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from the Department for
International Development

**Helpdesk Report: Health Sector Staff Salaries**
Date: 10th August 2011

**Query:** What evidence is there on which is the most effective method of supporting salaries of health staff in government clinics from a donor perspective? Specifically what evidence is there on the effectiveness of the different options below:

1 Donors don't pay salaries (instead seeing this as a government responsibility)
2 Donors pay salaries through NGOs
3 Donors support salaries through government systems

**Enquirer:** DFID Republic of South Sudan

## Content



## 1. Overview

This report gives the background and context of the situation regarding financing of human resources in developing countries. It then goes on to present papers on the different options.

- **Donor Support Through Governments:** Some experts have argued that this is the most effective, under some conditions. To do this, donors must provide some kind of budget support – general or health sector. This is the most vulnerable to fungibility. So, the final result may be that donors finance salaries, but that the governments of recipient countries reduce their support to the health sector. This report also presents a case study of donors supporting human resources through the Malawian government.

- **Donors Don't Pay Salaries:** Next, it presents two papers arguing for and against donor support of salaries. The World Bank believes uncertain financing flows mean donors should not commit to permanent expenditures such as salaries. In his paper, Gorik Ooms argues that this position no longer makes sense, now that donors are involved in other long term recurrent costs, such as AIDS treatment. He also argues that without doing this you end up with 'medicines without doctors' but that donors should give via organisations such as the Global Fund to ensure consistency.

- **Donors Support Salaries Through NGOs:** Specialists gave more support to a system wide approach such as donating through government systems. Examples in the literature warn of 'islands of excellence' through using this method and it has also been suggested that it may lead to privatisation of health services. Additionally, this section gives case studies of Afghanistan and Liberia and Merlin's experiences.

This report also presents evidence on different ways to pay salaries, sector wide approaches, the importance of human resources and has a section on comments from specialists.

## 2. Background and Context

**Health in South Sudan**

South Sudan is acknowledged to have some of the worst health indicators in the world. The under-five infant mortality rate was 112 per 1,000 (UN) in 2007, and maternity mortality was 2,054 per 100,000 live births (Southern Sudan Household Health Survey). In 2004, there was a total of three surgeons serving southern Sudan, which covers 80,000 square miles. There were three proper hospitals, and in some areas there was just one doctor for about 500,000 people. Experts estimate between 6 million and 8 million people live in the region. The epidemiology of HIV/AIDS in South Sudan is poorly documented but according to the Southern Sudan Household Health Survey in 2007 the prevalence is thought to be around 3.1% with less than 10% of people being able to name two ways to avoid HIV infection.

**Human Resources for Health**

Human resources are strongly linked to health outcomes and hold together health systems. Research commissioned by the Joint Learning Initiative on Human Resources ''strongly confirm the importance of human resources for health in affecting health outcomes''. The World Health Organization (WHO) estimates that to achieve the Millennium Development Goals (MDGs), health systems need at least 2.5 health workers per 1,000 people. WHO estimates a shortage of 2.4 million doctors, nurses and midwives worldwide, reaching a total of 4.3 million if all the workers required to manage and support their activities are included. The cost of training enough people to meet the shortfall by 2015 is USD 92 billion, and thereafter a minimum of USD 39 billion per year is required to pay their salaries. The health workforce gap is one of the major bottlenecks to the success of global health initiatives. For example, two studies found that health workforce constraints were the key issue in successful implementation of the Global Alliance for Vaccines & Immunisation (GAVI) programme. A recent World Bank study found that 26 of 28 Poverty Reduction Strategy Papers (PRSPs) from Sub-Saharan Africa identify the performance of the health workforce as an important issue. Of the 22 high-burden countries that account for 80 percent of the world's tuberculosis cases, 17 have reported that staffing problems are hampering their efforts to reach the 2005 targets. In Europe and Central Asia there are an average of 3.1 physicians per 1,000 people. In Sub-Saharan Africa there is just 0.1.

**Unpredictable aid flows makes planning and budgeting difficult.**

Predictable and sufficient amounts of aid are particularly important in the health sector where a large share of sector funds are allocated to long term recurrent costs such as staff salaries, supplies including vaccines, medicines, contraceptives and increasingly, life-long drug therapies, as well as the running costs of facilities and support services such as blood transfusion. Whilst there is increasing acceptance that donors need to support the recurrent costs of services, and some donors are increasing the medium term predictability of their funds by operating in multi-year funding horizons, many are still unable to make commitments beyond one year in advance, making it problematic for countries to develop and manage plans and budgets with confidence.

**Health Sector Financing**

OECD countries have committed to improving the quality of their aid through becoming signatories to the Rome and Paris Declarations and the Accra Agenda for Action. Health sector financing is a rapidly evolving policy area, where important progress is occurring alongside inherent tensions. Despite the growth of vertical programmes, there is also increasing recognition of the disadvantages of projects that are of limited duration and often driven by funding agency interests rather than country priorities. Research has shown that without a conducive financing and policy environment, the benefits of aid may not be sustained.

**Sector Wide Approaches**

The sector-wide approach is a relatively new way of working between governments and donors. It is one which a large number of donors are starting to favour, though it also has its opponents. Sector wide approaches (SWAps) work differently in different countries but they are typified by the following features:

- All significant government and donor funding for the sector supports a single sector policy and expenditure programme.
- Government leads the process and its implementation.
- Common approaches are adopted across the sector by all funding parties (government and donors).
- There is progress towards relying on government procedures to disburse and account for donor funds.

There has been a growing interest in alternative aid mechanisms. SWAps promote greater government ownership and leadership of the health sector and more efficient use of the resources available for health. Some donors are moving still further towards general or direct budget support. Agreement on a poverty reduction strategy and a related budget framework forms the basis for funding that is then allocated and used through the government budget, rather than being earmarked for particular programmes by the donor. At the same time as donors' policies are evolving, so too are national governments' own health sector financing policies.

- Budget support is thought to be a sustainable mechanism as it creates a sense of ownership of the national plan and of financing of the health sector.
- Budget support from development partners is usually matched with government financing of the sector (and of the programme) and would contribute to self-sufficiency.
- Given that planning, budgeting, and monitoring of use of budget support are integral to sector coordination, this will contribute to greater accountability.

**User Fees- Another Option?**

Both donor and government policy initiatives may involve separating finance from service provision, and attempts to shift the share of the various sources of revenue. Reforms are sometimes introduced in order to move from tax-based financing towards social health insurance, or seeking to reduce the share of out-of-pocket payments within total sector financing. User fees are an especially controversial form of out-of-pocket payments, with debate surrounding their effects upon access, how the poorest can be exempted from them and whether any viable alternative funding streams may exist.

**Example of the importance of sustaining health workers salaries: HIV/AIDS**

South Sudan has a unique position because it lies between the countries with significant HIV epidemics such as Uganda, Kenya, Congo, Central Africa and Ethiopia on the one hand and on the other, borders North Sudan which borders countries with relatively low prevalence such as Egypt and Libya. The dynamics of the HIV epidemic during the period of conflict and the great movement of people and social changes that have followed the coming of peace

remain largely unexplored. Several factors occurred during the war that would be relevant to the epidemiology of HIV in the South:
(a) large movement of soldiers between the North and the South
(b) internal displacement of people mainly from the South to the North, but also from rural to urban areas
(c) commercial sex work in the towns and garrisons with an impact on HIV infection in their clients especially soldiers and those with more disposable higher incomes.

The UNGASS report of 2008 gives the adult HIV prevalence in South Sudan as 3.1%; given a population estimate of 10 million this translates into 155,000 adults living with HIV/AIDS. This contrasts with a prevalence of 1.6% adults in North Sudan.

It is estimated that eight health workers are needed per 1,000 patients receiving ART. The numbers of health workers required to provide ART to 1,000 patients include one to two physicians, two to seven nurses, one to three pharmacy staff, and a wide range of counsellors and treatment supporters. These findings apply to ART programmes in their start-up phase, which require an intensive follow-up, but even if a mature ART programme could be effective with only four health workers per 1,000 patients, the number of additional health workers required remains a huge challenge.

## 3. Donors Support Salaries Through Government Systems

Some experts have argued that this is the most effective, under some conditions. To do this, donors must provide some kind of budget support – general or health sector. This is the most vulnerable to fungibility. So the final result may be that donors finance salaries, but that the governments of recipient countries reduce their support to the health sector.

The Global Fund stated that the institutional position is that donors should pay salaries – through NGOs or government systems - to make sure that patients are timely treated with qualified human resources. The lack of specialised health professionals is one of the main constraints in the health sector in developing countries. By paying salaries of those professionals, donors help to improve the “capacity” in the country and the aid effectiveness.

**Support through government- Case Study- Malawi**
**Tackling Malawi’s human resources crisis**
Palmer D (2006) *Reproductive Health Matters* 14:27–39.
http://www.who.int/healthsystems/gf17.pdf

In sub-Saharan Africa, health systems are fragile and staffing is grossly inadequate to meet rising health needs. Despite growing international attention, donors have been reluctant to undertake the significant investments required to address the human resources problem comprehensively, given social and political sensitivities, and concerns regarding sustainability of interventions and risks of rising donor dependency. Declining human resource levels have fuelled an accelerating collapse of public health services since the mid-1990s. As a result, the health sector has struggled to keep pace with demand for services, particularly given population growth and high levels of HIV and AIDS. An April 2004 report from the Ministry of Health stated that the human resources situation in the health sector has been described as ‘‘critical, dangerously close to collapse, collapsed, meltdown’’ and that the health sector is ‘‘facing a major, persistent and deepening crisis with respect to human resources’’.

In an effort to improve health outcomes, in 2004 the government launched a new health initiative to deliver an Essential Health Package, including a major scale-up of HIV and AIDS related services. Improving staffing levels is the single biggest challenge to implementing this approach. Donors agreed to help the government develop an Emergency Human Resources Programme with five main facets: improving incentives for recruitment and retention of staff through salary top-ups, expanding domestic training capacity, using international volunteer

doctors and nurse tutors as a stop-gap measure, providing international technical assistance to bolster planning and management capacity and skills, and establishing more robust monitoring and evaluation capacity. Industrial relations were a prominent consideration in determining the shape of the Programme. The combination of short- and long-term measures appears to be helpful in maintaining commitment to the programme.

In 2004 UNAIDS and DFID supported the development of a Malawian led initiative to address the human resources crisis. Their concern was that without a substantial increase in health workers, it would not be possible to roll out antiretroviral treatment without further undermining the already weak health system. The result was a shift from piecemeal donor support for a number of uncoordinated initiatives to a more comprehensive approach, through an ''Emergency Human Resources Programme'' which is now being implemented. This was an explicit decision by donors "to consider measures that might otherwise be dismissed as unsustainable" because of the scale of the crisis. It is not clear how serious a health workforce crisis needs to be for donors to consider "unsustainable" measures. Malawi was able to come to a special agreement with the International Monetary Fund (IMF). Malawi agreed to a ceiling on the "government wage bill" with the IMF in September 2003. In July 2005, the IMF accepted that the ceiling "will be adjusted upward ([or] downward) by the full amount of donor-funded supplementary wages and salaries for the health sector that is greater ([or] less) than the programme baseline".

The Board of the Global Fund decided to consider health systems strengthening (HSS) interventions for funding as a specific category under its Fifth Call for Proposals, and it was as an HSS intervention that the Malawi response was approved. But under the Sixth Call for Proposals, specific HSS interventions were no longer eligible.

## 4. Donors Don't Pay Salaries- Advantages and Disadvantages

**Donors Shouldn't Pay Salaries**

**The Millenium Development Goals for Health: Rising to the Challenges**
World Bank, 2004
http://www-wds.worldbank.org/servlet/WDSContentServer/WDSP/IB/2004/07/15/000009486_20040715130626/Rendered/PDF/296730PAPER0Mi1ent0goals0for0health.pdf

The World Bank believes that "it is not prudent for countries to commit to permanent expenditures for such items as salaries for nurses and doctors on the basis of uncertain financing flows from development assistance funds"

An increasingly common lament in international health is that faster progress toward the health-related Millennium Development Goals is being impeded by a variety of human resources problems. From a country perspective, development assistance is a very volatile source of funding for health. The ratio of external financing to total health expenditures increased or decreased yearly in selected countries in South and East Africa that showed improvements in child mortality between 1995 and 2000—in some cases sharply, as it did in Somalia. Obviously, then, it is not prudent for countries to commit to permanent expenditures for such items as salaries for nurses and doctors on the basis of uncertain financing flows from development assistance funds.

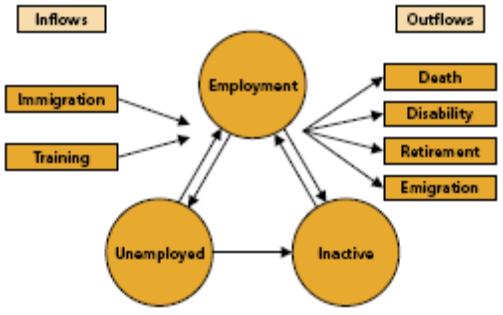
Donors often require that assistance be kept in parallel budgets outside the ministry of finance, which precludes appropriate planning and targeting of expenditures. In 2000 off-budget spending was estimated to represent more than 46 percent of health spending in Tanzania and more than 50 percent in Uganda. Although some off-budget spending, such as the resources collected from user fees, is domestically funded, most is funded by donors, who encourage this practice in order to facilitate accounting for the direct impact of their

resources. But because money is fungible, once external financing becomes available for health, ministries of finance may substitute donor funds for regular treasury financing of expenditures, resulting in only marginal increases in overall health expenditures. This is especially so in countries operating under strict budget constraints, where increased expenditures in many sectors have been suppressed for some time. As resources from abroad become available for health, political pressures are likely to divert resources previously available to health to other uses.

So a simple assessment of the impact of external resources on outputs or the purchase of additional inputs does not take into account the impact of reduced resources from regular budgets. Off-budget expenditures in health may partly explain the low government expenditures in some countries, such as Uganda. Moreover, off-budget expenditures make it impossible to properly target resources to particular interventions, geographic locations, or population groups. Such targeting may be essential for improving the impact of expenditures on outcomes and for reaching the health Millennium Development Goals. Most important, spending commitments in the health sector must be permanent. This means that any external financing must eventually be replaced by additional domestic revenues or by reallocating expenditures from other sectors. Because both these policy measures are difficult to implement, countries must carefully analyse the commitments they make to their populations on the basis of temporary external financing.

Donors need to make good on the promise of increased financing. Development assistance needs to be timely and predictable, so that it can be used to finance carefully planned recurrent expenditures that may eventually be covered by domestic financing. Donors need to improve coordination among themselves, eliminating off-budget financing, for example, which inhibits appropriate country budgeting and targeting. A practical lesson for donors is to work more closely with each other and with governments to ensure that the number of country coordination bodies for health is limited, that resources are pooled, and that aid is untied to procurement only from the country of origin of the funding.

Figure 7.3 Stocks and flows in human resources




Source: World Bank staff.

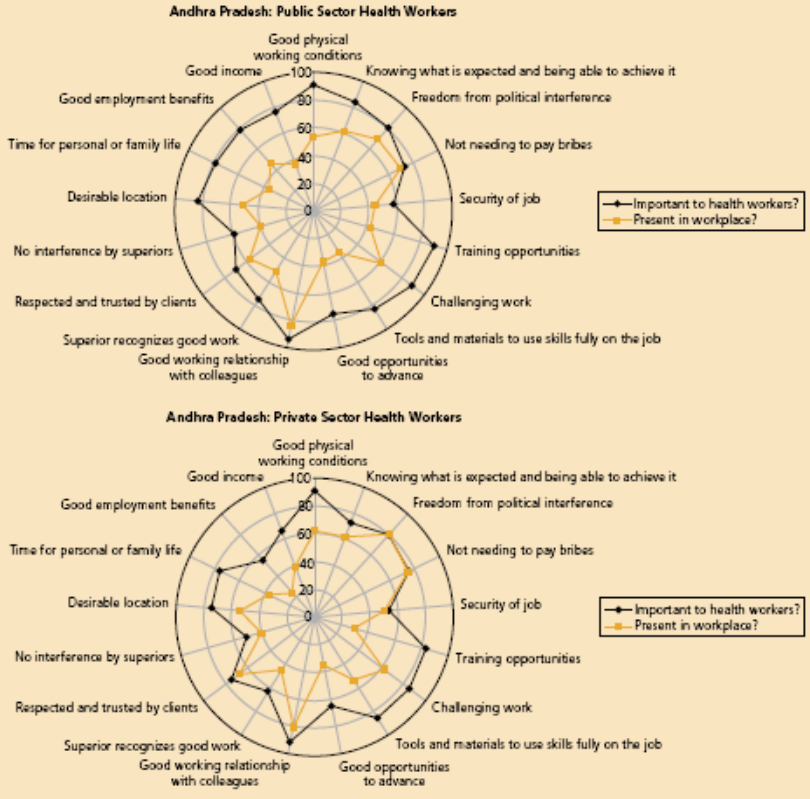
Differentials in compensation—both wages and benefits such as housing—have repercussions for inflows and outflows of human resources in the health sector. Low wages in the medical professions relative to wages in other professions discourage people from entering training institutions, from completing their studies, and from joining the profession if they graduate. They encourage people to think about leaving—by exiting the labour force, joining another profession, or leaving for another country where compensation is better. Low levels of compensation encourage absenteeism, as health workers seek other earnings to supplement the earnings in their regular health sector job. This creates heavier workloads for those left behind and reduces motivation, prompting further absenteeism and exodus. There are limits to what can be achieved through changes in compensation alone, however. Raising

salaries in the developing world to the levels in industrial countries (even at purchasing power parity exchange rates) is simply unfeasible. Neither is using compensating wage differentials to keep staff in the public sector from moving to the private sector. Other important issues to staff are training opportunities; challenging work; relations with colleagues; a desirable location (including proximity to a good school, for example); and good physical working conditions all ranked higher than pay in both the public and private sectors. And many workers felt that their jobs did not meet expectations, especially for training opportunities.

**Box 7.4 What do health workers in India want most?**

A recent study of motivation among health workers in the Indian state of Andhra Pradesh sheds light on the issue of staff morale (see figure).[37] What health workers in both the public and private sectors value most is a good working relationship with colleagues. And in both public and private sectors and in both states, a very high percentage (80 percent or so) of health workers feel that their current job provides this. Number two and three on the list of most valued job attributes are good working conditions and training opportunities to improve or learn new skills. On these issues, Indian health workers are less satisfied with their current jobs, especially with training. Although health workers in both states and in both sectors report earning less than they would like, a high income is not considered one of the most valued job attributes. Frustration over the discrepancy between actual and desired income is felt equally in both the public and private sectors.

What health workers in Andhra Pradesh want from their job—and whether they are getting it




Source: Reference 37.

**The fungibility in development assistance to health is substantial**

Much aid is earmarked—both across sectors and within them. One part of a development agency gives a grant to the ministry of health for a health sector reform while another does the same for a primary education project. One agency makes a loan to the ministry of health for a tuberculosis project while another makes a loan for a malaria control project. The intention of donors is that these activities remain tightly sealed—the health sector reform funds are to be kept separate from the primary education project funds, and the tuberculosis project funds are to be kept separate from the malaria control project funds. The idea is to

ensure that the government makes a certain spending choice that it would not have made had it been handed a check for the same amount. One view of aid is what-you-see-is-what-you-get: a government receives $1 million for a water project, and the net impact is $1 million worth of extra spending on the water sector. This view has recently been challenged, on the grounds that aid is fungible—at least partially. Where aid is not fungible, the recipient government increases spending on the health sector by an amount equal to the aid. For each dollar of aid to the health sector, government health spending rises by a dollar. The other extreme is where aid is fully fungible. The recipient government treats the extra dollar of aid as if it represented an extra dollar of government revenue, and it increases its spending in the health sector by whatever amount it increases its health spending when its own revenues rise by a dollar. The intermediate position is incomplete fungibility— government spending on health rises by less than a dollar but by more than it would if the government received an extra dollar in its overall budget. Assessing whether aid is indeed fungible is not straightforward.

The difficulty is knowing how the government would have responded if its own resources had increased by the amount of the aid, or equivalently if it had received a cheque for the same amount. Recent research suggests that while an extra dollar of development assistance does result in an extra dollar of government spending in some countries, in many it does not. Where it does, only 29 cents of the additional dollar of aid goes into government development programmes— the rest leaks out into nondevelopment programmes, though not apparently into reduced tax effort. So official development assistance at the level of overall government spending is fungible—the average government spends an additional dollar in exactly the same way, irrespective of whether it comes from domestic resources or from a donor. Research also suggests that aid in many countries is fungible across sectors within the government's development programme—aid intended for the health sector gets spent on other development sectors, and aid intended for other development sectors gets spent on health.

Fungibility implies, for example, that when development assistance to health is earmarked for primary health services and excludes tertiary care, governments simply focus their resources on health services for the population served by public hospitals—a wealthier, urban population in many poor countries. One important implication is that donors should not spend time and effort trying to channel their external funding to specific programmes for certain priority diseases and populations, without engaging in a dialogue with the government on basic changes in the overall patterns of public spending for health—the total allocation and the amounts allocated to, say, child health and communicable disease control services or improving community and primary level health delivery systems. If these basic changes were enacted, donors would then transfer their financial assistance to the health sector as a whole, knowing that they are likely to have a positive impact on Millennium Development Goal outcomes.

**What donors should do**

- *Create donor buy-in and coherence* by subscribing to a country based Millennium Development Goals for health strategy, including goals and targets, policy actions, financing proposals, and monitoring arrangements, within a framework guided by the Poverty Reduction Strategy Paper and associated sectoral strategies.
- *Build on existing mechanisms* at the country level, including Poverty Reduction Strategy Papers and sectorwide approaches, bilateral and multilateral funding streams, and those emanating from the global health initiatives.
- *Harmonise efforts* to overcome funding gaps, fungibility issues, rigidity in financing recurrent expenditures, and lack of predictability of aid flows.
- *Commit to providing additional long-term financial assistance disbursed through existing multilateral and bilateral channels and instruments.* No new funding body is envisaged. Donors would move toward long-term assistance in a reliable and timely manner, including support for recurrent expenditures.

- *Increase efforts to work with NGOs and communities.*
- *Reduce the transactions costs* of development assistance to health, by seeking to harmonise reporting requirements, procurement rules, and financial management systems.
- *Support capacity building for results-oriented monitoring and evaluation.* Donors would also commit to an independent review of their actions and to sharing the lessons of this review with other stakeholders.

**Human resources in health**
The Secretariat of the High-Level Forum will:
- Assess expenditures on human resources in health by development partners.
- Develop a series of in-depth human resources studies on selected developing countries addressing the current stock of health personnel, the requirements to meet the Millennium Development Goals, and deployment of health personnel. This work should link with related work in the World Bank, WHO, and the International Labour Organisation Joint Learning Initiative.
- Link with the Global Commission on International Migration to examine the impact of migration on health.

**Donors Should Pay Salaries But Not Bilaterally**

**Medicines without Doctors: Why the Global Fund Must Fund Salaries of Health Workers to Expand AIDS Treatment**
Gorik Ooms, Wim Van Damme, Marleen Temmerman, 2007, *PLoS Medicine,* 4(4):
http://www.who.int/healthsystems/gf9.pdf
http://www.icrh.org/files/academia-doctoraat%20Gorik%20Ooms_0.pdf

Recent internal comments from the Global Fund suggest an intention to focus more on the three diseases without supporting the fragile public health systems that are supposed to implement disease prevention on the ground., and to leave the strengthening of health systems and support for the health workforce to others. This could create a "Medicines without Doctors" situation in which the medicines to fight AIDS, tuberculosis, and malaria are available, but not the doctors or the nurses to prescribe those medicines adequately. This would be a strategic mistake, as the Global Fund has an advantage that makes it a key actor in the field of supporting health workforces. Most other donors are forced to aim for sustainability in the conventional sense (implying that beneficiary countries should gradually replace international funding with domestic resources); the Global Fund has been promised sustained funding by the international community, allowing it to make sustained commitments to beneficiary countries. This is what some of the countries most affected by AIDS, tuberculosis, and malaria need to increase their health workforce. Their health workforce challenges are too big to consider a gradual replacement of international funding with domestic resources. There has been a Global Fund controversy about strengthening health workforces. Some Global Fund supporters understood from the beginning that its success in expanding coverage of ART depended on its willingness to pay for the salaries of additional health workers. However, the Global Fund has never been keen to expand its novel approach to sustainability to the funding of the health workforce. Since Round 2, the Global Fund has applied strict criteria for the funding of salaries of health workers. With regards to salaries, applicants must explain "how these salaries will be sustained after the proposal period is over"

Dräger et al. note that this concern about sustainability "cannot be found for any other activities financed by the Global Fund" and suspect that it is closely linked to IMF and World Bank macroeconomic policies. The advocates of supporting salaries of health workers from the Global Fund obtained a short-lived victory in 2005, when Round 5 of the Global
Fund included a specific category for HSS interventions. The Global Fund has developed—perhaps implicitly—a novel approach to sustainability. Sustainability in the conventional

sense implies that beneficiary countries gradually replace foreign assistance with domestic resources. This is not realistic for low-income countries providing ART. Nonetheless, the Global Fund does support ART interventions in low-income countries: thus it shifted concerns about sustainability from national to international level (if the Global Fund can sustain these interventions, they are sustainable, albeit in a different manner). The international community endorsed this novel approach. In June 2006, the United Nations General Assembly committed itself to supporting and strengthening existing financial mechanisms, including the Global Fund and relevant United Nations organizations, through the *provision of funds in a sustained manner*" (emphasis added). It might sound like a nuance, but the difference between "sustainability relying on domestic resources in the long run" and "sustainability relying on the provision of external funds in a sustained manner" is fundamental.
This novel approach is what countries like Mozambique need to strengthen their workforce. They need to hire more health workers, but they are unable to sustain the costs of hiring additional health workers with domestic resources.

Some bilateral donors might be willing to consider "unsustainable" interventions to address health workforce crises, as they did in Malawi. But Malawi remains the exception that confirms the general rule. Bilateral donors will find it difficult to make their commitments reliable enough for the IMF to adjust the ceiling on the government wage bill. Most bilateral donors can only commit for as long as their government remains in place— only a few years.
It is easier to remedy the shortage of medicines with external funding than it is to remedy the shortage of health workers with external funding. Medicines can be bought; health workers need to be trained first. This underlines the importance of starting emergency human resources programmes now. Without support from the Global Fund, it will be difficult for Mozambique to develop its own emergency human resources programme. Bilateral donors are unable to support human resources programmes that rely on sustained external assistance over decades. The World Bank is unwilling to use foreign assistance for salaries of health workers. The IMF is unwilling to stretch ceilings on wage bills, because commitments from bilateral donors are unreliable. Without flexibility about these ceilings, bilateral donors cannot support salaries of doctors and nurses, even if they want to. It is a vicious circle. The Global Fund is probably the only actor able to break through this vicious circle. It is the only donor mechanism that benefits from an explicit endorsement from the international community to practice a novel approach to sustainability. But donors must give the Global Fund the resources to do so.

It is feasible to turn the Global Fund into a world health insurance, funded by rich countries in accordance with their wealth, and creating rights for poor countries to obtain assistance in accordance with their needs. It would allow individual donors to overcome their inability to make commitments beyond the term of their governments, because their contributions would be compulsory. (This is not a heresy. Many bilateral donors consider their contributions to the World Bank as compulsory. This can be achieved for contributions to the Global Fund.) Furthermore, the pooling of resources by many donors would increase continuity: if one donor reduces its contribution, another donor could compensate. And that is exactly what countries like Mozambique need to increase their health workforce: sustained assistance.

## 5. Donors Pay Salaries Through NGOs

Experts have stated that one down-side of donors funding through INGOs rather than a system wide strategy through government systems is the danger of "islands of excellence" and the potential to negatively influence the distribution of health staff as they try to work in facilities supported by INGOs. She also outlined the dangers of premature withdrawal of salary payments in particular the impact on the provision of services though also recognising the need to balance with the danger of substituting for government action. Also, funding through NGOs can lead to privatisation of health services.

**Monitoring & Evaluation of Technical Assistance for Strengthening Health of the Rural Poor [METASHARP],** Johns Hopkins University and Institute of Development Studies
http://www.jhuafg.org/meta.html

Afghanistan now contracts out its health services in different regions to NGOs who act as service providers for that area, including paying health worker salaries. Johns Hopkins University and the Institute of Development Studies are monitoring this system through the Future Health Systems Consortium.

**Rebuilding health systems after conflict**
Id21 Health Highlights 23, March 2008
http://www.dfid.gov.uk/r4d/PDF/Outputs/IDS/healthsystems23.pdf

The Ministry of Public Health (MOPH) in Afghanistan and major donors developed the Basic Package of Health Services (BPHS), providing guidelines for the reconstruction of infrastructure and staffing. Both the government and NGOs agreed to adopt a public-private design for service delivery, with the MoPH commissioning and directing services, and private NGOs delivering them.

There have been significant improvements in quality of care from 2004 to 2005, and 2005 to 2006. The number of outpatient visits, antenatal care and TB case detection rates have increased substantially. A newly established Grants and Contracts Management Unit has enabled the MoPH to improve contract management, a critical component of its collaborations with major donors and NGOs. Health sector funding is at a reasonable level, yet the country is likely to remain highly reliant on foreign funding for many years. Contracting for service delivery with NGOs and with three MoPH Strengthening Mechanism provinces has been successful. Competition for contracts has been strong, with a significant proportion awarded to Afghan NGOs set up after 2001.

**Human Resources for Health**
A Study for Merlin, Health and Policy Department, March 2007

This study was commissioned by the Health and Policy Department of Merlin in December 2006 as part of a wider review of their activities in support of human resources for health (HRH). The review is intended to help determine the impact of the organisation's work in this area and to feed into the on-going global discussion and debate on how best to tackle this challenge within the health systems in developing countries. The interviewees painted a picture of underpaid health workers forced into illicit or at best unofficial manoeuvres in order to support their families. All of these coping strategies have the potential to impact negatively on performance. If it is difficult for INGOs to staff projects in remote or hardship areas, it is even more difficult for state health systems to do so. Improving the salary situation is a pre-requisite for any improvement in performance. However, it should be accompanied by measures to restructure the workforce to better meet the needs, improve working conditions, establish performance management systems and promotion based on merit; and provide wider opportunities for professional development. Changes in work culture and behaviours are likely to take some time.

**Useful Information from the Report**

- "I didn't like (another medical INGO) because they were leaving abruptly. When they left, everything was collapsing, it was a waste of time not having a sustainable programme." Senior nurse, international staff member, Liberia
- Factors which led staff to prefer employment with INGOs over the government health sector in their home country were salary levels and working environment.
- Specific areas mentioned by national staff as needing improvement included basic salary, how many family members were covered by health insurance, help with travel

to work costs, allowances while travelling on business, support to staff working away from their home base to maintain family contact.

- Basic pay is perceived as very poor across all professions and at all levels. Provision of accommodation and other extras, which used to be available to help retain workers, have often disappeared as a result of financial pressures on the system.
- Even the very low official salary may not turn up on time either because of system failure or corruption. The payroll function tends to be poorly managed, susceptible to corruption and is likely to be processing payments to a significant number of ghost or absentee workers.
- Survival strategies include combining government health jobs with others in private clinics or other outside business, taking payments for drugs or services, looking for offsite training opportunities which attract per diems / allowances. a number of respondents pointed out that it was much easier to find 2nd or 3rd jobs in the cities and that these common survival strategies were not available in remote areas.
- "(Main problem is) low salaries for health professionals – unless you get that right, nothing else can be corrected… There is nothing to attract people into the profession right now, even medical staff are looking for other work." Office in Charge (receiving Merlin incentive), Primary Health Care Clinic, Liberia.

**Case Study- Liberia**

**Situational Analysis of Health Worker Support in Liberia, Implications and Recommendations for incentive payments**
Merlin Liberia, October 2006

Merlin has been operating a health services project in Maryland County Liberia with the support of the UK's Department for International Development (DFID) since March 2004. Within Merlin's current DFID project, the incentive allowance for Ministry of Health (MoH) workers is scheduled to end in December 2006. This brief outlines the current Liberia health system financing situation and the implications of early incentive withdrawal, and specifically that:

- The Liberian government has insufficient public funding to finance health services and pay salaries for clinical staff both currently and in the foreseeable year to come. The Ministry of Health's budget for 2007 will provide only $2.06 US dollars/per person year
- Evidence for early withdrawal of supportive incentive payments to MoH staff suggest loss of existing qualified staff, increased fees at point of service, and overall reduction in quality and accessibility to services that will negatively impact on morbidity and mortality within the population
- Merlin has taken numerous actions to prepare the Ministry for the planned incentive withdrawal in Maryland County at central and decentralised levels. However, little to no change has occurred and less than an estimated 20% of government staff are on payroll.
- Merlin recognises the need to end the incentive payments in the future, however, given the current context and in order avoid an immediate health human resource crisis while ensuring accessibility to basic essential health services, Merlin recommends the following four actions:
    1. Continue incentive payments for current DFID project-supported clinical staff until the end of the project period in February 2007,
    2. Recommend that DFID continue to provide incentives for service delivery support within next year's Liberia supported health projects
    3. Conduct a re-evaluation of the health financing situation in 2008 and possibly implement a graduated reduction of incentives in 2008. This will have

allowed sufficient time for donors and partners to liaise with the government regarding changing support levels to human resources in the public sector

4. Recognising the limitations of a single NGO advocate, Merlin would welcome increased advocacy support from DFID, other bilaterals, multilaterals, and the INGO community in order to affect the central level budget and policy changes necessary to provide salaries and sustain health human resources in Liberia.

**Case Study- Monrovia**
**Implications for Early Incentive Withdrawal**

The implications of limited public financing support is demonstrated when external international or private funding for health facilities is withdrawn. In early 2006 Merlin's funding in support of eight primary health care facilities in Monrovia ended. As previously planned, the organisation donated essential medical supplies to the facilities, communicated the changes to the affected communities, and held a refresher workshop for clinic staff on clinic management. Visits by Merlin staff to the clinics following the project completion reported on setbacks at every level.

Following Merlin's exit from the clinics, clinic staff began charging fees for service delivery and prescriptions. Drugs and other medical and hygiene supplies were sold to private clinics often run by clinic staff to help supplement their income. Many staff stopped working or only worked intermittently. In addition, vaccination of children and pregnant mothers decreased dramatically due to lack of cold chain management and supervision of vaccinators. Morbidity reports were either not submitted to the Ministry of Health, or were incorrectly completed.

The findings of the Merlin team are not unique and are typical of what happens when emergency incentives and support are discontinued from MOH clinics given the current financial and technical capacity of the ministry. An assessment was conducted by Merlin in Montserrado County in December 2005 to assess the level of clinic functionality of government primary health care (PHC) facilities after INGOs or national NGOs had withdrawn support. Some of the findings of the survey were as follows:

- Of thirteen clinics that were previously supported by INGOs (ten lost support in 2005), only five remained functional (38%)
- Clinics that were previously supported by INGOs and are now under the full operation of the MoH do not receive medical supplies and drugs from the government, forcing them to purchase their own. There is limited to no field supervision done by the CHT due to lack of resources
- Fee-for-service is employed in all clinics (Commonly $20 Liberian dollars (LD) for children, $35 LD for adults) in addition to charging for any drugs purchased
- In some facilities, there was a 75% reduction in patient load after NGO pull-out. One clinic was reporting 2,000-3,000 clients per month while they were supported by the INGO and recent figures showed only 75 clients/month. (As the number attending clinics decreased, morbidity patterns during this time which are based on utilisation rates were not available for comparison)

Despite a higher percentage of inhabitants in urban Monrovia having access to employment, the discontinuation of incentive payments has been shown to result in a decline of quality and access to healthcare. Lack of incentive payments encourages, and often necessitates, the implementation of user fees- a situation which seriously undermines the ability of the poor and vulnerable population to access healthcare. In the southeast of Liberia, where there is less access to employment, the ability of rural populations to access health care will be seriously hampered.

**Merlin's DFID-supported Project**

Merlin's DFID-supported proposal for the project "Ensuring integrated primary and secondary health services for the war-affected population of Maryland County, southeast Liberia" states that:

*Merlin will work towards the phasing out of decentralised incentive payments by the end of the year and will plan with and advocate to MoH, donors and other players to ensure this is possible. Merlin will not extend this deadline without careful review, justification and discussion with donors and with the MoH.*

At the time of project planning in 2005, Merlin agreed with DFID that incentive payments for MoH staff should not continue beyond the end of 2006. It was felt incentives would perpetuate the dependence on external support and that within the newly peaceful country context, the government needed to increase ownership and responsibility for placing staff on payroll. Merlin therefore agreed to end incentives at the end of 2006.
Merlin and DFID discussed that both donors and INGOs would need to inform and advocate heavily for this change.

Merlin has taken the following actions to encourage this change in policy and to further the transition to decreased financial support for health human resources:

- Established a memorandum of understanding with the Maryland County Health team outlining the incentive policy and the removal of incentive support at the end of 2006
- Discussed in recent County Health Team meetings about the planned withdrawal in December 2006
- Discussed at the Liberia health sector inter-agency meeting Merlin's plan for phasing out of incentives and the importance of other NGOs assisting in advocacy with the MoH for putting staff on government payroll
- Held discussions with the Minister of Health and the deputy ministers regarding the issue of incentives, donor's reluctance to continue paying allowances, and the need for increased financing for facility staff
- Brought the issue to the table at USAID, OFDA, and ECHO partner meetings held in country and with Irish and Netherlands donor representatives

As the date of Merlin's withdrawal of incentive payments in Maryland County comes closer, nursing staff and other mid-level professionals have begun indicating their plans to leave. Three nurses have left within the last month stating the incentive withdrawal as the reason. Merlin has not been able to obtain the payroll list for the MoH staff in Maryland but through informal discussions with staff, the situation is similar to Merlin's supported hospital in Buchanan with only 20% of staff on a minimal salary. There is no indication from the central level or county level that the government will be able to significantly increase either the payroll amounts or the number of people on the payroll given the limited 7.2 million USD budget for 2007.

As a result of the above context, Merlin believes that ending the incentives is unrealistic at this time. A possible lack of political will and limited stakeholder advocacy in addition to the weak economy has prevented the needed changes at a central budget/policy level within the ministry.

*The following is a summary of justifications for continued incentives support for MoH staff:*

- Based on the upcoming government of Liberia budget for 2007, the MoH are not ready to operate service delivery independently or provide adequate salaries for their staff.
- Until the economy in Liberia improves over the next several years, the budget for health services will continue to be poor.
- Withdrawal of incentive payments in the current context has shown an increase in charging for services at the point of delivery and a loss of staff.
- As a result of incentive payment withdrawal, increased user fees and a loss of staff will likely decrease accessibility to services at those facilities and will negatively increase levels of morbidity and mortality within the population.

- It is estimated that less than 50% of people are on salary and those who are on the payroll receive little.
- Salary levels have not been adjusted for many years and currently are insufficient to encourage health professionals to work in public facilities or rural areas.

**Requests and Recommendations**
As a result of the impending withdrawal of incentives at the end of this year, four of the ten qualified nursing staff at the JJ Dossen hospital in Maryland have already left. Other staff are also planning to leave as a result of the incentive withdrawal in December. Merlin believes that an extension of these allowances would retain the staff in the short-term and with the following recommendations sustain services in the year to come.

Recognising that Merlin and donors should not continue to pay incentives in the long-term, Merlin recommends the following to ensure a smooth transition of support for human resources:

- A two-month extension of the incentive allowances within the current DFID-Merlin project until the end of the project period of February 2007.
- Incentive allowances be provided to MoH staff for at least one additional year (end of 2007) with continued external support for secondary and primary health care services
- An evaluation mid-2007 to be undertaken and analysed once the 2008 MoH budget is known to determine future plans for appropriately phasing out of incentives. If appropriate, a graduated reduction of incentives in 2008 could be implemented.
- Increased donor and other INGO advocacy with the Ministry of Health to inform them of impending reductions in health service delivery support and decreased financing for health workers

Recognising the importance of transition planning in this recovery period to ensure the withdrawal of external support for service delivery as a whole over the next three to five years, Merlin will continue to do the following:

- Work with CHTs, central ministry, WHO, INGOs, donors agencies and health partners to contribute to a national health strategy and plan using our practical experience to help determine funding requirements, human resource needs required and the potential implications of cost sharing and cost recovery strategies on health seeking behaviour and health system management. Merlin recognises current donor policies within this area and will continue to work towards accessibility of services for all, including the most vulnerable
- Engage other NGO service delivery supporters in a wider discussion on the implications of incentive withdrawal and/or continuation and determine common actions for follow-up with the Ministry of health and donors
- Plan a transition strategy with central and local MoH levels to outline actions for the handover of selected administrative and management activities.

**Conclusion**
As Liberia transitions from an emergency period into a recovery and development phase, the donor and implementation environment is changing. Emergency agencies are phasing out operations and emergency donors are downsizing support. There is a large potential for essential support to service delivery and health system development to be reduced during this critical recovery period. As Liberia rebuilds, it is critical to continue supporting the MoH in the operation of the facilities in order to promote ongoing health system recovery and human development in Liberia.

Merlin's three year strategy for Liberia plans to continue supporting service delivery in Liberia while building the capacity of the decentralised MoH teams to take over the management of the health system. As part of this transition strategy, Merlin would like to initiate the process

of phasing out the provision of emergency allowances. However, given the above situational analysis and the current financial capacity of the government, Merlin believes it is premature to do so at this stage. The implications of early withdrawal have been demonstrated at certain facilities that have lost external support. Increased user fees, loss of qualified staff, and a resultant decrease in consultation rates suggest negative affects on the population's accessibility to services and therefore, their overall morbidity status.

Merlin therefore requests that DFID continue to support health human resources in Liberia through providing an extension of incentive payments at least for the following year. Merlin believes DFID can play a key role to plan for and assist in the Liberia recovery period to transition towards longer term development funding mechanisms and development programme priorities.

## 6. Ways To Pay Salaries

**Case Study: Teacher Compensation Paper Afghanistan**
Rebecca Winthrop and April Hammons Golden, not available online.

An alternative and quickly growing sector of the informal banking system is M-Paisa, the Afghan form of the popular Kenyan M-Pesa that provides access to financial services to millions of "unbanked" people through the use of mobile phones. M-Paisa is a software platform run through the mobile phone network that allows users to safely transfer or cash money, add airtime on their phones or use in stores and restaurants to buy food, other material goods and even airplane tickets (Munford, 2010). Afghanistan's mobile network penetration is 75% and given the increasing access to mobile technology, M-Paisa represents a viable innovation in banking system reform for the future (UNDP, 2010).

As discussed above, under the new salary scale teachers are supposed to be paid through banks, but this is only the case for a small percentage of teachers, mainly those in urban centers like Kabul (Venner, 2010; V. Khoja, personal communication, June 2011). In rural areas teachers are allowed to designate a proxy to collect their salary or they can choose to collect their salary every few months (Venner, 2010).

The process of transferring funds from central government to civil servant is similar in other civil service sectors; urban centers are paid in cash or through the formal banking system and rural civil servants are paid in cash. Some sectors are experimenting with payment of salary through the M-Paisa platform, which holds particular promise for regions that are outside of the formal bank system. M-Paisa registers each individual under its payment system and issues them an ID card. Once a pay period, they are sent an SMS as notification that their payment is available, after which they can go to a registered store, show their SMS and ID card and are given cash. Parts of the police force in several different provinces receive their salaries through mobile phone transfer, and pilot projects in other ministries are currently underway (V. Khoja, personal communication, June 2011).

## 7. Aid strategy: SWAps

**Building Blocks or Stumbling Blocks? The Effectiveness of New Approaches to Aid Delivery at the Sector Level**
Williamson T et al., Research Project of the Advisory Board for Irish Aid, 2008
http://www.odi.org.uk/resources/download/1526.pdf

In the continuing search for ways to provide more effective aid, donors have committed themselves to making greater use of government systems and harmonising the way aid is delivered. Donors who agreed to the Paris Declaration on Aid Effectiveness in 2005 are free

to choose their own modality, as long as they progressively shift towards those that use government systems in full.

Programme-based approaches have been developed with these principles in mind. While such approaches accommodate all modalities, direct budget support and debt relief provided to recipient governments are those best suited to the use of government systems. Yet, donors are hesitating to move decisively towards these modalities, even in contexts where programme-based approaches have been well established by the adoption of sector-wide approaches (SWAps) and national poverty reduction strategies (PRSs). Instead, they continue to use either project arrangements or intermediate modalities, such as common, pooled or basket funds. The justification usually offered is that recipient country systems are too weak for a shift to sector or general budget support (GBS). Common funds (CFs) are presented as 'transitional' aid modalities by means of which donors can help strengthen country policies and systems while ensuring that aid funds are well spent.

This working paper analyses the effectiveness of different aid modalities and the coordination mechanisms associated with programme-based approaches at the sector level. It draws from three case studies, covering the education sector in Tanzania, the water and sanitation sector in Uganda and the health sector in Mozambique, and also from the broader literature.

The report finds the deployment of uncoordinated project aid in many sectors has contributed and continues to contribute towards a vicious circle, compounding poor sector governance. Six reasons for this are listed.

The principles of country ownership, alignment with country policies and systems and improved coordination embodied in the new aid paradigm are largely well conceived, and have the potential to deliver a break from the vicious circle of aid ineffectiveness. However, to date, traditional behaviour in aid delivery remains prevalent. To achieve this the report suggests:

- A balance of sector-based aid and general budget support
- Delivering better aid and better dialogue at the sector level
- Avoiding using projects and common funds in support of service delivery wherever possible.
- Addressing the incentives within donor agencies and recipients.

Changes in aid and donor behaviour have delivered some improvements in domestic policies and systems, however, this has failed to deliver a decisive shift from past ineffectiveness, and the vicious circle of aid ineffectiveness is likely to continue. This paper asserts that the aid paradigm has the potential to deliver this decisive break. A key finding is that common funds can act as stumbling blocks rather than building blocks in strengthening service delivery. A more decisive shift in aid modalities towards budget support, plus a change in donor behaviour, is required to break out of this circle.
However, a key constraint is the incentives within recipient and donor agencies which perpetuate the circle of aid ineffectiveness. Recipient incentives can be addressed by a shift in aid modalities towards Direct Budget Support. This increases the importance of changing the incentive structures within donor agencies to deliver against the new aid paradigm.
Ultimately, the likelihood of reform at the sector level relies on political support and technical leadership within government. This is very difficult for the donor community to influence.

**SWAps in the 21st Century**
Grant K., HLSP, 2009, Not available online.

SWAps proposed a new way of working, and although many development agencies signed up to the principles, many individuals found the change from a project approach challenging. Progress in implementation apart from a few countries such as Ghana has been slow.

Two other striking features of international support to the health sector in low income countries over the last two decades added to the inefficiencies of fragmented bilateral aid. The first is the rapid and continuous introduction of new global initiatives for technical and financial support – often before previous ones have been tested and evaluated. The second is that most of these ideas originate in Geneva, Washington, New York or the head quarters of bilateral donors – in contrast to thirty years ago when many of the ideas were developed and written up in Africa and Asia.

The adoption of the Paris Principles in 2005 gave recognition both to the issues to be addressed and the principles in resolving them. However new global initiatives still continue to be approved and donor behaviour continues to be schizophrenic – providing financial support to Global Health Partnerships (GHPs) while supporting governments at country level to cope with the fragmentation that results.

A recently emerging issue is that the expansion of the global health partnerships has resulted in a 'brain drain' of those individuals best placed to provide national technical and managerial leadership. The International Health Partnership and related initiatives (IHP+) aims to address these issues at both a global and country level but there still remains a lot of work to do. This paper argues that the IHP+ needs a robust SWAp at country level to meet its ambitious targets.

The recent focus on new financial initiatives through the innovative financing taskforce, for example, the support to health systems strengthening through GFATM and GAVI and the discussions on a new joint funding platform for health system strengthening are again likely to risk further separating further technical and funding work streams at country level. A robust SWAp at country level will be needed to enable these initiatives to be effective.

Effective involvement of the non-state sector needs to be a key task of the new generation of SWAps. While there is now general recognition of the major role the private sector (both not for and for profit) plays in delivering health care to the poor, SWAps to date have not involved private providers in a way that will improve quality and value for money. Indeed one challenge is that governments are less willing to commission services from NGOs than development partners used to be when using a project approach.

The paper not only argues that using a SWAp at country level is needed now more than ever, but also sets out some of the lessons learnt. One clear lesson is not to be purist. The approach must be sufficiently inclusive to allow different agencies to use different funding modalities while signing up to the broader national health framework. Another is to recognise that building national capacity particularly for financial systems and management may take longer than originally thought: partners need to be realistic in assessing the overall management capacity and not be overly concerned by any need to provide interim support.

There is a risk that the SWAp becomes another "planner's dream", marked by a quest for coherent and consulted policies, actionable plans, robust and reliable financial management systems, with evidence pouring out of smart monitoring systems and donors aligning happily behind the bandwagon. This would set the goalposts so high that actual implementation becomes a remote possibility. Dealing with complexity by constructing a grand system with fixed norms, standards, checklists and measuring points is not the way forward.

The second risk is the polar opposite of the first. It lies in the dangers of adopting an approach that assumes that chaos is all-pervasive and continuous, and that all that can be done is to keep things basic and simple by way of an unprincipled, unguided 'muddling through'.

Between these two extremes is the promising middle ground for what this paper calls 'SWAp+', which recognises the complexity, accepts the disorder, and evolves a strategy for

dealing with both. This is a demanding and difficult option but shows most potential, and would involve:

- Moving beyond the aid effectiveness agenda in SWAps and adopting a sector development perspective as the basic point of departure, recognising that sectors and SWAps do not start from scratch.
- Adopting an explicit political economy perspective on the sector; developing greater understanding of the stakeholders (including donors) and the wider context in which the sector operates; recognising the fundamental political nature of sector development processes; and understanding the drivers and constraints to change.
- Adding a consistent actor/stakeholder perspective on SWAps and sector programmes, asking not only what is in it, but also who are involved and who does what.
- Strengthening managerial inputs in the process – stronger "management from the top" from domestic authorities, coupled with better "management from below" from donors.
- Focusing on results in a basic, common sense, practical way in processes and arrangements related to SWAps and sector development.

The paper argues that it will be through adopting a realistic, pragmatic, coordinated SWAp+ approach that the very substantial resources now available for health can be used to the greatest effect to improve health and reduce poverty.

**Is Harmonisation and Alignment Improving the Effectiveness of Health Sector aid?**
Lewis D, Dickinson C, Walford V, HLSP, 2010, Not available online.

This report outlines the approaches to improving effectiveness of health sector aid:

- SWAps
- General budget support and sector budget support
- International Health Partnerships (IHP+)
- Harmonisation and Alignment of Multilateral and Bilateral Partners working in AIDS

Evidence that these approaches are improving the effectiveness of health sector aid and delivering better health outcomes is limited. It is intrinsically difficult to measure the impact of particular measures such as improved coordination. Furthermore, health outcomes are determined by many factors within and beyond the health sector, making attribution difficult. In particular, it is unclear how to separate out the impact of aid practices such as having a SWAp or more aligned aid, from the impact of the health strategies and policies followed, and the adequacy of financing and implementation capacity. Anecdotal evidence of the impact of aid effectiveness on results is emerging e.g. WHO et al (2008) report that in Mali "improvements in harmonisation and alignment among health partners are correlated with health sector gains," but more systematic data on the impact of approaches and tools that have been developed to increase harmonisation and alignment in the health sector is needed to provide an overall assessment of progress.

The report discusses effectiveness under the following question headings:

- How far has harmonisation and alignment and a results focus been implemented in the health and AIDS sectors?
- Has the quality of health plans and strategies improved, and the extent of national
- ownership?
- Is H&A improving the efficiency of resource use in the health and AIDS sectors?
- Are there greater incentives and better systems for demonstrating results?
- Has plan implementation improved, and are more resources available for priority services?
- Has the availability, quality and coverage of health services increased?
- Have there been improvements in health status?

## 8. The Importance of Human Resources

**Health workforce issues and the Global Fund to fight AIDS, Tuberculosis and Malaria: an analytical review**
Sigrid Dräger*, Gulin Gedik and Mario R Dal Poz, *Human Resources for Health,* 2006, 4:23 doi:10.1186/1478-4491-4-23
http://www.human-resources-health.com/content/4/1/23

**Abstract**
Recent studies have shown evidence of a direct and positive causal link between the number of health workers and health outcomes. Several studies have identified an adequate health workforce as one of the key ingredients to achieving improved health outcomes. Global health initiatives are faced with human resources issues as a major, system-wide constraint. This article explores how the Global Fund addresses the challenges of a health workforce bottleneck to the successful implementation of priority disease programmes.

The comments reveal a struggle between the Global Fund's goal to fight the three targeted diseases and the need to strengthen health systems as a prerequisite for success. In realising the opportunities the Global Fund provides for human resources interventions, countries should go beyond short-term objectives and link their activities to a long-term development of their human resources for health.

**Background**
In the midst of accelerating advances in medicine and health technologies and a growing number of effective and affordable interventions, several low-income countries have experienced a decline in their health outcomes. Rates for child mortality are increasing and life expectancy is decreasing. There is a consensus emerging that one of the key ingredients to achieving improved health outcomes is stronger health systems, including an adequate health workforce. direct and positive causal link between numbers of health workers and health outcomes

At the programme management level it has also been noted that the employment of staff for the Global Fund on short-term contracts with salaries substantially higher than regular government employees has in some cases led to the exodus of technical staff from the ministry of health (MoH). At the health service delivery level, similar incidences have been observed with regard to health workers moving into higher-paid disease-specific positions. This could potentially weaken community-based services that are not related to one of the three target diseases Another observation from a Global Fund study highlights the strong linkages between macroeconomic policies and human resources for health (V.M. Nantulya, personal communication, 2005). The limitations introduced on public expenditure/GDP ratio as part of countries' fiscal policies in complying with International Monetary Fund requirements may result in ceilings on the recruitment of public servants and therefore on the recruitment of health workers. These restrictions may affect the feasibility, success and sustainability of projects of the Global Fund to scale up interventions in the fight against HIV, tuberculosis and malaria. As the guidelines have developed over the six Rounds, the necessity of functioning health systems and sufficient provision of human resources have been increasingly emphasised in the context of the required absorptive capacity of the recipient country.

**Health workers wages: an overview from selected countries**
Sigrid Dräger, Mario R. Dal Poz, David B. Evans, Evidence and Information for Policy, World Health Organization, Geneva, March 2006, Not Available Online

The overall objective is to describe variations in health worker wages across countries.

A good understanding of salaries and wages as push or pull factors for international migration of health workers is therefore essential to countries seeking to develop strategies to retain staff in high-burden disease countries. As the prospect of better remuneration is the single most important cause for migration of health professionals, how can adequate remuneration be defined and how much investment is needed first to employ, but also to retain, an adequate number of skilled health workers? The evidence needed to develop appropriate strategies is lacking, however. A major obstacle has been a lack of transparency and comparability of data on wages and occupational classifications, which has prevented assessment of the earnings of health workers across countries, and over time. The variety of sources and diversity of definitions and classifications pose a major challenge to comparative studies. To help fill this gap, this paper collates and presents the best available data we have been able to find on salaries across countries.

Health workers tend to be paid less than equivalent professionals – or at least teachers and engineers – in low-income countries. There are great incentives for health workers to migrate, posing challenges for the development of strategies to retain them in poor countries. Clearly, improved wages alone in sending countries will not fundamentally change the emerging patterns of migration, because the difference in wages between source and receiving countries is so great. Other, non-financial factors and improved working conditions are playing a vital role as well. A number of countries, largely supported by external donors, have recently financed experiments to increase the wages of health workers in low-income settings, but it is too early to evaluate their impact on rates of migration.

**Guidelines: Incentives for Health Professionals**
International Council of Nurses, International Hospital Federation, International Pharmaceutical Federation, World Confederation for Physical Therapy, World Dental Federation, World Medical Association. Pre-publication Copy, 2008, Not Available Online

The growing gap between the supply of health care professionals and the demand for their services is recognised as a key issue for health and development worldwide. Policy-makers, planners and managers continue to seek effective means to recruit and retain staff. One way to achieve this is to develop and implement effective incentive schemes.

Human resources are the key element of service delivery. Even in the most well resourced and technologically advanced countries the interactions between health professionals and their patients remain at the heart of service provision. Accordingly, staff costs dominate health services expenditure and ongoing shortages in the availability of health professionals present a real and direct threat to the continued delivery and development of health care services.

Incentives, both financial and non-financial, provide one tool that governments and other employer bodies can use to develop and sustain a workforce with the skills and experience to deliver the required care. This demands not just political will and continued hard work, but an acknowledgement by all key stakeholders of the commitment, skills and health benefits provided by health professionals worldwide.

A health service's greatest asset is its staff. The implementation of effective incentive packages represents an investment through which that vital asset can be protected, nurtured and developed.

## 9. Additional information

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