.

Measures to improve retention include pay increases, provision of allowances and enforcement of minimum periods of service prior to release from the public sector. Career ladders for all cadres are being improved and provision of housing for health workers is also planned. An HR information system is being developed to improve health workforce planning.

Programmes of Integrated Refresher Training for HEWs and for Woreda (district) and Health Centre Management Teams are in place.

Donor funding behaviour

Ethiopia's health system is grossly under-funded and FMOH plans are rightly ambitious. Support from partners for HRH is not yet commensurate with FMOH ambitions as it is mainly for in-service training, is sometimes provided in a fragmented manner (which does not enable health workers to achieve additional qualifications), and is often held in hotels rather than proper training facilities.

Ethiopia's International Health Partnership (IHP) roadmap urges donors to channel more of their support through pooled funding mechanisms including the FMOH Millenium Development Goal (MDG) Fund. The MDG Fund is designed to support strengthening of several generic elements of the health system including pre-service training. The MOH wants partner support to change to a training model focused on the development and use of national centers of excellence and regional training centers as regular venues for training, stronger and more accessible pre-service training, and an on-site approach for in-service training.

Health workers can only be effective if they have appropriately-equipped facilities to work in, steady supplies of essential commodities, regular supportive supervision, and a health management information system that feeds into decision-making at all levels. Hence FMOH urges partners to make unearmarked contributions to the MDG Fund.

In order to improve its management of gaps created by movement of public sector health professionals to employment with development partners, FMOH asks partners to provide information in advance of recruitment on their plans for recruitment of such staff, emphasizing the importance of following the Code of Conduct developed as part of the harmonization process launched last year.

Priorities for financing

- Training for some lower and intermediate cadres is covered but additional support is needed for to train 12,000 new doctors over the next 10 years, and additional cadres may need substantial support to achieve universal access and MDGs; expatriate service providers may be needed to fill some gaps until pre-service capacity is expanded to increase the supply of physicians and some other critical cadres
- Funding for the MSc in Emergency Obstetrics and Surgery is also sought
- Funding is required for bicycles for HEWs and for motorcycles to facilitate supervision of HEWs
- Rather than fragmented IST there is a need for training as part of strategic continuing medical education (CME) and continuing professional development (CPD)
- National centres of excellence and regional training centres exist and if supported appropriately can be used for CME and CPD training (instead of hotels)
- On-site training approach to minimize personnel absence from facilities
- External support for trainers/professors, service delivery, facility upgrades
- Analysis of incentives to prevent attrition

Key Actions Resulting

Key action	**Responsibilities**	**Outputs/indicators**
Planning and financing		
Fully costed strategic plan for HR expansion	Government, partners can provide TA to develop plan	# personnel trained (pre service) # in public sector service
Pooled fund with longer term, flexible resources	Partners	- Resources in pooled fund - Duration of partner commitments
Implementation		
Strengthening/expanding pre-service training	Government with partner financial and technical support	These were not specified at the workshop, but could include: # of new medical students # of medical graduates (and in other cadres)
Coordination of in service training	Government and partners	Timing of in service training sessions # staff attending
HR information system built and functioning	Government with partner TA support	HRIS exists
Development and costing of distance learning approach	Government and partners	# personnel trained through distance learning
Reduction of hiring of government staff	Partners	# of staff recruited from public sector
Hiring of training/teaching, service delivery and development staff from overseas	Government and partners	# training posts in institutions filled with foreign staff # service delivery positions filled with foreign staff
Incentives for retention of public sector staff, e.g .housing in rural areas	Government	# housing units for rural staff

Notes prepared by Marion Kelly (DFID) & Jamie Browder (PEPFAR)

Annex 6: Zambia – discussion and presentation

The HRH plan

- HRH plan has been developed. The main issue is taking forward implementation, financing and demonstrating effective results to parliament, MoF and donors.

Donor funding behaviour *(i.e. specific changes required on specific issues)*

- Increase in flexible financing from donors

Priorities for financing (e.g. over next 12-36 months)

- Production of health workers?? i.e. overall shortage of skilled staff
    - Better coordination between line ministries responsible for training
- Performance management and improve capacity (quality and numbers) of health managers
- Design and implementation of HRH IS
- Implementation of Retention and redistribution policies
- Financing and implementation of the HRH plan at each level of the H. system
- Need to tackle attrition and internal migrations from rural to urban areas and to international NGOS and donor projects.
- Improvement to the SWAp, including better coordination and better pooled resources
- HRH infrastructure

Key Actions Resulting

Key action	Key Changes in behaviour required	Responsibilities	Outputs/indicators
1. Strengthen HRH Production Systems			50% increase in intake of nurse & COs training by 2010
- investment in infrastructure (space, housing, materials, equipment)	• Donors committing to increased flexibility in funding esp. investing in infrastructure • Government adopting more innovative ways to overcome systems capacity constraints		Increase in proportion of donor resources committed to infrastructure development
-train, recruit and retain XXX tutors (including expatriates) *How, by when?*	• Promote culture of skills sharing in short term i.e. hiring of tutors from better resourced countries or contracting(on part time) those working for NGOs in-country		Number of expatriate tutors hired
Explore opportunities for public private partner ship for training with MOH doing accreditation of private facilities	MOH and government of Zambia in general open to PPP		
2. Introduce performance management package for increased mgt productivity *(what, by when, how much, output?)*	• Promote a culture of accountability & transparency • Provide incentives for accountability & transparency		Increase in % of appraisals that result in quality improvements
-plan for implementation of PM package for managers and health workers	Performance management taken as core function of HR managers at all levels.		
3. Mobilise funding for HRH plan (from disease specific programmes)	• GFATM to support pre-service training • More donors + MoF to provide flexible financing to HRH plan		MoF & doors to reduce funding gap by 60% by 2010, based on results

Key action	Key Changes in behaviour required	Responsibilities	Outputs/indicators
4. Speed up recruitment & distribution of Staff (urban/rural + competencies)	• GoZ & donors ensure resources committed for recruitment at least 3 months before graduation		
	• Introduce competence based retention/incentives (e.g. transport, phone, distance learning)		
5. Improve retention/expansion to other cadres beyond doctors	• Donors compensate GoZ for results of distortions (e.g. hiring of staff out of public sector)- agree code of conduct and wage cap for NGOs/Donor projects		Reduce annual attrition by 1% Reduce vacancies in rural areas for key cadres.
6. Design HRH information system which is integrated with existing health and finance information systems (e.g. IFMIS, HMIS, PMEC etc.) *(what, by when, how much, output?)*	• PEPFAR able to provide financing to this		
7. Monitoring & evaluation			

Notes prepared by Benedict David / Dyness Kasungami (DFID)

Annex 7: Kenya – discussion and presentation

N.B: due to the current situation in Kenya no officials were present from the Ministry of Health. The discussion therefore focussed on actions for development partners. The DFID and USAID country advisers committed to take forward discussions with the Ministry of Health on their return to Kenya when the political situation allows.

Key constraints

- 50% vacancy rates across the public health service, with inequitable distribution and retention a challenge in hard to reach areas.
- HRH plan not yet finalised and insufficient resources available for implementation.

Key needs

- Equitable deployment and retention
- Capacity development
- Vacancies to be filled

Some good news

- PMTCT coverage increased from less than 10% to close to 40% since 2005.

The HRH plan

The HRH plan has been developed by the MOH. Completion is expected soon. The plan responds to the key HR priorities in the health sector and uses the information that is available. During the recent MTR immediate priority activities were identified, which will require technical support and additional funding.

Headline message: to provide quality health care to all Kenyans – with adequate numbers of equitably distributed and appropriately skilled and motivated health workers.

Strategic plan outputs include:

- Strengthen recruitment and deployment
- Make jobs more attractive
- Improve institutional and HW performance
- Strengthen HR development systems and practices
- Strengthen planning and management at all levels

Innovative ideas include the use of SMS to speed up resolution of issues, and developing a retention policy for hardship areas.

Task shifting / new cadre of community health workers (CHWs)

Government has announced the establishment of a new cadre of community health workers. This will be implemented as an integral part of national strategy.
Need to facilitate operationalisation of the new cadre, with coordination at the different levels, under the umbrella of the MoH.
Need to assess how to support the CHWs, including certification, retraining, regulation etc.
CHWs will have 6 months training; work on standardisation and a legal framework is ongoing.
They will focus on community level and first referral level. Need to develop a scope of practice for each level.

Maximising flexibilities of available funding
Since HR is an overriding constraint to scaling up the AIDS response, in principle PEPFAR can allocate money for HR strengthening more generally
It may be possible to access these funds by amending PEPFAR annual plans.
There is also $3 million available in every country for pre-service training that is not earmarked for any specific public health programme.

Civil Society
Need to maximise the involvement of civil society. Hennet (an umbrella organisation for health NGOS) recently signed the Code of Conduct.

Priorities for Development Partners
Support finalisation of HRH plan based on best practice and explicit targets whilst ensuring country ownership.
Explore opportunities for additional financing and maximise flexibilities of current financing.

Key Actions resulting:

Key action	**Responsibilities**
Maximise flexibilities of donor funding (e.g. PEPFAR, GFATM, other)	Donor partners in discussion with MoH
Provide TA and funding to finalise and implement the HRH plan, as needed	Donor partners in discussion with MoH
Support implementation of the strategic priorities identified in the recent MTR	Donor partners in discussion with MoH
Facilitate, where appropriate, civil society engagement in development and implementation of the HRH plan	Civil society
Summarise best practice and innovation; facilitate dialogue	GHWA, IHP

Notes prepared by Tanya Cross (DFID)