Human Resources for Health and World Bank Operations in Africa

A review of Experience

A. Edward Elmendorf and Kathryn Larusso
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HUMAN RESOURCES FOR HEALTH AND WORLD BANK OPERATIONS IN AFRICA

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Contents/Outline
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Preface by Ok Pannenborg, Senior Advisor for Health, Nutrition and Population, Africa Region, World Bank

To be written at the end

I. Introduction – to be written by Elmendorf and Dussault

This chapter sets the stage for the remainder of the study. It starts with a description of the purposes of the study:

- to summarize and distill experience, and lessons thereof, of WB work with clients in Africa on HRH, under different instruments;
- to inform future action by the Bank and, as appropriate, its clients and partners;
- to propose ideas for future agendas informed by lessons of past work;
- to present some tools for use by operational staff and, as appropriate, partners and clients in HRH work in Africa

The chapter should include a statement of the problem(s), some intellectual and policy history (since the HNP investment operations covered go back into the 1970s), the changing international context (from the Addis Ababa Conference of 2001 through the Joint Learning Initiative of 2004 and the initial responses to it). The chapter should also cover how HRH issues were addressed, or failed to be addressed, in key Bank HNP strategy documents since the 1970s, including the sector strategy note of the early 1980s, WDR93, Better Health in Africa (1994), sector strategy paper (1997), AFR strategic options for HNP (2005), AFR Africa Action Plan (after Gleneagles Summit of 2005).

The chapter should conclude with a summary statement, or ‘road map’ of what is covered in the subsequent chapters.

The chapters themselves will be fully integrated and separately authored pieces, able to be read by themselves; annex material, such as questionnaires, and methodological material unique to the chapters, should be included in the chapters, rather than in the overall introduction or in the annexes to the overall study.

II. Human Resources for Health in World Bank Human, Nutrition and Population Investment Operations in Africa

This chapter, authored by A. Edward Elmendorf and Kathryn LaRusso, reviews the findings of 25 years of HNP operations. A draft of the chapter is presented in the paper embedded here; it will require some revision to fit into the larger study. This is, largely, an editorial task and can be undertaken at a later stage, after the other chapters have begun to take shape.
III. **Human Resources for Health under World Bank Macroeconomic Instruments in Africa**

This chapter, authored by A. Edward Elmendorf and Cesar Palacios, would consist of several sections:

(a) an introduction with a statement of the instruments, including their purposes and uses, including their evolution and a description of the conceptual framework and organization of the chapter – to be written by Elmendorf, with inputs on the methodology and the data bases by Palacios;

(b) a section on HRH and structural adjustment loans – to be written by Elmendorf and Palacios;

(c) HRH in Africa PRSPs – to be written by Palacios and Elmendorf on the basis of early draft material by Palacios;

(d) HRH and PRSCs, to be written by Elmendorf and Palacios; and

(e) a synthesis, concluding section, comparing HRH under PRSPs and PRSCs, and documenting the change to growth in interest and concern with HRH over the past decade. Overall, the Chapter will draw heavily on a presentation on HRH in WB AFR operations made by Elmendorf at the American Public Health Association annual convention in December 20005.

IV. A potential addition is a chapter on **HRH in economic and sector studies in Africa**. This would be a significant addition, yet the work done largely by Agnes Soucat on HRH in public management, under the country status reports for the HIPC initiative is significant. Possibilities to be discussed as the remainder of the work matures.

V. **Country Cases of World Bank Engagement in HRH in Africa**

This chapter would take the material discussed previously in connection with various instruments, and bring a country-specific perspective, in a limited number of case study countries. It would examine, probably chronologically, the Bank’s overall engagement in HRH in several countries where all or many of the instruments were used. Probably, the chapter will find that the Bank’s involvement was non-strategic and that the Bank did not deploy its instruments in ways to gain maximum impact, though this finding will be attenuated by the somewhat different times covered. Whether this chapter will be needed/written will depend on the results of Chapters II and III, and the time of the authors. The chapter would be written by Elmendorf and Palacios, with assignments to be determined. Since the Bank has recently received HRH trust fund resources from NORAD and the Gates Foundation for work at the country level in Africa, it might be a good idea to prepare this chapter as a synthesis of what has been done by the Bank in HRH in one of the countries expected to be in the initial group: Ghana, Mozambique (?), Malawi (?), Zambia

VI. **Conclusion: Lessons Learned and Tools for Future Work**

This chapter will be written at the end, and will pull together the various strands of analysis, with a particular focus on what type(s) of instruments are appropriate for what type(s) of issues. It is possible that we will decide, after the work on the others is reasonably complete, to drop the idea of a country-focused chapter and simply include a more limited number of country cases of boxed essays in a concluding chapter. The chapter should include one or more tools to assist staff with HRH work, including an assessment tool. Authors – Elmendorf, Dussault, and Palacios.
This paper is written in the authors’ personal capacity, and nothing in the report should be taken to commit
the World Bank, its Executive Directors or the countries they represent.
ABBREVIATIONS AND ACRONYMS

AIDS  Acquired Immunodeficiency Syndrome
CIDA  Canadian International Development Agency
CBO  Community Based Organization
CBD  Community Based Distributor
CDA  Community Development Agents
CSPS  Health and Social Development Center (Burkina Faso)
DfID  Department for International Development (United Kingdom)
DPSD  Department of Population and Social Development (Mozambique)
EPI  Expanded Program of Immunization
FHFE  Family Health Field Educators
FP  Family Planning
HIV  Human Immunodeficiency Virus
HMIS  Health management information system
HNP  Health, Nutrition, and Population
HR  Human Resources
HRD  Human Resources Development
HWA  Health Workforce Activity
ICR  Implementation Completion Report
IDA  International Development Association
IEC  Information, Education, and Communication
IFPRI  International Food Policy Research Institute
KNH  Kenyatta National Hospital
LGA  Local government authority
MCH  Maternal and Child Health
MOF  Ministry of Finance
MOH  Ministry of Health
MOHCW Ministry of Health and Child Welfare
MOHSW Ministry of Health and Social Welfare
MOPH  Ministry of Public Health
MOPHSA Ministry of Public Health and Social Affairs
NCPD  National Council for Population and Development (Kenya)
NGO  Non-governmental Organization
NHS  National School of Health
NHTC  National Health Training Center
OED  Operations Evaluation Department
PCMA  Protestant Churches Medical Association (Kenya)
PCU  Project Coordinating Unit
PHC  Public Health Care
PMU  Project Management Unit
SCN  State Certified Nurse
SIDA  Swedish International Development Agency
STD  Sexually Transmitted Disease
STI  Sexually Transmitted Infection
TB  Tuberculosis
TBA  Traditional Birth Attendants
TA  Technical Assistance
UNFPA  United National Fund for Population Activities
VHC  Village health committees
VHW  Village Health Worker
WHO  World Health Organization
WID  Women in Development
ZNFPC  Zimbabwe National Family Planning Council
HEALTH WORKFORCE ISSUES UNDER WORLD BANK-FINANCED HEALTH, NUTRITION AND POPULATION PROJECTS IN AFRICA, 1974 – 2002

A. Edward Elmendorf and Kathryn LaRusso

Introduction

The purpose of the present paper is to shed light on the treatment of health workforce issues under health sector investments by the World Bank and its African country borrowers and their project agencies. In doing so it aims to facilitate the design and execution of health workforce activities under on-going and future Health, Nutrition and Population (HNP) operations in Africa. The audience for the study is, largely, World Bank staff, but it may also be useful for the Bank’s external partners. The paper is written in an environment increasingly influenced by the Bank’s Strategic Options study for its HNP operations completed in May 2004. The Strategic Options paper finds strengthening the health workforce the single greatest challenge to health care delivery systems in Africa.

The paper examines all HNP operations completed through the end of 2002. The paper begins with a discussion of the methodology and data set used for the analysis. It then sets forth preliminary results. It concludes with a discussion of the implications of these results and of further work to be done. Annexes contain data on the total costs, including health workforce activity costs, and World Bank financial commitments and disbursements for the projects covered by the review; detailed information from implementation completion reports on health workforce activities carried out under each of the Bank-financed HNP projects in Africa since the mid 1970s; summary information responding to the issues raised in the questionnaire used to compile the data base prepared for this paper; and covenants on health workforce issues and the extent to which they were respected.

VII. Methodology and Data Set

The design of the present review proceeded from two critical assumptions. First, cost and other constraints would make direct contacts with borrowers impossible, and interviews with Bank staff unfeasible. Second, a review based on documents would be

1 A. Edward Elmendorf is Adjunct Associate Professor at the Johns Hopkins School of Public Health and World Bank consultant; Kathryn LaRusso is a recent graduate of Georgetown University and research analyst at the World Bank. This paper is written in the authors’ personal capacity, and nothing in it should be considered to represent the views of the World Bank, its Executive Directors or the countries they represent.

most instructive if based on completed projects as executed, as reflected in the Implementation Completion Reports (ICRs) required of Bank staff following the final disbursement of each loan, rather than on plans for projects, as reflected in project appraisal reports, memoranda of the Bank’s President to its Executive Directors, and other appraisal documents. This approach, however, led to several weaknesses. First, ICRs tend to be less complete than appraisal reports, and the data set has obvious gaps for this reason. Second, basing the study on ICRs means that its examination is unable to take into account the most recent developments in Bank thinking on workforce issues and its reflection in HNP operations. Third, while the treatment is consistent across operations, basing the analysis on ICRs and ICRs alone, without country visits and interviews, means that the study is unable to capture the full realities of health workforce issues in individual countries. Fourth and finally, since the study is based on ICRs, it is inevitably subject to the biases of ICR writers, including a natural tendency towards justification of World Bank actions.

The present analyses began by identifying all HNP projects completed from the inception of World Bank lending for HNP operations in Africa with a population project in Kenya in 1974, through the end of 2002. HNP operations were identified from the Bank’s internal ‘Image Bank’ of World Bank reports and studies. The reports cover 63 projects in 34 countries for which the Bank’s Africa Region is responsible. The resulting data set included 63 ICRs and those project evaluation studies on Africa Region HNP projects carried out by the Bank’s independent Operations Evaluation Department (OED). With the significant exception of South Africa, the data set may be considered representative of health projects in Africa and the Bank’s Africa Region.

A detailed questionnaire was created to extract data from the individual ICRs. It was adapted from an earlier questionnaire used in connection with examination of behavior change under Bank-financed HNP projects in Africa. The questionnaire, with summary results, is at Annex III.

For reasons that are not entirely clear, the ICRs and OED reports examined in the review contained detailed financial information on 61 rather than 63 projects. These 61 projects represent total project costs of $1.8 billion. The Bank and its soft loan affiliate the International Development Association (IDA) committed a total of $1.4 billion to support the projects, and disbursed $1.2 billion. Health workforce activities detailed in the ICRs were tabulated, wherever data were contained in the ICR. For 34 of the 61 projects the ICRs contained had health workforce activity cost data. These 34 projects had a total cost of $900 million, Bank and IDA commitments of $816 million, and disbursements of $663 million. For these 34 projects, the health workforce activity costs were $93 million, or 10 percent of total project costs. Since these 34 projects may not be fully representative of the total population of 61 projects, we cannot conclude that 10 percent of all HNP project funds were devoted to health workforce activities. However, 10 percent is a reasonable order of magnitude. The project cost and World Bank and IDA commitment and disbursement data are summarized in Annex I.

3 The dataset also included the predecessor of ICRs, Project Completion Reports; for the purposes of this study, the two are considered the same.
VIII. Results

Virtually all of the Bank HNP operations in Africa in our database had some type of health workforce activity. This finding suggests that, despite impressions to the contrary, the Bank has been widely active on some aspects of health workforce issues. The evidence collected under the various issues raised in the questionnaire suggests that 61 of the 63 projects (97 percent) had some type of Bank health workforce activity. In many of these cases the cost of these health workforce activities were not given in the ICRs. This is the reason why the financial data above are limited to 34 projects. The fact that the health workforce activities reported in the ICRs were relatively small actions, often not reflected in the detailed cost information in the ICRs, confirms the view of observers that health workforce issues have not been a central concern of the Bank’s HNP operations in Africa.

Using data in the ICRs and extrapolating where necessary, we find that by far the largest share of the $93 million reported as spent on health workforce activities was devoted to training of health personnel, both local and overseas. $56 million in total project costs was spent on training. $11 million was spent on institutional strengthening and technical assistance. $12 million was spent on consultants’ services\(^4\), and $14 million on manpower development. Because of difficulty in identifying and allocating project cost data in the ICRs to common categories, these cost figures contain a margin of error, and should be considered approximate rather than definitive.

Despite widespread inclusion of health workforce activities in Bank-financed HNP operations in Africa, the information on overall health workforce issues in the ICRs is extremely limited. With but one exception (Box 1), the health workforce experience under the project is rarely placed in the ICR in the broader context of health workforce activity in the country. A detailed project-by-project summary of the information on the various health workforce activities executed under the individual projects and reported in the ICRs was compiled from the questionnaires. This summary is at Annex II. Some caution is needed in reading the summary. Despite its appearance of detail, there is no assurance that it is exhaustive, since it can do nothing more than reflect whatever detail the authors of the ICRs decided to include in those reports. Nonetheless, we can be reasonably confident that the overall picture conveyed by this large number of ICRs is accurate. Reading the summary confirms the impression from the cost data that training actions were by far the largest health workforce activities carried out under the projects. However, the evidence in the ICRs does not suggest that the training activities always resulted from detailed training needs assessments. While this is the kind of information that is typically not captured in ICRs, the tendency towards non-systematic approaches to training reflected in the health workforce activity summary probably reflects an underlying reality.

\(^4\) This figure includes some expenditures on training, also; it was difficult to separate consultant services and training costs, since the disbursement categories frequently overlapped.
**Box … Human Resources for Health in Malawi: An Exemplary ICR Review**

**I. Current Situation as Stated in ICR**

Malawi in now in the midst of a human resources crisis in health, and the Government simply does not have the resources for pre-service or in-service training. Neither does it have the resources to upgrade the salaries and benefits of health workers so that their retention can be assured. IDA supervisory site visits in the last two years of the project indicate that under-staffed and under-supplied facilities have become increasingly common, with adverse effects on quality of care. According to the GOM Budget Book, vacancies of various health cadres involved in direct patient care ranged from 33% to as high as 80% in some critical positions. A survey conducted by the KPMG in 1999 showed that many district hospitals do not have doctors, that lower-level staff were performing higher-skill functions, and that even in tertiary facilities patients rarely see a doctor. In fact, among neighboring sub-Saharan countries, Malawi has consistently registered one of the worst population to health worker ratios, with 1 physician per 45,000 people in Malawi, compared to 1:22,000 in Kenya and 1:11,000 in Zambia.

**II. The Nursing Problem**

Although Malawi has struggled with a nursing shortage in the past, the situation became acute starting in 1998. As much as 50% of the available nursing posts are now unfilled. The nursing shortage has arisen from a complex set of demand and supply factors. On the demand side: (a) the low pay and poor staff benefits of government workers; (b) the liberalization of health service delivery resulting in the exodus of government workers to private practice (both non-profit and for-profit providers) which offer better salaries and benefits; and (c) the increasing demand for skilled nurses in neighboring countries and in Europe. On the supply side: (a) the Malawi Nursing and Midwifery Council’s insistence that Malawi should produce degreed nurses (i.e., higher skilled registered nurses, mainly hospital-based, with a longer and therefore more expensive training period) rather than the lower-skilled but more cost-effective community health nurses (enrolled nurses); (b) the serious lack of nursing tutors, many of whom have left the civil service for greener pastures; (c) the severe scarcity of secondary school graduates in general, and those going to nursing in particular, which is also due to the training system’s focus on degree-nursing; (d) limited science education needed to underpin medical and nursing training; and (e) increasing death and morbidity from the AIDS epidemic.

**Possibilities for future action**

Not all of these factors are amenable to GOM action or influence, but it certainly could have set stronger policy direction with respect to the types of nurses needed by the health system. It could have expedited civil service reform to “right-size” the bureaucracy and enhance the benefits of trained health workers. It could have set a program to produce more secondary school graduates and strengthen science education for nursing and medicine. The ICR author noted that “for a long time, the situation was worsened by the absence of a national policy on human resources generally, and training specifically”. However, because of the project’s strict focus on government services, it was unable to take advantage of opportunities presented in the private sector. Thus, as civil service wages and benefits stagnated and government health workers found it more attractive to work elsewhere, the project was unable to offer creative mechanisms that would have tapped the skills of these health workers, i.e. through service contracts. The ICR found the project focused too much on health inputs – using a ‘checklist’ monitoring approach – and not whether activities were critical or necessary to achievement of project objectives. Although the project trained a substantial number of public servants, many have left. Little was done to improve the organizational structure and to improve the incentives in public service. The project indeed trained a number of hospital administrators, but poor pay, many staff vacancies, and commodity shortages (drugs and supplies) combine to reduce their administrative effectiveness.

**Wide Range of Health Workforce Activities Supported**

Box 2 shows the wide range of health workforce activities in Africa supported by the Bank, with indications of countries where different types of health workforce activities were carried out. These include:
Construction, equipping, rehabilitation, and upgrading of training facilities and staff housing
Pre-service and in-service training of many different types of health care personnel and managers, including facility and MOH managers
Training of trainers
Distance education of health care personnel
Curriculum development, training policy, and training needs analysis
Census of health care workers

Development of new cadres of health workers
Computerized health care personnel and training files
Health workforce plans and staffing norms
Health workforce management capacity building in MOH
Recruitment, deployment, development, and retention planning and implementation

It is striking but hardly surprising that the health workforce issues in which the Bank has been engaged under HNP operations in Africa fall largely – indeed almost exclusively – under the authority of Ministries of Health.

Involvement and Support of Organized Health Workers

The data in the ICRs (see Annex III) suggest that, overall, execution of the health workforce activities supported by the Bank has been fairly satisfactory. 50 percent of the activities are judged by the Bank’s ICR writers to have been satisfactorily implemented, and nearly 40 percent partially satisfactorily. However, it is striking that health workers or their representatives had virtually no organized association with execution of the health workforce activities, despite the well-known capacity for the health workforce to disrupt activities of health care through strikes and other job action [insert reference – GD can you give me a good one?]. There are few indications in the ICRs that health workers or their representatives were consulted on the health workforce activities undertaken under the Bank-financed projects. The closest health workers came to reported association with execution of health workforce activities financed under Bank HNP operations in Africa were in Comoros, Kenya, and Mozambique. In Comoros, midwives promoted and supervised project-supported family planning activities, but no effort is reported to have been made to interest health center physicians in the provision of family planning services. In Kenya, a nurses organization was involved with the training and supervision of community nurses under a Bank-financed project. Opposition of the Chief Nursing Officer eventually led to disappearance of Nurse Trainer/Supervisors as a separate cadre of health personnel. In Mozambique, students from the University were placed in internship assignments, which is reported to have provided government policy making units with a pool of young talent.

Only two HNP operations in Africa provided support to professional associations and/or regulatory bodies, according to the evidence in the ICRs. The Gambia National Health Development Project supported the development of the Nurses and Midwives
Council, and the Zimbabwe Second Family Health Project provided support to the Nursing Directorate in the MOH.

**Health System Reform and Health Workforce Activities under Bank-financed HNP Projects**

According to evidence in the ICRs, 60 percent of the projects included some elements of health system reform, but did not substantially address health workforce issues. 30 percent of the projects included health system reform and health workforce issues. The remaining projects did not include health system reform, but this does not mean that the projects contained no health workforce activities. No information is given in the ICRs indicating that health workers or their representatives (such as professional associations and/or statutory bodies) were involved in health system reform activities carried out under the Bank-financed HNP operations in Africa, whether actively engaged in execution, consulted but not engaged in execution, or otherwise consulted.

**Health workforce planning and projections**

Over half of the ICRs contained no data relevant to health workforce planning and projections. In connection with three projects, health workforce planning was undertaken limited to public sector personnel. Under only one project was such planning undertaken and reported to cover both public and private sector personnel. 20 percent of the ICRs reported work having been undertaken on health labor force planning and projections without indicating whether it covered only public or public and private sector personnel.

**Training of health personnel under Bank-financed HNP operations in Africa**

40 percent of the projects financed the construction and/or equipping of physical facilities for training of health workers. However, the Bank’s engagement in the training of health care providers has gone well beyond construction and equipping of training institutions.

The design of this study provided for tabulation of the numbers of different types of health care personnel trained under Bank-financed HNP projects in Africa. The nature and quality of the data in the ICRs did not, however, permit this kind of tabulations. Such information as was provided is reflected in the health workforce activity summary in Annex II. The ICRs rarely denoted whether training was pre- or in-service, and usually stated training numbers in terms of topics trained in, not specific cadres trained. For example, a typical ICR entry would be a simple statement that 100 people were trained in MCH/FP, with no further detail.

11 projects – almost 20 percent – undertook curriculum planning or revision beyond that required for personnel trained under the project, generally for nurses. The Chad Safe Motherhood Project, for example, revised the curricula for the nursing school. The Gambia National Health Development Project revised the curriculum for State Enrolled Nurses and Community Health Nurses. The Senegal Human Resources
Development Project reformed the curriculum on reproductive health at all health training schools. It is striking that no ICR reported work on curriculum planning for medical doctors.

Four projects are reported in the ICRs to have undertaken evaluation and/or accreditation activities associated with health training institutions. The Comoros Health and Population Project reports an evaluation study on training provided at the National School of Public Health. The Cote d’Ivoire Health and Demographic Project ICR reports an evaluation of two new nursing schools constructed under the project. The Gambia National Health Development Project ICR reports completion of a project-supported assessment of the training program for nurses. The Kenya Health and Rehabilitation Project ICR reports changing the status of the Eldoret Referral and Teaching Hospital and the Kenya Medical Training College into parastatal institutions. This limited information suggests that accreditation issues need to become a more central consideration in the design of the training components of Bank-financed HNP operations in Africa.

Much of the training activity supported in-service training. However, we were able to identify in the ICRs only one project, the Guinea Health Services Development Project, developed a policy for continuing education and development of human resources for health. 6 projects, in Ghana, Guinea-Bissau, Kenya, Lesotho, ex-Zaire, and Zimbabwe, provided ad hoc, specialized training for specific categories of health cadres, such as training of nurses in new contraceptives, or training of existing cadres of health workers in new immunizations who have not provided such services previously.

**Establishment of New Cadres of Health Workers**

Five projects (8 percent) introduced policy or institutional changes associated with the health workforce, such as establishment of a new cadre. This work included (a) integration of auxiliary health personnel into the civil service in Cote d’Ivoire; (b) a failed attempt in Kenya to establish nurse trainers/supervisors as a new cadre and a successful attempt to introduce and train a new class of field worker, the family health field educator; (c) introduction of a new cadre of district health service administrators in Lesotho; (d) recognition of nurses’ aides in Rwanda as specialized health workers; and (e) introduction of a new cadre called District Health Services Administrators in Zimbabwe.

**Promotion of appropriate deployment of health care personnel**

Ten projects (16 percent) involved incentives or other measures to promote deployment of personnel to under-served areas, or to encourage them to remain within the country or service. As reported in the ICRs, measures adopted included construction of staff housing facilities in Benin, Gambia, Ghana, Nigeria, and Uganda; flexible, decentralized management agreements, serving as a motivator for district health teams in Burkina Faso; better working conditions for providers, through improved access to water and electricity, in Guinea-Bissau; equipping of district health offices and support to
salaries, supplies, seminars, and training, in Kenya; provision of financial incentives with the product of cost recovery, in Mauritania; facilities rehabilitation with beneficial impact on staff morale, in Tanzania and Uganda.\(^5\) Aside from the measures reported above, no other changes in working conditions, career structure, promotion criteria and other actions affecting staff motivation were noted in the ICRs.

**General institutional development affecting the health workforce**

Under 6 projects further general institutional development activities affecting the health workforce are reported in the ICRs. These activities included (a) strengthening the MOH Department of Human Resources in Angola\(^6\); (b) development of personnel norms and decentralized training in Chad; (c) creation of hospital management boards in Comoros, with representatives of health care personnel included; (d) offering of new remuneration packages to clinical staff in Gambia, following the granting of semi-autonomous status to hospitals, to reduce attrition; (e) establishment of Women in Health committees in 29 local government areas under the Nigeria Sokoto State project; and (f) establishment of an Inspectorate Unit in the Department of Manpower Development and Training in the Tanzania MOH, to monitor staff performance.

**Execution of health workforce activities**

The health workforce activities financed under Bank HNP operations in Africa were executed in a wide variety of different ways:

- Through a human resource development unit in the MOH (6 projects, 10 percent)
- Through an autonomous health training institution or institutions under the MOH (10 projects, 16 percent)
- Through a parastatal (7 projects, 11 percent)
- Directly, by a PMU or PCU (16 projects, 15 percent)
- Otherwise, such as by NGOs (7 projects, 11 percent)

For 18 projects (30 percent) the ICR did not specify how the health workforce activity was executed. No ICR mentions execution of health workforce activities through the Ministry of Education; this is, presumably, a reflection of the Bank’s non-engagement on issues of medical education.

The number of different government ministries or agencies involved in implementation and monitoring of the project-supported activities mentioned in the ICRs is indicative of the coordination problems affecting such components. Four projects had four different agencies involved; 11 projects had three agencies; 13 projects had two agencies; and 14 projects mentioned only one agency involved. 15 ICRs (24 percent of

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\(^5\) In Uganda, however, the OED report observed that staff retention in the MOH Planning Unit was difficult, since standard civil service salaries were not competitive enough to keep staff from finding other better paying jobs.

\(^6\) In the view of the authors, it is quite likely that other projects also supported manpower planning units; however, it was difficult to discern this clearly in the ICRs.
the projects) had no information on the number of agencies involved in implementation and monitoring.

**Overall conceptualization of health workforce issues in the ICRs**

In collecting data from the ICRs on health workforce issues, we endeavored to gain an understanding of how ICR authors conceive of such issues, overall. Less than 30 percent (17) of the projects conceived of health workforce issues in their macroeconomic context. Of these 17 projects, 7 simply took the macroeconomic environment as given, and 10 executed activities that aimed to influence it, in Benin, Burkina Faso, Comoros, Gambia, Guinea-Bissau, Lesotho, Malawi, Mauritania, Nigeria, and Senegal. 20 projects, or one-third of the total, conceived of health workforce issues in their overall sectoral context. Of these 20 projects, 75 percent (15, i.e, only one quarter of the total population of over 60 projects) undertook activities that endeavored to influence the sectoral context, in Angola, Cameroon, Chad, Gambia, Ghana, Guinea, Lesotho, Madagascar, Mauritania, Mozambique, Nigeria, Tanzania, and Togo. Only one-half of the total ICRs conceived of health workforce issues as a standard issue in the development and expansion of health facilities and services in the country, such as, as a minimum, by introduction and use of a check-list of routine issues to be examined.

**Technical support by the Bank during project execution and supervision**

The evidence in the ICRs suggests that the health workforce activities supported by the Bank have had a low level of technical support and supervision by the Bank during execution. In our compilation of the ICR data, a project was considered ‘fully supported’ by technical supervision if a training or manpower specialist was present throughout the project cycle. Only 3 projects (5 percent) were ‘fully supported’ by supervision – the Chad Health and Safe Motherhood Project, the Guinea-Bissau Social Sector Project, and the Zimbabwe Second Family Health Project. 12 projects (20 percent) received some input from staff or Bank consultants with health workforce expertise. Nearly one-half of the ICRs report no input from staff or Bank consultants with specialized expertise on health workforce issues. Finally, nearly 30 percent of the ICRs contain no data shedding light on this matter.

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7 This question was given a positive response if (a) the ICR presented the country-wide political environment with its impact on the health workforce; OR (b) the ICR linked health workforce issues and policies to macroeconomic variables, such as civil service conditions, overall budget levels and allocations, or the fiscal feasibility of implementing major change; OR (c) otherwise treated health workforce issues as an inter-sectoral problem.

Census of health personnel: Cameroon, Nigeria

Computerized personnel files/HR database building: Benin, Guinea, Lesotho, Mauritania, Nigeria, Tanzania, Zimbabwe

Construction and/or upgrading of training facilities and provision of equipment: Angola, Chad, Ethiopia, Kenya. Lesotho, Malawi, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Sierra Leone, Uganda, Zimbabwe

Curriculum development/revision: Angola, Botswana, Gambia, Nigeria, Sierra Leone, Togo

Development of a new cadre of health worker: Cote d’Ivoire, Kenya, Lesotho

Development of training guides/guidelines developed: Chad, Nigeria, Senegal, Tanzania

District level training of management officers/health team etc: Burkina Faso, Mozambique, Senegal, Sierra Leone, Tanzania, Zimbabwe

Establishment of training norms: Cameroon

Fellowships/Graduate study abroad: Burundi, Comoros, Lesotho, Mauritania, Mozambique, Nigeria, Senegal

HR/MOH strengthening/support: Benin, Ghana, Lesotho, Malawi, Senegal, Zaire, Zimbabwe

HRD plan development/management framework: Angola, Guinea, Mozambique

Improved staff training capacity, training of tutors: Cote d’Ivoire, Mozambique, Nigeria, Zimbabwe

In-service primary healthcare training: Malawi, Sierra Leone

Institutional strengthening for inter-ministerial population activities: Burkina Faso, Nigeria

Management strengthening (district or regional health personnel/management): Cameroon, Chad, Equatorial Guinea, Ethiopia, Guinea, Mauritania, Nigeria, Tanzania

MOH support in planning and management: Uganda

Overseas training MOH and other management/health staff: Kenya, Nigeria

Recruitment or Retention plan: Comoros

Redeployment of personnel: Benin, Madagascar, Mauritania, Rwanda

Reorganization of MOH: Comoros, Lesotho

Social/Community Mobilization: Chad, Tanzania

Specialized medical training: Lesotho, Niger, Togo, Zimbabwe

Specialized technical training: Benin

Staff and student housing for health professionals: Cote d’Ivoire, Zimbabwe

Strengthening of health planning and development: Angola, Burkina Faso, Kenya, Sierra Leone, Tanzania

Training in blood screening: Burkina Faso

Training database/Staffing database: Chad, Guinea

Training, in-service (areas not specified): Burkina Faso, Burundi, Guinea-Bissau, Niger

Training module revised/developed: Chad, Madagascar, Mozambique, Niger, Nigeria

Training of community based distributors: Ghana

Training of medical doctors: Burkina Faso, Mali, Niger, Nigeria, Senegal

Training of health personnel (areas not specified): Chad, Mali, Mauritania, Togo

Training of health personnel in HIV/AIDS/STI detection, screening, and management: Angola, Burkina Faso, Cameroon, Chad, Kenya, Malawi, Zaire, Zimbabwe

Training of hospital staff in hospital management: Cote d’Ivoire, Equatorial Guinea, Kenya, Lesotho, Malawi, Niger

Training of Ministry of Finance personnel: Chad

Training of MOH/Public Health staff: Angola, Chad, Malawi, Mali, Niger, Rwanda

Training of Nurses: Equatorial Guinea, Gambia, Guinea-Bissau, Lesotho, Mali, Niger, Nigeria, Senegal, Zimbabwe

Covenants on Health Workforce Issues
Nearly one half of the projects reviewed in this paper had covenants in the Loan or Credit Agreement concerning health workforce issues. A detailed summary of the covenants, and the extent to which they were respected, is in Annex IV. As a general rule, the covenants address project-specific issues, and suggest that the dialogue between the project authorities and the Bank staff on health workforce issues was rather narrow. Exceptions to this rule include:

- **Benin, Guinea**: redeployment and reassignment of MOH staff
- **Burkina Faso**: execution of a hospital study that was expected to but did not lead to more rational staff deployment within the sector
- **Cote d’Ivoire**: development of a plan for long-term utilization of auxiliary health workers; creation of a new employment category of nurse specialist in health service management
- **Ghana**: preparation of health facility staffing norms, a manpower master plan, and a master training program for health staff
- **Kenya**: establishment of a manpower information system at Kenyatta National Hospital
- **Lesotho**: curriculum revision for paramedical staff to include family planning
- **Malawi**: appointment of a training officer in the MOH to coordinate in-service training programs
- **Mali**: submission of studies on the labor market for graduates in health-related fields
- **Mozambique, Tanzania**: completion of a health manpower development plan
- **Rwanda**: submission of a proposed career path for nurses aides
- **Tanzania**: action plan for strengthening of MOH Department of Manpower Development and Training; adoption of an incentives package for health sector staff
- **Uganda**: transfer of excess staff

IX. Discussion and Implications

Despite the Bank’s substantial engagement in health workforce issues in connection with its HNP operations in Africa, the information collected in the questionnaires makes clear that the Bank has not been deeply concerned with major African health workforce issues under the projects covered by this analysis. The current health workforce agenda in Africa focuses on major issues in the pre-service and in-service training, recruitment, deployment, remuneration, development, and career management of different cadres of staff. The agenda deals also with the profound challenges to health services posed by civil service reform, changing perspectives on the role of the state, fiscal ‘right-sizing,’ widespread emigration of health personnel under an increasingly integrated world-wide market for health services, and – last but certainly not

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8 The Tanzania incentives package was reported to have created many internal problems in the health sector, especially between medical and non-medical staff, and to have been revised three years after introduction.
least – HIV/AIDS and its devastating impact at the dual levels of rising demand for health services and reduced supply due to lower recruitment and staff losses.9

Why has the Bank not been deeply engaged in health workforce issues under its HNP operations in Africa? Answering this question would require detailed interviews with clients and Bank staff. The following hypotheses are offered:

1. First, for most of the period covered by the ICRs analyzed here, health workforce issues in Africa were widely perceived to be largely concerned with adequate numbers of paramedical personnel; in this area, the health workforce activity information in Annex II makes clear that the Bank has been well engaged.

2. Second, answers to the problems of the new agenda outlined above are hard to identify, even harder to implement, and extraordinarily political. This means that the Bank’s clients, and consequently its staff, have been reluctant to address them. Yet, if the Millennium Development Goals are to be achieved in Africa, these issues must be on the policy agendas of African countries and their development partners.

3. Third, at least some critical dimensions of the issues, such as remuneration, conditions of employment and basic training, require intensive collaboration across ministerial departments, including the core agencies of Finance, Planning, and Civil Service, and – for basic training of doctors – Ministries of Education. Collaboration across sector and ministry boundaries is usually difficult and not rewarding. Instead of responding to the needs of the countries’ epidemiology and health care systems, Ministries of Education, for example, may be responsive in curriculum design and in admissions to medical schools to pressures from faculty oriented towards technology-dependent models of care and to pressures from large numbers of secondary school graduates seeing higher education as the key to their future income and social prospects. The World Bank Institute is currently designing and building consensus on a work program of analysis and policy dialogue on linkages between macroeconomic policy makers and health sector leaders that should strengthen African countries’ capacity for cross-sectoral dialogue.

4. Fourth, the health professions have often been resistant to change. Decision makers have been reluctant to engage professional associations and other groups of providers in the policy debate. This has tended to freeze positions and make change even harder.

As this report is written, the tone is changing. Both the Bank’s Ministry of Health clients and its staff are increasingly placing health workforce issues on the agenda for policy dialogue, analysis, and action. It is hoped that this work will be adequately informed by the gaps in prior work. The Strategic Options study points out that health workforce bottlenecks are a major obstacle to achieving poverty reduction and progress towards the Millennium Development Goals. It argues that the Bank is well positioned to advance the policy dialogue, convene critical players, mobilize resources for workforce revitalization, and help develop the required analytical capacity. The exploitation of the information assembled in this study should assist in informing the new work now being designed.
Annex I
COST, COMMITMENT, AND DISBURSEMENT DATA FOR HEALTH WORKFORCE ACTIVITIES IN WORLD BANK-FINANCED HEALTH PROJECTS IN AFRICA 1974-2002

<table>
<thead>
<tr>
<th>HEALTH WORKFORCE ACTIVITY (HWA) COST (In millions of dollars)</th>
<th>TOTAL PROJECT COSTS (In millions of dollars)</th>
<th>HWA COST AS PERCENTAGE OF TOTAL COSTS</th>
<th>TOTAL IDA/IBRD COMMITMENTS (In millions of dollars)</th>
<th>TOTAL IDA/IBRD DISBURSEMENTS (In millions of dollars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>X. TOTAL ALL 63 ICRs</td>
<td>NA</td>
<td>NA</td>
<td>$1.42 billion</td>
<td>NA</td>
</tr>
<tr>
<td>XI. AVERAGE OF 63 PROJECTS</td>
<td>NA</td>
<td>NA</td>
<td>$22.5 million</td>
<td>NA</td>
</tr>
<tr>
<td>XII. TOTAL FOR 61 ICRs WITH COST AND DISBURSEMENT DATA</td>
<td>NA</td>
<td>$1.78 billion</td>
<td>$1.41 billion</td>
<td>$1.23 billion</td>
</tr>
<tr>
<td>XI. AVERAGE OF 61 PROJECTS</td>
<td>NA</td>
<td>$29.3 million</td>
<td>$23.2 million</td>
<td>$20.2 million</td>
</tr>
<tr>
<td>TOTAL FOR ALL 36 ICRs WITH HWA COST DATA</td>
<td>$93.2 million</td>
<td>$901.5 million</td>
<td>$816.9 million</td>
<td>$663.4 million</td>
</tr>
<tr>
<td>AVERAGE HWA COST FOR 36 PROJECTS</td>
<td>$2.6 million</td>
<td>$25.0 million</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| BREAKDOWN OF HWA COST DATA BY CATEGORY                         | Training of health personnel (local and overseas) including IDA and external contributors | $56.3 |
|                                                               | Institutional Strengthening and Technical Assistance | $10.9 |
|                                                               | Consultants’ Services, Training and Fellowships    | $12.2 |
|                                                               | Manpower Development                               | $13.8 |

10 Source: ICRs; all sixty-three ICRs on HNP projects, 1974-2002, were reviewed. Sixty-two ICRs reported a health workforce activity.
# HEALTH WORKFORCE ACTIVITIES CARRIED OUT UNDER WORLD BANK-FINANCED HEALTH PROJECTS IN AFRICA, 1974 – 2002, BY COUNTRY AND PROJECT

<table>
<thead>
<tr>
<th>Country: Health Project –</th>
<th>Activities Executed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola: Health Project – 20338</td>
<td>Staff in the departments of planning and public health have been trained, but there has not been much continuity in the planning and public health departments because of periodic changes in staff. The dept of HR has developed a framework for personnel management in the sector. Ghost workers have been by and large been eliminated, records of medical personnel have been established. A training curriculum for MCH has been developed, including guidelines on FP and trainers have been trained. Constructed a school for health professionals in Lubango and equipped three other health facilities. However, few patients have come in for treatment, since the hospital is short on staff and basic supplies. Personnel were also trained for the National AIDS program.</td>
</tr>
<tr>
<td>Benin: Health Services Development Project – 17963-BEN</td>
<td>Strengthened the Human Resource Division and developed a staff redeployment plan. Developed computerized personnel files for the 3 project regions (but system not operating). Redeployed staff but unsuccessful because most of the personnel eventually left their posts. Some training provided for primary level staff and formal specialized technical training for staff in project zones (80% achieved). In-service training was provided in program planning, management, &amp; health services delivery.</td>
</tr>
<tr>
<td>Botswana: Family Health Project – 12014</td>
<td>Curricula for basic training of health personnel at all levels have been revised to incorporate appropriate lessons on FP. Appraisal targets for both in-country and overseas training were exceeded.</td>
</tr>
</tbody>
</table>

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11 The projects are listed by country, rather than chronologically; the information consists largely of synthesized extracts from information and staff judgments in ICRs, with editorial material added by the authors to facilitate comprehension out of context. Extracts from OED project evaluation reports are included where OED has undertaken a project evaluation, and identified as such.
**Burkina Faso: Population & AIDS Control Project – 23520**

- TF-20003, IDA-26190
- 3/13/2002
- 5/02/95-9/30/01

Trained community agents (2 per village) to be able to distribute contraceptives. Staff trained on STD screening and treatment. Project provided institutional training for the inter-ministerial population committee. Trained trainers through a pilot scheme of micro HIV/AIDS projects. Trained workers in blood screening.

**Burkina Faso: Health and Nutrition Project – 23519**

- IDA-25950
- 3/12/02
- 5/02/95-9/30/01

Provided training for all District Medical Officers and District Health Teams, with a particular focus on the management of health districts, essential surgical care, and clinical specialization. MOH has made in effort to strengthen staffing of health facilities – they have since seen staffing norms rise from 65 to 75 percent. Trained about 80 district officials and community health workers in micronutrient management. Funded the training of a pharmacist of the Directorate of Pharmaceutical Services.

**Burkina Faso: Health Services Development Project – 15204**

- 1607-BUR
- 12/27/95
- 1/16/86-12/31/94

Training of health workers in FP in six provinces that lacked FP services. Financed training programs for district doctors in emergency surgery & district management. Provided practical in-service training to health workers at the Health and Social Development Center (CSPS) and Medical Center. Financed unplanned long-term training for about 20 doctors in public health & surgery. Financed long- and short-term training for all staff of the Professional Training Directorate. The in-service training program was interrupted in 1990 to be replaced by a training program in health district management for district doctors, who under the new decentralized system of Burkina Faso will be responsible for training and supervising the staff operating in their districts.

**Burundi: Population and Health Project – 15538**

- 1862-BU
- 4/16/96
- 7/28/88-9/30/95

Developed a well-integrated in-service training program and fellowships awarded to strengthen the MOPH. All but two of the grantees work for the MOPH (one is still studying & the other works for the private sector).

**The OED Report Notes:**

Staffing shortages continue to be an issue at all levels of the Botswana health system, particularly doctors, specialists and nurses at the tertiary level and for nurses and midwives at the health center and PHC level. Project design appears to have undervalued questions of overall training capacity, since shortages of physicians as well as nurses continue to constrain sectoral performance. The OED report found that the Princess Marina Hospital has encountered difficulties recruiting sufficient numbers of specialized personnel to manage some of the new services being provided i.e. physiotherapy, and a shortage of 68 nursing staff.
<table>
<thead>
<tr>
<th>Country</th>
<th>Project Description</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameroon</td>
<td>Provided training on management of drugs at the district level for 164 people; helped prepare a census of health personnel, helped to elaborate national norms for allocating HR by level of district health infrastructures; published a training policy. Trained people in management of health districts and applied epidemiology, expanded program of immunization (EPI), impregnated mosquito nets, management of AIDS and lab technicians on HIV/STD/TB and malaria detection.</td>
<td>1/31/96-6/30/01</td>
</tr>
<tr>
<td>Chad</td>
<td>Held workshops for NGOs, opinion/traditional leaders, women and religious leaders, and journalists, on IEC. Trained medical personnel in STD management and HIV/AIDS clinical management. Guides were developed and have been distributed at the prefecture and district level for the training of medical personnel in both STD and HIV/AIDS management.</td>
<td>9/08/95-12/31/01</td>
</tr>
<tr>
<td>Chad</td>
<td>The Training Division produced 46 training modules rather than expected 20, covering different themes developed, tested, and used for in-service training. Constructed and equipped two training centers for paramedical personnel in the regions, which are fully operational. Long-term training was also provided for MOPH staff in anesthesia, pharmacology, community health, IEC, laboratory, and public health. A training bank was created and updated on a regular basis by the Training Division. The ICR notes that more needs to be done to improve the amount and composition of health manpower, the strengthening of the nurses training program has laid the foundation for a more enduring improvement in health manpower. Over 1000 district health personnel were trained throughout the country using the training modules developed by the project for skills upgrading. 165 personnel of the MOPH and the MOF at the national and regional levels were trained in budgetary processes and management. Staff of the Division for IEC received long-term training. The Division also trained 23 trainers at the central level, 95 health personnel and 40 social mobilizers on IEC aspects at operational level.</td>
<td>2/24/95-6/30/01</td>
</tr>
<tr>
<td>Chad</td>
<td>Training was provided to staff and health committees on management and operations of the cost recovery system. The project also helped to define policies, develop manuals, and train health professionals in the distribution and use of essential medicines.</td>
<td>4/14/91-4/30/98</td>
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<tr>
<td>Country</td>
<td>Project Description</td>
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<tr>
<td>Comoros</td>
<td>Conducted a study on the training provided at the National School of Public Health and awarded two fellowships. The ICR states that problems were encountered with the director of the NHS and that the activities planned ‘could have provided a foundation for better allocation and management of health personnel, one of the priority areas of the economic adjustment programs negotiated in 1991. It is unfortunate that a component so relevant to the analysis of priority problems in the sector and the deployment of remedial strategies and measures could not have been carried out under better conditions.’ Project also trained midwives, auxiliary midwives, and traditional birth attendants.</td>
<td></td>
</tr>
<tr>
<td>Comoros</td>
<td>Reorganized the MOH with more emphasis on the regional directorates and a redefinition of the role of central units. A total of about 500 poorly qualified staff were declared redundant. A program to lure back Comorian doctors living abroad was successfully implemented. A comprehensive program to train health staff was designed, but administrative and bureaucratic inefficiencies prevented about half of the planned training activities from proceeding. Health center staff were trained in FP issues.</td>
<td></td>
</tr>
<tr>
<td>Cote d’Ivoire</td>
<td>Improved nurse training and pedagogical capacity at the three nursing schools. Student housing units constructed and health centers rehabbed for practical training. Report prepared on auxiliary health personnel and new category of nursing aide was recognized. Staff training was provided in hospital management, prescription practices, and for hospital ward supervisors to improve performance and efficiency. A planned long-term manpower study was not executed.</td>
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<tr>
<td>Equatorial Guinea</td>
<td>Trained 50 nurses, 40 TBAs, and 18 hospital administrators. Two training courses for mid-level administrators were held in 1993 &amp; 1997 and one training course for pharmacy administrators in 1998. Records about training courses such as curricula, participant list, current status of participants are not complete and therefore total number of participants is unknown. Two auxiliary nursing courses took place, which trained additional 97 nurses.</td>
<td></td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Training in MCH/FP program management conducted with UNFPA support; training of trainers of FP conducted with SIDA support; in-service training conducted annually; regional training bureaus are being established by the Regional Health Bureaus. Rehabilitated and upgraded training schools for different types of paramedics. Basic and in-service training materials provided to schools; for the testing and evaluation unit, awaiting a Governmental proclamation for establishing a Health Professional Council for testing and certifying all categories of health professionals; and for the distance education unit, a survey was completed, and report submitted to Minister of Health.</td>
<td></td>
</tr>
<tr>
<td><strong>Gambia: National Health Development Project – 15738</strong></td>
<td>The project established an ‘at risk nurse’ management training program and a nurse anesthetics training program. Both programs were highly commended by the Western Africa College of Surgeons and WHO for their effective and appropriate response to the local situation. In-service training was provided to nurses in communicable disease prevention and treatment. Establishment of a nursing school with teaching equipment and materials, which lead to the development of a cadre of local nurse instructors and senior nursing staff, and promoted the integration of primary health care courses into the curricula of the Community Health Nurses training program. The project also created an in-service training unit within the MOH and training centers for all district health teams. The ICR states that ‘although training was provided to many medical and paramedical personnel, the limited success of this component is attributable to the lower level of education of candidates, which coupled with high requirements for admission into training programs, resulted in a reduced pool of potential participants and made it difficult for the project to reach its intended target in terms of number of trainees per category of health worker.’</td>
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<tr>
<td><strong>Ghana: Health and Education Rehabilitation Project (HERP) – 11080</strong></td>
<td>The project established an in-service training system. THE OED REPORT NOTES: Overseas training was completed for 34 MOH staff, mainly in aspects of planning, management, and administration, and in-country training for more than 1,500 MOH staff through courses, workshops, technical assistance, computers, office and didactic equipment, and textbooks.</td>
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<tr>
<td>Country</td>
<td>Project Description</td>
<td>Dates</td>
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</tr>
<tr>
<td>Ghana: Second Health and</td>
<td>Supported training of pharmacists and pharmacy techs and trained 3 staff in drug quality assurance at the University of Science and Technology. In-service training was completed for physicists, medical assistants, and pharmacists on safe prescription, as well as 500 health staff on the ‘cash and carry’ system for drug distribution. Provided funds to extend the training in district health team planning across the country, so that all 110 districts now produce annual plans and budgets. Trained and supplied 800 community-based distributors of contraceptives. The project also supported the MOH’s training in Safe Motherhood, training health staff in new approaches to antenatal, delivery, and post-natal care.</td>
<td>6/18/91-12/31/97</td>
</tr>
<tr>
<td>2193-GH 6/23/98</td>
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<td></td>
</tr>
<tr>
<td>6/18/91-12/31/97</td>
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<tr>
<td>Guinea: Health and Nutrition</td>
<td>Training was provided at all levels and involved all cadres of formal and informal staff. Scholarships were also provided for overseas training. 108 villages were involved in training, education, and surveillance of childhood malnutrition. Trained/provided support to the Division of Communicable Diseases in training and setting up of an effective national surveillance system. Developed a good computer based health staff and staffing pattern database for the whole country. HRD plan for 2001-2010 prepared.</td>
<td>12/21/94-3/31/02</td>
</tr>
<tr>
<td>Sector Project – 24243</td>
<td></td>
<td>10/3/02</td>
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<tr>
<td>IDA-25740 10/3/02</td>
<td></td>
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<tr>
<td>12/21/94-3/31/02</td>
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<tr>
<td>Guinea: Health Services</td>
<td>Produced &amp; implemented a staff re-deployment plan, a computerized HR database, &amp; a national continuing maintenance policy; strengthened staff skills in MCH/FP, IEC &amp; Nutrition; supported the development of management skills through local training, fellowships on PH, health services administration, &amp; disease management; comprehensive in-service training program for Middle Guinea health care staff. National continuing education policy produced, but neither the ICR mission nor MOH found continuing education component achieved expected results.</td>
<td>3/11/88-6/30/95</td>
</tr>
<tr>
<td>Development Project – 15766</td>
<td></td>
<td>6/17/1996</td>
</tr>
<tr>
<td>Guinea-Bissau: Population,</td>
<td>Establishment of an in-service training program for about 500 health worker in MCH, epidemiology, FP, nutrition, and drug prescription/utilization, health and nutrition education and other health care areas.</td>
<td>12/18/87-12/31/91</td>
</tr>
<tr>
<td>Health and Nutrition Project</td>
<td></td>
<td>11759</td>
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<tr>
<td>– 11759</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1800-GUB 3/31/1993 12/18/87-12/31/91</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guinea-Bissau: Social Sector</td>
<td>Comprehensive training of health workers was completed. For in-service training/refresher courses 1,112 personnel attended various courses. For in-service upgrading 207 nurses were trained and promoted to technical staff or state nurse. For in-service medical specialization, 39 attended. 165 health staff were trained in IEC and interpersonal communication training sessions. Project also excelled in providing better trained laboratory and radiology technicians and public health nurses. The ICR states that ‘although training was provided to many medical and paramedical personnel, the limited success of this component is attributable to the lower level of education of candidates, which coupled with high requirements for admission into training programs, resulted in a reduced pool of potential participants and made it difficult for the project to reach its intended target in terms of number of trainees per category of health worker’.</td>
<td>7/7/93-6/30/00</td>
</tr>
<tr>
<td>Project – 20516</td>
<td></td>
<td>4/16/01</td>
</tr>
<tr>
<td>IDA-24650 4/16/01 7/7/93-6/30/00</td>
<td></td>
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</tr>
<tr>
<td><strong>Kenya: Sexually Transmitted Infections Project – 22867</strong></td>
<td></td>
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<td>---------------------------------------------------------</td>
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<td></td>
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<tr>
<td>IDA-26860 9/30/01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8/7/1995-6/30/2001</td>
<td></td>
<td></td>
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<tr>
<td>Comments also include relevant notes from OED Report Number 25016 for Kenya: STI Project, dated 10/15/02</td>
<td></td>
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</tbody>
</table>

Trained health care workers in management of the STD by syndrome; sponsored students for graduate education; lab staff trained in HIV screening.

**NOTES FROM OED REPORT:**
Training covered STI treatment guidelines, patient counseling, provision of condoms, and partner tracing. There is no systematic data regarding the impact of training on treatment quality. The OED report also notes that ‘the project gave relatively little attention to training private providers, despite evidence that many clients prefer private care for STI treatment.’ A study in Nairobi (2001) also suggests that despite training, providers are not providing adequate counseling on behavior change or condom use.

<table>
<thead>
<tr>
<th><strong>Kenya: Third Population Project – 16514</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1904-KE 4/23/97</td>
</tr>
<tr>
<td>1/31/89-12/9/96</td>
</tr>
</tbody>
</table>

Training and study tours were financed through NCPD for a total of 29 people, including 19 NCPD staff. Total of 40 people, including 24 NCPD staff and nine NGO staff, received graduate school training from funds. Trainees who went to universities obtained degrees in communication, public health, and PhD’s in demography. Ten people from NCPD have become District Population Officers, and 3 are still at NCPD headquarters, but the remainder have left, retired, were discharged, or still studying (with funds from ‘Population IV’).
<table>
<thead>
<tr>
<th>Project</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Kenya: Fourth Population Project – 19210</strong></td>
<td>Financed overseas training for National Council for Population and Development staff. Attrition resulted in little capacity being gained. Project sponsored overseas training for 80% of the 48 NCPD staff trained under the project. Only 7 (15%) remained employed by NCPD. Another 6 (13%) were on extended study leave, despite the fact that most had already been sponsored for 3-4 years. Minimal retention of the staff by NCPD – mostly trained overseas at high cost – ‘means that there was little institutional building within the agency.’ Project also financed assessment of the staffing needs of the NCPD to be implemented into a manpower development plan.</td>
<td>NOTES FROM OED REPORT: OED report states that ‘non-transparent selection of trainees and poor utilization of trained staff resulted in only seven individuals trained still employed by NCPD at the conclusion of Population IV. The NCPD was supposed to develop a manpower development plan to help rationalize trainee expenditures, but the plan was not developed, and the Bank regularly issued ‘no objections’ for training based on limited justification.’</td>
</tr>
<tr>
<td><strong>Kenya: Health Rehabilitation Project – 18740</strong></td>
<td>Trained managers and technicians at Kenyatta National Hospital (KNH), which they have been able to retain; strengthened the Division of Planning and Development through local and international training for staff. The ICR notes ‘rapid turnover of staff and loss of experienced staff within the Central Bureau of Statistics resulted in declining capacity and created systemic problems.’ In house training was established at KNH Training Centers in the areas of management and clinical courses. KNH continues to develop annual training plans and set aside substantial annual training budget. Staff being trained under the credit will continue to serve as trainers within the hospital.</td>
<td>NOTES FROM OED REPORT: The OED reports that wages and benefits of KNH were also upgraded from civil service levels to those for parastatals. This translated into nearly a 50% wage increase for many cadres, which allowed the hospital to attract doctors from the university medical school and made nurse wages competitive with the private sector. These changes improved the retention and motivation of staff, but also had a significant budgetary impact.</td>
</tr>
<tr>
<td><strong>Kenya: Integrated Rural Health and Family Planning Project – 11079</strong></td>
<td>Family Planning Association of Kenya, Kenya Catholic Secretariat, Maendeleo Ya Wanawake Organization, National Christian Council of Kenya, Protestant Churches Medical Association (PCMA) and the Salvation Army were all identified to undertake an interagency information and education program on population and FP to improve health and FP in rural areas. Refresher courses were held for Family Health Field Educators (FHFE) and traditional birth attendants; organized seminars to train nurses, social workers etc on natural FP. PCMA trained members of the Central Advisory Committee and other trainers. The Dept. of Adult Education produced a training manual and trained trainers in FP. Other educational seminars were held for youth, teachers, nuns, and other adults. A workshop was held for 200 doctors by the Kenya Medical Association.</td>
<td></td>
</tr>
<tr>
<td>Country</td>
<td>Project Description</td>
<td>Details</td>
</tr>
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<tr>
<td><strong>Lesotho</strong>: Health and Population Project – 13055</td>
<td>Construction of a National Health Training Center (NHTC); however, the ICR says it remains constrained due to the shortage of full-time tutors. Relatively little of the training in FP was provided due to funding that became available from UNFPA. Three NHTC staff received graduate training abroad in public health, educational administration, and advanced nursing. Also, 41 full and part-time staff attended a month long course in curriculum development offered in country. A new organizational structure for the Ministry was developed, but the necessary analysis of staffing needs was never completed.</td>
<td>1585-LSO 5/16/1994 10/11/95-12/31/92</td>
</tr>
<tr>
<td><strong>Lesotho</strong>: Second Population, Health, &amp; Nutrition Project – 18507</td>
<td>Intensive training of public health nurses &amp; health assistants by the NHTC; training program to enhance the skills of hospital medical, technical, &amp; administrative staff; training workshops in contraceptive technology &amp; surgical contraception; trained community-based Planned Parenthood Association distributors. Trained &amp; equipped VHWs in 2-3 pilot areas; provided fellowships for masters-level training; established a manpower department in the MOHSW – including a computerized personnel info system; provided support to NHTC’s 5-yr development plan including funding for college infrastructure, long-term &amp; short-term training initiatives; established &amp; trained a new cadre of district health service admin. The ICR states that the new cadre of district health administrator proved to be very beneficial for district management.</td>
<td>2059-LSO 10/28/98 11/1/89-3/31/98</td>
</tr>
<tr>
<td><strong>Madagascar</strong>: Health Sector Improvement Project – 20304-MAG</td>
<td>Reviewed leprosy module &amp; trained district personnel through training of trainers – 38% of districts use continuing education modules; training center for public and community health opened in 1998, with Univ. of Bordeaux; national training policy &amp; master plan introduced, and continuing education of paramedical personnel executed with 11 modules formulated; updated all personnel files; continuous redeployment of staff introduced, based on objective criteria; MOH authorized district leader to re-deploy staff within district; MOH obtained exemption from recruitment freeze and was able to hire 79 medical specialists, 927 general practitioners, 416 paramedical personnel; project actions permitted conversion of 897 health facilities to be upgraded from</td>
<td>IDA-22510 6/12/00 4/30/92-12/31/99</td>
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leadership by a paramedical person to leadership by a doctor. Partner comments in the ICR state “personnel qualifications improved through multiple training, but in view of the decay of infrastructures and the lack of renewal of technical equipment, these investments have not had noticeable effects on the quality of care provided to the population.” The MOH did not implement a redeployment plan as such but started to correct the staffing discrepancies between urban/rural and central/periphery in a more progressive way.

**Malawi: Second Family Health Project – 13508**

Trained 77 medical assistants, MOH staff, and village health workers. Completed the Zomba School of Nursing and a Manpower Development Unit. Cost overruns precluded the building of regional in-service training centers, and the manpower analysis was affected by sketchy information on the number, type, physical location and function of the various health cadres employed by MOH. Training of health staff and providers in child spacing did NOT take place.

**OED REPORT NOTES:**
Achievements in FP include: TBAs now allowed to distribute pills under the new CBD program and services of trained personnel are available in all hospitals and more than half of government health centers at least one day per week. However, FP experts interviewed by the OED mission stated that there has been little follow-up in the form of orders, significant increases in staff or changes in incentives to encourage promotion of family planning by VHWs who are inherently conservative and unlikely to take any initiative on their own. The Report also provides information on a govt. funded medical school project. Students went to Europe or North America for medical training and the OED report shows the pros and cons for whether the Bank should have funded such a project given the low ratio of doctors per capita and the retention rate.

**Malawi: Population, Health, and Nutrition Project – 22328**

Trained health surveillance assistants (HAS) & nurse-teachers; training was provided in drug revolving funds. Trained health workers in malaria case management, STD syndromic management, and counseling. Trained lab techs and assistants in the serving of ELISA machines. Funded training of trainers in management of AIDS related illnesses & supervision of STD patients, HIV sentinel surveillance, and CBDS in child spacing and reproductive health. Provided basic management training to 140 community development agents (CDAs) & WID officers. Trained community health volunteers in nutrition. Trained hospital administrators and pharmacists.

**Mali: Health Development Project – 11502**

MOPHSA officials received training in planning and coordination, although this did not ensure strengthened planning and coordination, according to the ICR. Project did not achieve curriculum reform or institutionalization of a rural intern practicum. Trained approx. 1,622 health care workers. ICR notes village health workers, traditional birth attendants, doctors, nurses, auxiliary nurses, midwives, and matrons.
<table>
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<tr>
<th>Country</th>
<th>Project Title</th>
<th>Details</th>
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<tbody>
<tr>
<td>Mali</td>
<td>Second Health, Population, and Rural Water Supply Project – 19350</td>
<td>Trained approximately 6,000 staff. No other details provided. The ICR observes that project ‘introduced and established the concept of community health sector to complement govt. government health services where local committees manage the centers and medical and paramedical staff are no longer employed by the govt. but by the community.’</td>
</tr>
<tr>
<td>Mauritania</td>
<td>Health and Population Project – 19112</td>
<td>More than 500 staff of all health personnel categories were trained. Further the govt.’s decision to first train the trainers &amp; to develop a national capacity for post-graduate medical training (National Institute for Medical Specialties), staff from the National Hospital Center &amp; other specialized facilities were sent abroad to be trained in surgery, internal medicine, obstetrics, &amp; emergency pediatrics. Financed rehabilitation works at the National Institute of Medical Specialties and the National School of Public Health. Redeployment of personnel undertaken. Management information system set up. These activities made possible the training of regional clinical health personnel at a smaller cost. Other activities were conducted to train the regional health managers to work more independently from the center and, hereby, to foster decentralization.</td>
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<tr>
<td>Mozambique</td>
<td>Food Security Capacity Building Project – 19502</td>
<td>Neither the overseas training of govt. officials nor the formal training program was undertaken. However, the project did provide on-the-job training and informal short-term training for technical capacity building. Staff of the Department of Population and Social Development (DPSD) took a number of brief study trips abroad, including courses at Sussex University, IFPRI, and courses held by World Bank Economic Development Institute (EDI) in South Africa. Training modules were also developed for food security and poverty issues by consultants. A list of the training modules is set out in the ICR. Course materials prepared by EDI were also translated into Portuguese, which were used for training. The ICR notes that “key staff at National Directorate of Planning and Budgeting and the DPSD benefited substantially from the training and seminars undertaken…The benefits of on-the-job training and capacity building at DPSD would have been even greater if the unit had been staffed with more government officials than the 3 to 5 that staffed the unit…” For pre-service training, the University Eduardo Mondlane is now staffed with 10 faculty specialized in food security and poverty and has become of focal point nationally for pre-service training and research.</td>
</tr>
<tr>
<td>Mozambique</td>
<td>Health and Nutrition Project – 18103</td>
<td>The project strengthened HR planning and training in the health sector through the development and implementation of the National Health Manpower Development Plan, rehabilitation, and refurbishing of three training facilities, provision of training equipment, and learning materials for all training facilities, training of training institutions’ staff, long-term training of health workers, revision of job descriptions for health personnel, and provision of TA to strengthen curriculum development and training management.</td>
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<tr>
<td>Country: Niger</td>
<td>Description</td>
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<tr>
<td>Health Project – 15818</td>
<td>Support for long-term training courses (specialization), in-service training (seminars/workshops), and short-term internships. About 119 MOH professionals trained. Sponsored workshops and seminars for internships &amp; continuing education programs. Support in the form of equipment &amp; teaching materials were provided to training institutions. Trained staff in the maintenance of health facilities (technicians and a biomedical engineer).</td>
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<tr>
<td>1668-NIR</td>
<td>6/25/1996</td>
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<td>11/3/86-6/30/93</td>
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<tr>
<td>Population Project – 17762-NIG</td>
<td>Health management training of health administration personnel, development of training modules, training of doctors in ob/gyn &amp; minor surgery. Training of midwives, nurses, TBAs, and first aid workers. Training of auxiliary health workers/nurses/midwives to include promotion of family well-being. Trained health workers in planning, coordination, monitoring, and evaluation of nutrition programs.</td>
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<tr>
<td>2360-NIR</td>
<td>5/1/98</td>
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<td>12/1/92-12/31/97</td>
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<tr>
<td>Nigeria: Sokoto Health Project – 13730</td>
<td>Trained and retrained between 2,400 and 4,500 traditional birth attendants and institutionalized their role in health care delivery. Provided TBA certificates and ID cards. Purchased and distributed TBA training materials to all local government areas in Sokoto State. Trained around 300 community health extension workers, trained 36 Senior Health Tutors on clinical instruction, trained 620 local government authorities (LGAs) health personnel on drug revolving fund scheme, trained 60 senior community health extension workers on clinic management, provided overseas training for 15 senior health personnel, and about 148 LGA supervisors were trained. Established 235 village health committees (VHCs) and 29 Committees of Women in Health, which monitor health facilities and activities. Sponsored a series of workshops and seminars for Community Health Extension workers in MCH/FP and Women in Health Activities. Supported the School of Nurse Midwifery with library books.</td>
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<tr>
<td>2503-UNI</td>
<td>11/29/1994</td>
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<td>1/15/86-5/31/93</td>
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<tr>
<td>Nigeria: Imo Health and Population Project – 17251</td>
<td>The project developed a training manual for each local government authority based on the curriculum provided by the FMOH and integrated field visits into the training programs. Various training was conducted for trainers at LGA level. The trainers trained health workers in village health facilities. Due to the fact that LGAs were facing budget constraints, the project was not able to carry out as much training as required. Twenty-three state ministries of health and project coordinating unit staff benefited from overseas training. The project also conducted intensive training for 838 village health workers and traditional birth attendants. The State also provided various local training to different cadres (doctors, pharmacists, nurses, accountants, and policy makers) at the state level. The overall impact of the training provided is mixed due to a significant number of staff leaving the sector or not using trained skills.</td>
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<tr>
<td>3042-UNI</td>
<td>12/22/1997</td>
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<td>12/15/89-6/30/97</td>
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<tr>
<td>Nigeria: Essential Drugs Project – 17245</td>
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<tr>
<td>3125-UNI 12/19/1997</td>
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<tr>
<td>9/10/90-6/30/97</td>
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<td>Health workers in the public sector now prescribe and dispense almost exclusively in generic drugs (though the same is not true for the private sector). The curricula for health workers include the main elements of the essential drug policy. The ICR notes that it is not clear if prescribing patterns have improved, as supervision of health workers is generally lacking.</td>
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<tr>
<th>Nigeria: National Population Project – 19507</th>
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<tr>
<td>2238-UNI 6/29/1999</td>
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<tr>
<td>2/10/92-12/31/98</td>
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<tr>
<td>Health officers/clinical service providers from 14 states received training in FP logistics and management. A training manual for VHWs and TBAs was developed and field-tested, but the manual has not yet been printed for distribution. Partially established a training center in a northern university and the university of Ibadan for health education and PHC. Training of trainers for state and LGA health officers on FP for IEC activities. Study tours were undertaken and local and overseas training was conducted.</td>
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<tr>
<th>Nigeria: Health System Fund Project – 20713</th>
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<tr>
<td>2106-UNI 6/30/00</td>
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<tr>
<td>3/13/92-12/31/99</td>
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<td>Training was conducted at the community, state, and federal levels (1,203 trainees) and overseas (302 trainees). Priority at the state and community levels was given to training the staff of new or renovated facilities, and the staff of key state-wide services such as essential drug supply and the health management information system (HMIS). There was a good deal of sharing of ideas and approaches between states. One example was training the members of local theatrical groups to help get key health messages across to communities. Yet another trained health personnel in advocacy techniques to enable them to deal more effectively with local govt. The project strengthened the planning division of the MOH, improved state databases, and trained LGA and private healthcare providers in the collection and processing of key HMIS data. Federal inventory of health research and workers in the Universities, Medical Research Institute and Center of Excellence was completed. The ICR finds that, ‘despite the difficult climate of governance, including arbitrary dismissals and transfers of personnel, and the lack of any systematic state-level human resource planning, the Health System Fund annual work programs provided a useful framework for analyzing staffing needs and implementing training. By 1996, training plans became a standard feature of the annual work program.’</td>
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<th>Rwanda: Family Health Project – 13136</th>
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<td>1678-RW 6/13/1994</td>
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<tr>
<td>2/27/87-12/31/93</td>
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<td>Implemented a MCH/FP/Nutrition in-service training program, training of regional trainers for the MOHSA, and provided pre-service training and deployment of about 200 nurses aides to remedy the serious shortage of auxiliary staff in health centers and financed the construction of two new nursing schools with an estimated capacity of about 120 students.</td>
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<td>Country</td>
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<tr>
<td>Sao Tomé and Príncipe</td>
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<td>Senegal</td>
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Another 16 physicians were also trained in supervision and training of paramedical personnel. Five fellowships were awarded: three in health planning and two in statistics.

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<th>Country</th>
<th>Project Details</th>
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<tr>
<td><strong>Sierra Leone:</strong></td>
<td>Health and Population Project – 15924 1695-SL 7/29/1996</td>
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<td>Short-term training was provided to the Planning, Management, and Information, and Statistics Unit. Long-term overseas training for District Medical Officers. Upgrading of two training schools, the revision of training curricula to introduce a community health content, and the training of 90 MCH aides. In-service PHC training is being provided but a comprehensive training program has not been developed. ‘Although the PHC system has been strengthened, the services as such are hardly operational at this time.’</td>
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<td>9/19/86-12/31/95</td>
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<tr>
<td><strong>Tanzania:</strong></td>
<td>Health and Nutrition Project – 19964 20980 12/28/99 4/6/90-6/30/99</td>
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<td>Project training inputs were substantial in providing better management by district medical officers and planning in the MOH. In all, 30 persons received Masters degrees and no fewer than 66 persons also received short-term training. More of the project-trained government personnel are still in civil service. The project also supported the development of district health planning guidelines, which have become standard requirement for govt. financing of district health services. Project supported the development of an HMIS and trained all 114 district and 20 regional health management teams. The project also initiated the reform of the Dept for Manpower Development and Training through the creation of an Inspectorate Unit responsible for monitoring staff performance as well as the establishment of technical, administrative, and logistics units within each MOH division. Project also trained rural medical aides in the recognition of the clinical requirements for vitamin A and iron. Training was provided to district-level staff in community mobilization, IEC campaigns, and district health planning. Training was given to 5 District Medical Officers and 1 Regional Medical Officer.</td>
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<td>4/6/90-6/30/99</td>
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<td><strong>Togo:</strong></td>
<td>Health and Population Sector Adjustment Program12 – 16781 2211-TO 6/25/97</td>
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<td>More than 100 health posts equipped &amp; their personnel trained in FP techniques. Trained and deployed nearly 40 ‘motivators’ in FP throughout the country, plus 200 trained in specialized services. Teaching of FP was introduced in training programs at the National Midwives School &amp; at the school for medical assistants. Training provided to health workers to improve their handling of deliveries, referral for prenatal care, tetanus immunizations, handling at risk cases etc.</td>
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<td>3/31/92-6/30/96</td>
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<tr>
<td><strong>Uganda:</strong></td>
<td>First Health Project – 16259 1934-UG 1/28/97 1/11/89-3/31/96</td>
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<td>Training was provided to journalists and educators to enhance the quality of health messages in the newspapers, TV, and radio. Also trained hospital maintenance workers. The MOH planning unit was strengthened through technical assistance and training. Rehabilitated living quarters for health staff. Proposed a referral system for rationalization of staff distribution.</td>
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<td>1/11/89-3/31/96</td>
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12 While this project is labeled an adjustment operation, it contained many activities common to investment operations and is included in this list for that reason.
<table>
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<tr>
<th>Country</th>
<th>Program Description</th>
<th>Notes</th>
<th>OED Report Comments</th>
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<tbody>
<tr>
<td>Uganda</td>
<td>Project trained local workers in counseling, community health, and traditional birth attendants. Workers were equipped and deployed in the community to augment MOH programs, but the majority of workers were trained for the Masindi community based health development sub-component.</td>
<td>NOTES FROM OED REPORT: ‘At the beginning of the project, the project team identified ‘demoralized and underpaid staff’ as a risk to the project that was to be addressed by rehabilitating health facilities, improving the working environment and increasing community involvement (which was latter dropped). Yet no analysis was undertaken to examine what factors influenced staff morale. In retrospect, it is evident that morale and productivity remain low today, so whatever factors contribute to the problem must still be present.’ OED found that the sustainability of the project is therefore threatened. OED reported that interviews and district workshops revealed that motivation among some staff had been increased by the provision of a clean working environment, accommodations, and water. Among others, however, low salaries and failure to pay salaries – sometimes for as much as several years – had a highly negative impact on motivation that outweighed the other positive impacts, something the ICR did not address.’ The OED report states that some staff then engage in corruptive activities such as collecting supplementary ‘fees’ or selling pharmaceuticals privately etc. ‘Lack of training among lower-level health workers and job insecurity resulting from civil service reform are also a problem.’ OED cites evidence that rural health workers lack any formal training and that unemployment is high among newly certified doctors and other trained health care workers. In OED’s view, ‘the Bank could play an important role in negotiations with the MOF to lift the ban on hiring new, qualified staff at the lower levels in the health care system.’</td>
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<td>Zaire</td>
<td>Trainers trained in HR, held training sessions for health workers on different types of AIDS control activities</td>
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<td>Zimbabwe</td>
<td>Provided in-service training for provincial and district staff. Set up a training program for District Health Service Administrators (DHSA) and strengthened the Health Manpower Department in MOH. The Manpower Department carried out a number of studies (staff retention, training capacity, and needs, etc.) and developed a very good in-service training of trainers course and system for planning and monitoring training. MOH has created 29 DHSA posts for all those districts, which have a district hospital. This cadre is said to be very useful. A computerized personnel information system was developed, although hardware failures and inadequacies caused delays. Trained MCH/FP nurse tutors, nurses and</td>
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village community workers. 19,000 traditional midwives were upgraded through refresher courses, 120 nurses and midwives in surgical contraception methods, technicians in cytology, and equipped nurse/doctor teams in voluntary surgical contraception. Constructed 10 staff houses and 2 simple training center hostel blocks for midwifery training. The ICR notes that ‘in order to plan and carry out in-service training in a coordinated and effective manner, the provinces and districts themselves must plan and budget for the training on an annual basis.’ Scattered in-service training activities are not easy to monitor, document expenditures for. Training is only fully effective when trainers are able to follow-up and supervise trainees.

OED REPORT NOTES:
Strengthened health service management through the establishment of the DHSA training program. While in-service nurse and midwifery training activities were successful, the project design did not pay sufficient attention to building capacity for basic midwifery training. ‘Despite appropriate and persistent efforts by Bank supervision missions and MOH to persuade the Public Service Commission to establish special training positions, it has remained reluctant to sanction nurse-tutor posts in the districts, resulting in a high turnover among nurse tutors, and thus undermining the sustainability of this project component. OED noted that of the management related activities, only the DHSA program survives. ‘This is generally acknowledged to have made a significant contribution to management at the district level, freeing medical staff from administrative duties’. However, there has been high turnover. There was some progress with training of doctors and nurses in sterilization and providing equipment in the urban hospitals. However, high turnover among doctors meant that these skills were not accessible following the departure of newly trained staff. Similar problems affected the cytology component. Though additional technicians were trained, there was no IEC support, and the services were not well known to providers or the public.

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<tr>
<th>Zimbabwe: Second Family Health Project – 19522</th>
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<tr>
<td>Provided in-service FP training programs for government nurses. Provided training and refresher course for nursing staff. Trained health education officers and trained midwifery tutors. Planned expansion of training schools was not undertaken under the project as donor financing collapse. The govt. intends to fund activity. Constructed staff housing and training facilities in each project district. The ICR notes that staffing remains a problem, not only due to a lack of established posts, but also the consequence of unfilled existing posts, partially as a result of failing to boost the output of various cadres of basic health workers.’ Supervision missions claim that hospitals constructed under the project are either completely unstaffed or under staffed to manpower shortages. The manpower component was never fully implemented. Project objectives were hampered due to a confluence of events during project implementation period. The ICR notes that the faltering economy had eroded civil servants salaries and led to a large losses of public sector health staff, negatively impacting on the availability of health human resources, with over 50% of basic nursing graduates opting to work outside the public sector in 1997. The government also decided in 1993 to stop training and phase out State Certified Nurses (SCN’s), which reduced the output of new nurses</td>
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available to support the health sector and, in particular, reduced the pool of the basic nurse cadre which was the back-bone of the rural health delivery system. This situation has also caused the inability to staff district hospitals, the loss of ZNFPC staff, including trainers, the firing of striking staff and attrition of key headquarters staff. However, according to Borrower comments in the report, the ICR exaggerates the number of employees fired due to striking. And also the MOHCW did not make the decision to stop the training of SCNs, but that it was a political issue (ZINA) leading to a political directive to the Ministry to do so.’

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<tr>
<th>Zimbabwe: Sexually Transmitted Infections Prevention and Care Project – 22322</th>
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<tr>
<td>IDA-25160</td>
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<td>6/30/2001</td>
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<td>9/14/93-12/31/00</td>
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Comments included from OED Report No. 24432, dated 6/21/02

OED REPORT NOTES:
DFID trained providers in the syndromic approach to STI treatment to complement the drugs supplied by IDA in the project. A 1997 review of the DFID STI training component found that the training was contributing to improved treatment practices, but expressed concern about continued drug shortages.
HEALTH WORKFORCE ACTIVITIES UNDER WORLD BANK-FINANCED HNP OPERATIONS IN AFRICA: RESULTS FROM ICR QUESTIONNAIRE

Total Number of Projects: 63
Total Number of Projects with Health Workforce Activity under IDA credit: 61

PRELIMINARY QUESTIONS

1. Did the project undertake one or more health workforce activities\(^\text{13}\) described in the ICR?

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<tr>
<td>No</td>
<td>3% (2 projects)</td>
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<tr>
<td>Yes</td>
<td>97% (61 projects)</td>
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If the answer is yes, please assess the overall implementation and results of the health workforce activities:\(^\text{14}\)

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<tbody>
<tr>
<td>S - Implemented with satisfactory results</td>
<td>51% (31 projects)</td>
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<tr>
<td>PS - Implemented with partially satisfactory results</td>
<td>38% (23 projects)</td>
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<tr>
<td>U - Implemented with unsatisfactory results</td>
<td>8% (5 projects)</td>
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<tr>
<td>N - Planned but hardly or not implemented at all</td>
<td>3% (2 projects)</td>
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1a. If the answer to question 1 is yes, does the ICR indicate that health workers or their representatives (such as professional associations and/or statutory bodies) were:

No information is given in the ICR on the involvement of health workers or their representatives in the project. 95% (60 projects)

Actively engaged in project execution?

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<tr>
<td>No</td>
<td>0% (0 projects)</td>
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<tr>
<td>Yes</td>
<td>5% (3 projects)</td>
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Below is a description of the three projects denoted above that indicated in the ICR that health workers were actively engaged in project execution.

\(^\text{13}\) The questionnaire is to address all health workforce activities captured in the ICR. Naturally, health workforce activities will be more important if they are the subject of one or more of the principal components of the project and are reflected as such in the project objectives and M&E. This questionnaire endeavors to cover not only such principal components but also lesser subordinate activities, which may in sum have considerable importance even if they do not have the ‘status’ of a principal component of the project.

\(^\text{14}\) In some instances, the ICR rated or commented on the outcome of the health workforce activity in regard to the above criteria. In other cases where no rating was given, an informed judgement was made based on the material presented in the ICR. All judgements were made consistently by one person as to how well the activity was implemented and executed.
• Comoros Health and Population Project (report no. 11257) relied on a team of five well-trained, well-motivated midwives to promote and supervise FP activities. The ICR also states that ‘no effort was made to interest the health center physicians in the provision of family planning services.

• Kenya First Population Project (report no. 3536) had a ‘nurses organization’ that was involved with the training and supervision of community nurses. The initial plan called for the 46 registered public health nurses trained as Provincial and District Nurse Trainer/Supervisors to report to the head of the Clinical Services Division in the National Family Welfare Center. Due to lack of support from the Chief Nursing Officer, ‘reflecting the general political mood of the country, was not favorably disposed to give family planning activities a high priority in relation to general nursing duties, nor was she favorably disposed to the degree of power sharing suggested by the proposed organizational arrangements.’ Her opposition eventually resulted in the disappearance of Nurse Trainer/Supervisors as a separate cadre (they were merged with the District and Provincial Public Health Nurses). ‘The organizational strategy for family planning relied on strong vertical integration through the provincial and district medical offices and strong lateral coordination with the nursing organization and the Health Education Unit, with interministerial coordination provided by the committees. The ICR also states that the project ‘failed to supply linkages to external sources of support for family planning activities, i.e. the MOF&P and the NGOs. Its design relied heavily on the MOH where the commitment to family planning was not very strong.

• Mozambique Food Security Capacity Building Project (report no. 19502) had the Faculty of Agronomy of Eduardo Mondlane University (UEM) help in the coordination of the project. The coordination that took place between the Faculty of UEM and the Department of Population and Social Development was stated in the ICR as one of the most notable successes of the health workforce component. Students from the faculty were placed on short-term internship assignments in DPDS and the line ministries. The ICR states that ‘the close link not only helped to increase participation of Mozambican’s in policy research, but provided the government’s policy making units with a pool of young trained talent, particularly important in a public sector in which rapid turnover is the norm.’

The following questions did not produce any data from the ICRs.

Consulted but not actively engaged in project execution?
0. No  0% (0 projects)
1. Yes  0% (0 projects)

Otherwise consulted, according to the ICR?
0. No  0% (0 projects)
1. Yes  0% (0 projects)

2. If the project included system reform\textsuperscript{15}, does the ICR indicate that the project also addressed health workforce issues?

\textsuperscript{15} For the purposes of this questionnaire, health system (or sector) reform is understood to mean, following Berman (Berman, Peter and Thomas J. Bossert, \textit{A Decade of Health Sector Reform in Developing Countries: What Have We Learned?} pp. 1-16, Paper prepared for the USAID-DDM Symposium ‘Appraising a Decade of Health Sector Reform in Developing Countries’, Washington, D.C. March, 2000), major, purposeful change in one or more of the major components of the system – its organization, its financing, its ownership, and its law and regulation; expansion of existing organizational structures, as in the construction and equipping of clinics to provide services to additional clients, does not constitute reform.
0. No  60% (38 projects) included health system reform, but did not address health workforce issues.
1. Yes  29% (18 projects) included health system reform and also addressed health workforce issues in the documentation.
2. Project did not include system reform  11% (7 projects) did not include system reform, although the project may have otherwise addressed health workforce issues.

2a. If the answer to question 2 is yes, does the ICR indicate that health workers or their representatives (such as professional associations and/or statutory bodies) were:

No information is given in the ICR on the involvement of health workers or their representatives in the project.
100% (18 projects) In none of the 18 projects did the ICR provide any information as to the involvement of health workers or their representatives.

The following questions did not produce any data from the ICRs.

Actively engaged in project execution?
0. No  0% (0 projects)
1. Yes  0% (0 projects)

Consulted but not actively engaged in project execution?
0. No  0% (0 projects)
1. Yes  0% (0 projects)

Otherwise consulted, according to the ICR?
0. No  0% (0 projects)
1. Yes  0% (0 projects)

3. If no specific health workforce activity was executed under question 1 does the ICR otherwise address health workforce issues?

0. No  0% (0 projects)
1. Yes  3% (2 projects)
2. Not Applicable, because there was a specific HWA under question 1  97% (61 projects)

Below is a description of the two projects denoted above that were considered to otherwise addressed health workforce issues in the ICR.

- In the Somalia: Special Emergency Assistance Grant (report no. 14299), UNICEF was to provide training to health care workers, but there is no data in the ICR as to whether the training was completed or not.

- In the Zimbabwe Sexually Transmitted Infections Prevention and Care Project (report no. 22322) DfID sponsored a parallel health workforce activity.

HEALTH WORKFORCE ACTIVITY QUESTIONS

4. If a health workforce activity was executed, list the project objectives as stated in the ICR specifically related to health workforce issues:

Not developed further due to lack of measurable and illustrative data collected from the question.
4a. Describe the activities executed:

See separate Annex.

5. Summarize health workforce activity costs, and state them as a percentage of total costs of the project as executed.

See Annex 1.

6. Does the ICR indicate that the following was undertaken in connection with project pre-appraisal and/or sector studies that preceded project preparation, or whether such studies were part of the health workforce activity executed under the project (check all that apply):

   A. Health labor force planning and projections limited to public sector personnel
      5% (3 projects)
   B. Health labor force planning and projections for public and private sector personnel
      2% (1 project)
   C. Health labor force planning and projections without indicating whether it covered only public
      or public and private sector personnel 21% (13 projects)
   D. Training needs assessment 21% (13 projects)
   ND. No data 54% (34 projects)

7. Were the following trained, according to the ICR?

   • Doctors
     Pre-service:
     In service:
   • Nurses
     Pre-service:
     In-service:
   • Midwives
     Pre-service:
     In-service:
   • Trainers, under a system for training of trainers (TOR)
     Pre-service:
     In-service:
   • Other health workers [specify type(s)]
     Pre-service:
     In-service:

Due to the material provided in the ICRs, one is not able to tabulate the data in the above-delineated cadres with any accuracy. It simply proved unfeasible. The ICRs rarely denoted whether the training was pre- or in-service and usually stated training numbers in terms of topics trained in, not specific cadres trained, i.e. the ICR would only record that 100 people were trained in MCH/FP.

8. If the project as executed contained a health workforce activity, according to the ICR, did it include:

   [Note: the following percentages are out of a total of 61 projects or those that had a health workforce activity. Most projects executed more than one of the following.]
a. Curriculum planning or revision beyond curricula for personnel to be trained under the project? If so, for what type(s) of personnel? 18% (11 projects)

- Angola Health Project (report no. 20338) supported curriculum development for nurses and midwives who were being trained under the project.
- Botswana Family Health Project (report no. 12014) revised curricula for basic training of health personnel at all levels to incorporate appropriate lessons on family planning.
- Burkina Faso Health Services Development Project (report no. 15204) supported the Professional Training Directorate (DFP) who was in charge of planning and coordinating the in-service training to be carried out at the provincial level by a team of national trainers. The unit was responsible for preparing training modules on six subject matters for the training that was to be carried out under the project. Theses included organization and management of primary health care; expanded program of immunization; maternal and child health and family planning; detection and treatment of malnutrition; sanitation and the control of parasitic diseases; and prescription and use of essential drugs.
- Chad Health and Safe Motherhood Project (report no. 24345) revised curricula for the nursing school.
- Gambia National Health Development Project (report no. 15738) revised curriculum for State Enrolled Nurses and Community Health Nurses.
- Kenya Third Population Project (report no. 16514) provided support for the revision of curriculum for clinical officers to include family planning – as an effort to expand FP activities under the project.
- Mozambique Food Security Capacity Building Project (report no. 19502) revised curricula at the Eduardo Mondlane University to include issues of food security and the teaching format was updated for training to be provided under the project. The faculty also developed a masters program in food security.
- Senegal Human Resources Development Project I (report no. 17097) reformed the curriculum for reproductive health for all health schools accompanied by the development of better teaching materials (for persons to be trained under the project).
- Sierra Leone Health and Population Project (report no. 15924) introduced community health content into training curricula for personnel to be trained under the project objectives.
- Zimbabwe Family Health Project (report no. 13784) redesigned basic curriculum for state registered nurses to include FP and in-service midwifery training for nurses to be trained under the project.
- Zimbabwe Second Family Health Project (report no. 19522) supported curriculum review for midwifery and basic curriculum as well. [COMPONENT WAS AN EXTENSION FROM FIRST HEALTH PROJECT]

b. Evaluation and/or accreditation of health training institutions? 7% (4 projects)

- Comoros Health and Population Project (report no. 11257) contained an evaluation study on the training provided at the National School of Public Health.
- Cote d’Ivoire Health and Demographic Project (report no. 15032) evaluated the two new nursing schools built as part of the project.
- Gambia National Health Development Project (report no. 15738) completed an assessment of the training program for nurses. The assessment report recommended a restructuring of the curriculum of all nurse training schools (State Registered Nurse/State Certified Nurse, State Enrolled Nurse, and Community Health Nurse) and the merging of the State Enrolled Nurse Program and Community Health Nurses into a graduate school for health service workers. [UNSURE WHETHER THIS FITS INTO THE CATEGORY]
- For Kenya Health and Rehabilitation Project (report no. 18740), the ICR states that the status of Eldoret Referral and Teaching Hospital and the Kenya Medical Training College have changed into parastatal or semiautonomous institutions. However, the ICR is unclear how the teaching hospital become autonomous and for what reasons. It only states that it now generates a
substantial percent of its recurrent expenditures from cost sharing, and at the same time has managed to improve the quality of care.

c. Introduction and/or expansion of widespread, structured and usually national continuing education for health workforce cadres? 3% (2 projects)

- Guinea Health Services Development Project (report no. 15766) developed a MOH policy for continuing education and development of human resources in health.
- Rwanda Family Health Project (report no. 13136) developed curricula for MCH/FP training for nurses and health workers.

d. Ad hoc, specialized in-service training for specific categories of health cadres, such as training of nurses in new contraceptives, or training of existing cadres of health workers in new immunizations who have not previously provided such services? 10% (6 projects)

- Ghana Second Health and Population Project (report no. 18050) trained health staff of Planned Parenthood of Ghana in new approaches to antenatal, delivery, and postnatal care.
- Guinea-Bissau Social Sector Project (report no. 20516) provided training to Guinean doctors with at least two years experience to undergo specialized training in pediatrics, obstetrics, general surgery, and public health.
- Kenya Fourth Population Project (report no. 19210) introduced surgical contraceptive services into the private sector.
- Lesotho Second Population, Health, and Nutrition Project (report no. 18507) held training workshops in contraceptive technology and surgical contraception.
- Zaire National AIDS Control Program Assistance Project (report no. 14743) provided specialized in-service training on types of AIDS control activities.
- Zimbabwe Family Health Project (report no. 13784) provided training in surgical contraception methods for nurses and doctors.

e. Policy or institutional changes associated with the health workforce, such as introduction of a new cadre? 8% (5 projects)

- Cote d’Ivoire Health and Demographic Project (report no. 15032) integrated auxiliary health personnel into civil service function.
- Kenya First Population Project (report no. 3536) attempted to establish nurses trainers/supervisors as a new cadre, but due to lack of support they were merged with another category of nurses. The project also supported the introduction and training for a new class of field worker – the family health field educator and their supervisors.
- Lesotho Second Population, Health, and Nutrition Project (report no. 18507) introduced a new cadre of district health service administrators. The ICR states that the new cadre had proved to be very beneficial for district management.
- Rwanda Family Health Project (report no. 13136) attempted to influence policy toward nurses’ aides. A Ministry of Health and Social Affairs Directive stated that these personnel should be recognized as specialized workers and provided with the same the benefits as ‘aides-infirmiers,’ thus creating budgetary positions for this cadre.
- Zimbabwe Family Health Project (report no. 13784) introduced a new cadre called District Health Service Administrators to supervise district hospitals.

f. Support to health professional associations and/or councils or regulatory bodies? 3% (2 projects)

- Gambia National Health Development Project (report no. 15738) supported the development of the Nurses and Midwives Council, which regulates nursing practice.
- Zimbabwe Second Family Health Project (report no. 19522) provided support to the Nursing Directorate.
g. Construction and/or equipping of physical facilities for training of health workforce personnel?
39% (24 projects)

- Angola Health Project (report no. 20338) construction of a school for health professionals (capacity 100 students)
- Burkina Faso Health and Nutrition Project (report no. 23519) built 60 accommodations for medical personnel at the health and social development center to improve working conditions and provide incentives to work in rural areas.
- Cameroon Health, Fertility, and Nutrition Project (report no. 23154) equipped training facilities project district.
- Chad Health and Safe Motherhood Project (report no. 24345) constructed and equipped two training centers in the project regions. Graduates must work in their region of origin for at least two years, thereby providing health personnel at the periphery.
- Cote d’Ivoire Health and Demographic Project (report no. 15032) built two new nursing schools and another renovated. Project also constructed roughly fifty student houses.
- Equatorial Guinea Health Improvement Project (report no. 19955) extended the national school of health for the purpose of increasing training capacity. But according to the ICR, the extension has not been used or equipped since it was constructed.
- Ethiopia Family Health Project (report no. 17928) upgraded and renovated two nursing schools, two health assistants’ training schools, one sanitary school, and another school for laboratory technicians.
- Gambia National Health Development Project (report no. 15738) created training centers for all district health teams.
- Guinea-Bissau Social Sector Project (report no. 20516) constructed and rehabilitated 31 housing units for nurses; supplied books, journals, and technical reviews to the National Medical School; and provided medical and other equipment required to train doctors and other health professionals to the Simon Mendes Hospital.
- Kenya First Population Project (report no. 3536) constructed five community nurse training schools and a National Family Welfare (NFWC) building was constructed and equipped.
- Lesotho Health and Population Project (report no. 13055) constructed a National Health Training Center.
- Malawi Health Project (report no. 9258) constructed three training centers.
- Malawi Second Family Health Project (report no. 13508) constructed the Zomba School of Nursing and staff housing facilities for rural health facilities.
- Malawi Population, Health, and Nutrition Project (report no. 22328) constructed training hostels for the Kamuzu College of Nursing, the Lilongwe School of Health Services and Central Hospital, the Zomba School of Nursing, the Queen Elizabeth Central Hospital, and the Mzuzu Central Hospital. The Project also rehabilitated and extended the Magomero Development Training College.
- Mauritania Health and Population Project (report no. 19112) rehabilitated the National Institute for Medical Specialties and the National School of Public Health.
- Niger Health Project (report no. 15818) constructed 20 medical staff houses. Equipment and teaching materials were provided to training institutions in Niamey and Zinder. Classrooms in Zinder were also rehabilitated.
- Niger Population Project (report no. 17762) constructed housing for health personnel.
- Nigeria National Population Project (report no. 19507) partially established a training center in a Northern university and the University of Ibadan for health education and PHC.
- Nigeria Health System Fund Project (report no. 20713) renovated or extended and upgraded eight training schools.
- Rwanda Family Health Project (report no. 13136) constructed and equipped two nursing schools.
- Sierra Leone Health and Population Project (report no. 15924) renovated the National School of Nursing and the Bo Paramedical School.
- Tanzania Health and Nutrition Project (report no. 19964) supported the Continuing Education Division for the upgrading of five training schools equipped and supplied textbooks. However, the ICR notes that the training schools lack qualified staff.
- Zimbabwe Family Health Project (report no. 13784) built ten staff houses and two simple training center hostel blocks for midwifery training. The OED report states that the provision of accommodation was a major incentive to staff, encouraging both relocation and lower turnover.
- Zimbabwe Second Family Health Project (report no. 19522) constructed staff housing and training facilities in each project district.

**h. Incentives or other measures to promote deployment of personnel to under-served areas, or to encourage them to remain within the country/service? 16% (10 projects)**

- Benin Health Services Development Project (report no. 17963) constructed housing facilities for health personnel as a means of attracting and keeping them in undeserved areas.
- Burkina Faso Health and Nutrition Project (report no. 23519) adopted improved motivation of district health teams by having flexible and decentralized procedures (management agreements) for channeling funds, which improved ownership and accountability at all levels, according to the ICR. The project introduced performance based, contractual approach of financing district health activities. By assuring a source of funding and liquidity to use the funds efficiently, it ‘served as a major source of motivation for district health teams,’ as well as improving ownership and accountability (p.16).
- Gambia National Health Development Project (report no. 15738) constructed about 32 staff housing units, which the ICR states has helped to partially alleviate the perennial problems the MOH has faced in redeployment of health personnel to remote and under-served areas.
- Ghana Second Health and Population Project (report no. 18050) provided staff housing for district health management teams.
- Guinea-Bissau Social Sector Project (report no. 20516) improved access to water and electricity to health facilities to promote deployment and improved working condition for health personnel. The ICR notes that ‘these physical outputs have brought considerable improvement to the quality of health services and created better working conditions that have helped to retain staff in rural areas.’
- Kenya Third Population Project (report no. 16514) in line with support infrastructure equipped district offices and a portion of the sub component (implemented by UNFPA) was to support the corresponding staff salaries, supplies, and fund seminars and training.
- Mauritania Health and Population Project (report no. 19112) enforced regulations for personnel posting and that incentives are being provided from the benefits of cost recovery.
- Nigeria Imo Health and Population Project (report no. 17251) constructed staff housing. The ICR states though that nurses and midwives now live on the premises of the health centers, and that this has increased the number of live-in health care providers and increased the number of patients encouraging utilization of these facilities.
- For Tanzania Health and Nutrition Project (report no. 19964), the ICR notes that ‘although staff salaries have remained the same, staff morale was improved due to better workplace conditions through the rehabilitation of facilities.’
- Uganda First Health Project (report no. 16259) rehabilitated staff houses and health facilities to which the ICR notes improved staff moral and motivation. However, the OED report noted that retaining staff in the Ministry’s Health Planning Unit was difficult as their standard civil service salaries were not competitive enough to keep them from finding other better paying jobs.

**i. Other changes in the working conditions, career structure, criteria for promotion, etc? 0% (0 projects)**

**j. An assessment of the impact of HIV on the health workforce? If so, describe, and state actions being taken to address the problem. 3% (2 projects)**
• Kenya Sexually Transmitted Infections Project (report no. 22867) recorded occupational safety measures provided for health workers through distribution of gloves and antiseptics.
• Kenya Third Population Project (report no. 16514) provided funds for protective non-pharmaceuticals that were necessary for protecting MOH staff (request made by the government).

**k. Other types of institutional development activity? 10% (6 projects)**

• Angola Health Project (report no. 20338) project significantly strengthened the Department of Human Resources.
• Chad Health and Safe Motherhood Project (report no. 24345) developed personnel norms for health facilities and new budgetary nomenclature was put in place for the MOPH. The project also introduced ‘decentralized training,’ also referred to *FID* in the ICR.
• In Comoros Population and Human Resources Project (report no. 21320) as part of project-supported health reforms, management boards were created in public hospitals with representatives of health care personnel included.
• Gambia National Health Development Project (report no. 15738) granted semi-autonomous status to the government hospitals, which has not only enabled them to improve their daily management, but to also have access to private funding. The ICR states that ‘clinical staff were offered remuneration packages to reduce attrition.’ This autonomy has allowed hospitals to offer incentives outside the civil service structure, leading to improved recruitment and retention of staff.
• Nigeria Sokoto Health Project (report no. 13730) provided support to the State Women Commission and established committees of Women in Health in twenty-nine local government areas.
• Tanzania Health and Nutrition Project (report no. 19964) created an Inspectorate Unit as part of the Department for Manpower Development and Training to monitor staff performance and implemented modest cost sharing in the training programs.

Percent (and number) of ICRs without data in ICR regarding the above categories 33% (20 projects)

**COVENANTS OR OTHER LEGAL COMMITMENTS REGARDING HEALTH WORKFORCE ISSUES**

9. Does the ICR state any legal commitments by the borrower to the Bank on health workforce issues? If so, describe each such commitment, and state whether it was respected.

   Out of the 61 projects with a health workforce component, 54% or 33 projects, contained legal covenants pertaining to health workforce activities. The remaining 30 projects contained no data.

   See separate Annex.

**CONCEPTUALIZATION OF HEALTH WORKFORCE ISSUES, EXPLICIT OR IMPLICIT**

10. If the ICR offers an overall characterization of health workforce ‘issues’ or ‘problems’ in the country, please state it here.

   It proved not feasible to synthesize information under this heading.

11. Does the ICR conceive of health workforce issues:
a. In country-wide or macroeconomic context\textsuperscript{16}: 

\begin{itemize}
  \item 0. No 72\% (44 projects)
  \item 1. Yes 28\% (17 projects)
\end{itemize}

b. If the answer to 11a is yes, is the countrywide or macroeconomic context taken as a given, OR were activities to influence it executed under the project?  
[Note: all percentages are out of the number of projects that replied yes to question 11a] 

\begin{itemize}
  \item 0. No, taken as given 41\% (7 projects)
  \item 1. Yes, activities to influence executed 59\% (10 projects)
\end{itemize}


12. Do the ICR conceive of health workforce issues: 

a. In their overall sectoral context\textsuperscript{17}: 

\begin{itemize}
  \item 0. No 67\% (41 projects)
  \item 1. Yes 33\% (20 projects)
\end{itemize}

b. If the answer to 12a is yes, were activities to influence the overall sector-wide context undertaken under the project\textsuperscript{18}?  
[Note: all percentages are out of the number of projects that replied yes to question 12a] 

\begin{itemize}
  \item 0. No 25\% (5 projects)
  \item 1. Yes 75\% (15 projects)
\end{itemize}

Projects listed: Angola Health Project (report no. 20338), Cameroon Health, Fertility, and Nutrition Project (report no. 23154), Chad Health and Safe Motherhood Project (report no. 24345), Gambia National Health Development Project (report no. 15738), Ghana Second Health and Population Project (report no. 18050), Guinea Health and Nutrition Sector Project (report no. 24243), Guinea Health Services Development Project (report no. 15766), Lesotho Second Population, Health, and Nutrition Project (report no. 18507), Madagascar Health Sector Improvement Project (report no. 20304), Mauritania Health and Population Project (report no. 19112), Mozambique Food Security Capacity Building Project (report no. 19502), Mozambique Health and Nutrition Project (report no. 18103), Nigeria Health System Fund Project (report no. 20713), Tanzania Health and Nutrition Project (report no. 19964), and Togo Health and Population Sector Adjustment Program (report no. 16781).

13. Does the ICR conceive of health workforce issues: 

a. As a standard issue in the development and expansion of health facilities and services in the country\textsuperscript{19}: 

\_____________
\textsuperscript{16} This question merits a ‘yes’ answer if (a) the ICR presents the country-wide political environment with its impact on the health workforce; OR (b) the ICR links health workforce issues and policies to macroeconomic variables, such as civil service conditions, overall budget levels and allocations, or the fiscal feasibility of implementing major change; OR (c) otherwise treats health workforce issues as an inter-sectoral problem.

\textsuperscript{17} This question merits a ‘yes’ answer if the ICR presents a sector-wide policy or operational environment with its impact on the health workforce, as distinct from the project-specific context.

\textsuperscript{18} Examples might be manpower planning for the total health workforce, or annual consultations with the Bank on the MOH budget.
0. No 51% (31 projects)
1. Yes 49% (30 projects)

14. Does the ICR use any other overall conceptual framework for health workforce issues, whether implicit or explicit?

0. No 93% (57 projects)
1. Yes 7% (4 projects)

The four projects that used an alternate conceptual framework for health workforce issues are listed below:

- Guinea-Bissau Social Sector Project (report no. 20516) included three levels of personnel training (in-service training refresher programs, local training upgrading, and short-term training for medical specialization) within the project design to improve all cadres’ skills and foster career development.
- Kenya Health Rehabilitation Project (report no. 18740) attempted to improve the delivery of health services through investments in training managers and technicians at both the national hospital and area services.
- Lesotho Health and Population Project (report no. 18057) emphasized achieving inter-ministerial and inter-agency cooperation. The project specifically tried to confront issues surrounding redeployment of human resources to rural areas, training at a multidisciplinary level, and in a number of different areas.
- Nigeria Imo Health and Population Project (report no. 17251) conceived of the project by means of a ‘Minimum Basic Health Package.’ The Minimum Basic Health Care Package approach was to involve local communities in defining and implementing a package of primary health care services that meets the minimum requirement of the community. The package was combined with intensive training of the village health workers and traditional birth attendants to ensure understanding and implementation of the package.

XIV. MANAGEMENT OF HEALTH WORKFORCE ACTIVITIES

15. How were the health workforce activities implemented? (Check all that apply)

Through an HRD Unit in Ministry of Health?
10% (6 projects)

Through an autonomous health training institution or institutions under the Ministry of Health?
16% (10 projects)

Through the Ministry of Education or a subordinate body of it?
0% (0 projects)

Through a Parastatal?
11% (7 projects)

Directly, by a Project Management or Project Coordinating Unit?
26% (16 projects)

Other (i.e NGOs)?
11% (7 projects)

Not specified in ICR
30% (18 projects)

16. How many different government ministries or agencies were involved in the implementation and monitoring of the health workforce activities?

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19 This might, for example, imply a ‘check-list’ approach to health workforce issues, meaning that in the implicit or explicit view of the ICR, health workforce issues should be considered as a matter of a standard routine set of issues to be addressed.
Projects specified:

1. One 23% (14 projects)
2. Two 21% (13 projects)
3. Three 18% (11 projects)
4. Four 7% (4 projects)
5. Four or more 7% (4 projects)

Projects specified:
- Angola Health Project (report no. 20338),
- Gambia National Health Development Project (report no. 15738),
- Mozambique Health and Population Project (report no. 19502),
- Zaire National AIDS Control Program Assistance (report no. 14743).

6. Not specified in ICR 24% (15 projects)

17. Does the ICR indicate that professional associations or other health workforce groups were involved in management and monitoring of the health workforce activities? If so, how?

- Yes 7% (4 projects)
- No 93% (57 projects)

Below are the four projects noted above:
- Comoros Health and Population Project (report no. 11257) FP program was monitored by a group of midwives.
- Gambia National Health Development Project (report no. 15738) had representatives from the Gambia Family Planning Association and Medical Research Council were members of the Project Implementation Committee.
- Kenya Integrated Rural Health and Family Planning Project (report no. 11079) noted in the ICR that the Kenya Medical Association organized a workshop for 200 doctors and also embarked on the FP motivation project for private medical practitioners in FP.
- Kenya First Population Project (report no. 3536) had a ‘nurses’ organization that was closely integrated with the training and supervision of community nurses.

18. If a health workforce activity was executed, according to the ICR, how much technical support was provided by World Bank supervision of the health workforce component of the project?

- A. Fully supported by technical supervision 5% (3 projects)
- B. Some input from staff or Bank consultants who have health workforce expertise 20% (12 projects)
- C. No input from staff or Bank consultants with specialized expertise in health workforce issues 46% (28 projects)
- D. No data in ICR 29% (18 projects)

Listed below are the projects that were fully supported by technical supervision and any information given in the ICR related to this question. For a project to be ‘fully supported’ by technical supervision, a training or manpower specialist needed to be present throughout the project cycle as documented in the ICR during the various supervision missions.
- Chad Health and Safe Motherhood Project (report no. 24345) was fully supported by training and paramedical training specialists according to the ICR.
- Guinea-Bissau Social Sector Project (report no. 20516)
- Zimbabwe Second Family Health Project (report no. 19522)
## COVENANTS ON HEALTH WORKFORCE ISSUES IN ICRs FOR WORLD BANK-FINANCED HNP PROJECTS IN AFRICA

<table>
<thead>
<tr>
<th>Country</th>
<th>Project – Report Number</th>
<th>L/C Number</th>
<th>ICR Date</th>
<th>Period of Effectiveness</th>
<th>Covenants and whether they were respected</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benin:</strong> Health Services Development Project – 17963-BEN</td>
<td></td>
<td>2031-BEN</td>
<td>5/28/98</td>
<td>1/10/90-9/30/97</td>
<td>'Prepare a plan, acceptable to the Association for the restructuring of the Ministry of Social Planning’s central &amp; provincial units, and redeployment of part of the Ministry’s staff to health service delivery in the field.' – Complied. ’Prior to awarding the contracts for such works, reassign health staff to facilities to be extended or rehabilitated.' – Redeployment took place, but some did not go to their assignment or asked &amp; obtained another assignment. ’The borrower shall take all measures necessary to ensure that all staff, after receiving training financed under the project, remain in their new assignment for a period of not less than 3 years.' – Not complied with at the central level b/ of staff turnover. At the regional level, staff re-deployed after training did not remain in their assignment. DCA covenant not respected, calling for annual preparation of salary and non-salary operating budget. Covenant not widely known, nor understood in its intention to support operating costs of project and sector.</td>
</tr>
<tr>
<td><strong>Botswana:</strong> Family Health Project – 12014</td>
<td></td>
<td>2413-BT</td>
<td>6/18/1993</td>
<td>5/21/85-1/31/92</td>
<td>'Borrower to maintain, until completion of the project, the Manpower Development and Utilization Dept. and to employ a qualified and experienced training coordinator.' – The Dept has been retained as a unit of the MOH and the training coordinator was obtained through bilateral sources. ’The Borrower shall submit to and review with the Bank annual training plans.' – Complied.</td>
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<tr>
<td><strong>Burkina Faso:</strong> Health and Nutrition Project – 23519</td>
<td></td>
<td>IDA-25950</td>
<td>3/12/02</td>
<td>5/02/95-9/30/01</td>
<td>The ICR notes compliance with virtually all legal covenants except the completion of a hospital study that did not lead to ‘an agreement for a more rational deployment of staff within the health sector.’</td>
</tr>
<tr>
<td><strong>Burundi:</strong> Population and Health Project – 15538</td>
<td></td>
<td>1862-BU</td>
<td>4/16/96</td>
<td>7/28/88-9/30/95</td>
<td>'Borrower to recruit at least four additional nurses for each health center to be rehabilitated.' – Not all nurses recruited. Only two additional nurses per health center had been recruited by the end of 1992.</td>
</tr>
<tr>
<td><strong>Comoros:</strong> Health and Population Project – 11257</td>
<td></td>
<td>1408-COM</td>
<td>10/8/1992</td>
<td>2/10/1984-6/30/1991</td>
<td>'The Borrower shall ensure that the health facilities and pharmaceutical departments included in the project carry out their operations appropriately and have access to adequate financial and human resources.' – Not all the health facilities renovated or constructed under the project were operational because of the strike in the sector. There were no operating funds and the training of personnel was inadequate.</td>
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<td><strong>Cote d’Ivoire:</strong> Health and Demographic Project – 15032</td>
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<td>‘The borrower shall assign to each project area a qualified and experienced regional health management &amp; training coordinator satisfactory to the Bank.’ – Only fulfilled for in two areas,</td>
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<tr>
<td>Project Description</td>
<td>Details</td>
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<tr>
<td>Equatorial Guinea: Health Improvement Project – 19955</td>
<td>‘For all fellowships the borrower shall (a) submit to the Association for its review the functions and qualifications of the candidates and the proposed training program (b) take all necessary measures to ensure that all trained staff remain assigned to the job for which it was trained for a period of 3 years.’ – There was no foreign training program and the training category was only disbursed up to 41%, ‘The Borrower shall (a) submit proposals for staff nominations to the rural health centers (b) thereafter ensure that such centers are staffed at all times with qualified and experienced persons in adequate numbers.’ – Complied.</td>
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<tr>
<td>Ethiopia: Family Health Project – 17928</td>
<td>‘The Borrower shall train qualified personnel, in adequate numbers, in health management and health teacher training, nurse-midwifery and MCH nursing and for the institutions participating in the Project.’ – Complied with, done largely with donor financing</td>
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<tr>
<td>Ghana: Health and Education Rehabilitation Project (HERP) – 11080</td>
<td>‘Strengthening of MOH’s ability to manage and execute primary health care programs through the provision of fellowships for MOH staff in planning, management, and economics; and short-term overseas observation training for MOH staff.’ – Complied. ‘Supporting studies and planning through an analysis of health policies and studies on health manpower.’ – Complied.</td>
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<tr>
<td>Ghana: Second Health and Population Project – 18050</td>
<td>‘MOH shall prepare and furnish to the Association (a) staffing norms for health facilities, (b) a manpower master plan and (c) a master training program for health staff.’ – All complied with.</td>
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<td>Guinea: Health Services Development Project – 15766</td>
<td>‘Submit a redeployment program to IDA yearly.’ – Provided irregularly, part of a condition for new a project ‘Submit to IDA training program for next year.’ – No data as to whether the covenant was complied with ‘IDA to approve candidates for training abroad and MOH to ensure that trained staff remain assigned to area.’ – No data.</td>
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<tr>
<td>Guinea-Bissau: Population, Health and Nutrition Project – 11759</td>
<td>‘The Borrower shall review in detail with IDA for each year of the project the in-service training program.’ – Complied.</td>
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<td>Country</td>
<td>Project Details</td>
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<tr>
<td><strong>Kenya</strong></td>
<td><strong>Third Population Project – 16514</strong>&lt;br&gt;1904-KE 4/23/97&lt;br&gt;1/31/89-12/9/96&lt;br&gt;“National Council for Population and Development (NCPD) to have defined the roles of District Provincial Officers (DPOs) and proposed appropriate institutional arrangements and training programs for them.” – Complied with after delay. ILO/UNFPA consultants’ report of 1989 completed.</td>
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<td><strong>Kenya</strong></td>
<td><strong>Health Rehabilitation Project – 18740</strong>&lt;br&gt;2310-KE 12/23/98&lt;br&gt;7/7/1992-6/30/1998&lt;br&gt;“Kenyatta National Hospital (KNH) shall establish a manpower information system comprising of personnel records, personnel statistics, and personnel registry.” – Complied. “KNH shall review its training projections in a systematic manner by March 31 of each year to ensure that the training programs remain consistent with the overall objectives of the hospital.” – Complied with after delay.</td>
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<td><strong>Lesotho</strong></td>
<td><strong>Health and Population Project – 13055</strong>&lt;br&gt;1585-LSO 5/16/1994&lt;br&gt;10/11/95-12/31/92&lt;br&gt;“Revise curricula to include FP; and introduce such revised curricula during the 1986/97 academic year for basic and post-basic training of paramedical staff.” – Curriculum revised, but FP not yet adequately incorporated into either basic or post-basic training curricula. Being followed up under PHN II.</td>
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<td><strong>Malawi</strong></td>
<td><strong>Health Project – 9258</strong>&lt;br&gt;1351-MAI 12/28/1990&lt;br&gt;8/22/1983-12/31/1988&lt;br&gt;‘In order to improve the staffing of the health centers in its primary health care program, certain staffing levels at health centers, PHC training units and districts should be achieved’ – in compliance in health centers. Staffing posts for the 3 training units have not been created, and not staffed.</td>
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<td><strong>Malawi</strong></td>
<td><strong>Second Family Health Project – 13508</strong>&lt;br&gt;1768-MAI 9/8/1994&lt;br&gt;6/15/87-6/30/93&lt;br&gt;‘The borrower to ensure staffing of the new or upgraded rural health centers (RHCs) with at least one medical assistant and two enrolled nurses per facility.” – Nine RHCs have staff, but not the requisite one medical assistant and two enrolled nurses. (3 facilities have neither category of staff) ‘Appoint a training officer to coordinate in-service training programs in MOH.’ – Officer appointed and manpower development unit created. ‘Submit to IDA in service training program for the following fiscal year and annually thereafter.’ – Not implemented. ‘Appoint 6 clinical officers and 16 enrolled nurses to urban clinics after their completion.’ – Activity cancelled.</td>
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<td><strong>Mali</strong></td>
<td><strong>Health Development Project – 11502</strong>&lt;br&gt;1422-MLI 12/29/1992&lt;br&gt;5/17/84-9/30/91&lt;br&gt;‘GOM will establish and then maintain within MOH Family Planning Directorate a full-time statistician, health planner, training specialist, and evaluation specialist.’ – Complied.</td>
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<td><strong>Mali</strong></td>
<td><strong>Second Health, Population, and Rural Water Supply Project – 19350</strong>&lt;br&gt;2217-MLI 6/1/99&lt;br&gt;‘The Borrower shall submit to IDA studies on (a) efficiency of hospitals, including financial, organizational, and staffing aspects, (b) the labor market for graduates in health related field.’ – Completed.</td>
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<td>Country</td>
<td>Project Description</td>
<td>Status/Comment</td>
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<td>Mauritania</td>
<td>Health and Population Project – 19112</td>
<td>'The Borrower shall implement measures of recruitment, redeployment, &amp; training of MSAS personnel for the satisfaction of the needs of the health system for the period 1992-1996.' – Complied.</td>
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</table>
| Mozambique       | Food Security Capacity Building Project – 19502                                     | 'The Borrower shall staff the Poverty Alleviation Unit with at least 5 local technical and professional staff.' – Complied with after delay.  
'The Borrower shall cause Agricultural Training Center to complete 6 training modules by 7/30/94 and complete training by 12/31/94.' – Not complied with. |
| Mozambique       | Health and Nutrition Project – 18103                                               | 'The Borrower shall complete and furnish to IDA with MOH’s comments the MOH health manpower development plan, review said plan jointly with IDA, and promptly thereafter implement training programs as agreed.' The ICR states that the manpower development plan became the foundation of an extensive redefinition of health staff functions and training plans being implemented. |
| Niger            | Health Project – 15818                                                              | 'Submit an annual in-service training plan, including study tour & fellowship proposals provided for selected health care personnel under the project.' – Complied. |
| Niger            | Population Project – 17762-NIG                                                      | 'Adoption of the policy document defining the personnel recruitment and redeployment plan’ – 50% accomplished.  
'Adoption of the revised departmental in-service training modules for MHC/FP and nutrition.’ Includes a detailed in-service training plan for the 1st two years of project implementation. Also, implementation of a detailed training plan for health personnel – only the 1993-94 plan was prepared, 20%. |
| Rwanda           | Family Health Project – 13136                                                       | 'Borrower to employ an additional training specialist for MOHSA training division.’ – Complied with delay.  
'Borrower to submit to MOHSA a proposal for a career path for nurses aides.’ – Not complied with by due date. However, a MOHSA directive of March 1990 stated that these personnel should be recognized as specialized workers and provided with the same benefits as ‘aides-infirmiers.’ Moreover, budgetary positions were provided for nurses’ aides. |
| Senegal          | Rural Health Project – 12319                                                        | 'Preparation of a national in-service training program.’ – Conditions not met.  
'Operate the facilities included in the Project in accordance with appropriate administrative, health and training policies and practices.’ – Staff not trained at the time of opening health centers.  
'The Borrower shall maintain adequate staffing at all health centers.’ – The ICR states that the new health center in Goudiry has no physician, as well as other centers experiencing insufficient paramedical personnel. |
<p>| Sierra Leone     | Health and Population Project – 15924                                              | 'Borrower shall commence the training of health workers on drug storage, distribution and prescription.' – Complied with delay. |</p>
<table>
<thead>
<tr>
<th>Country</th>
<th>Project Type</th>
<th>Project ID</th>
<th>Start Date</th>
<th>End Date</th>
<th>Notes</th>
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<tbody>
<tr>
<td><strong>Tanzania:</strong></td>
<td>Health and Nutrition Project</td>
<td>19964</td>
<td>1/11/89</td>
<td>3/31/96</td>
<td>'Six vacant positions filled in MOH Planning Department: Public Health Specialist, Epidemiologist, Health Economist, Economist.' – Completed.</td>
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<td>20980</td>
<td>4/28/87</td>
<td>9/29/93</td>
<td>'Commence implementation of Health Manpower Plan.' – Part of the plan started implementation i.e. Introduction of cost sharing of medical training and streamlining of cadres.</td>
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<td>12/28/99</td>
<td>6/30/99</td>
<td></td>
<td>'Action plan for strengthening Dept of Manpower Development and Training; criteria for selecting candidates for external training; disbursement condition for overseas training,' – MOH has implemented an acceptable plan.</td>
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<td>4/6/90-6/30/99</td>
<td></td>
<td></td>
<td>'Adopt incentives package for Health Sector Staff.' – Revised incentives for health workers implemented through GOT circular in 1990 created many internal problems in the health sector, especially between medical and non-medical staff. A revised policy was put in place in 1993.</td>
</tr>
</tbody>
</table>

| **Uganda:**      | First Health Project          | 16259      | 1/11/89    | 3/31/96  | 'The borrower shall submit to IDA a review of existing manpower in the health sector, including an optimal staffing and implementation plan for the sector.' – Complied. |
|                  |                               | 1934-UG    | 1/28/1997  |          | 'To the extent practicable, transfer excess staff to understaffed categories of the sector and provide training as appropriate.' The ICR notes that 'action was taken as part of the civil service reform as well as through the govt.’s decentralization policy (1994-1995).' Manpower study was carried out in 1991, in addition to a National Health Personnel Study in 1993. |
|                  |                               | 1/1/1989-3/31/1996 |          |          | 'In order to improve the management and manpower standards of the facilities to be rehabilitated under the project, the Borrower shall a) during rehabilitation carry out a manpower analysis and management study of each facility, b) submit staffing plans, c) establish staffing standards, eliminate redundant positions & workers and finalize redeployment of staff by date of completion of physical works.' – Complied. |

| **Zimbabwe:**    | Family Health Project         | 13784      | 12/12/94   |          | 'The Borrower shall cause the Health Management Development Unit to begin a training program for District Health Services Administrators and establish the positions for them.' – Complied. |
|                  |                               | 2744-ZIM   | 4/28/87    | 9/29/93  | 'The Borrower shall take all necessary measures to ensure each health center in the project districts is staffed with at least 2 state certified nurses or state certified maternity nurses and one health assistant.' – Complied. |
HUMAN RESOURCES FOR HEALTH IN WORLD BANK OPERATIONS IN AFRICA

A. Edward Elmendorf, Kathryn LaRusso, Cesar Palacios, and Isabel Rocha Pimenta

American Public Health Association
December 2005
Outline

- Strategic Context
- HRH in Health, Nutrition and Population (HNP) Investment Operations
- HRH under Structural Adjustment Loans and Credits
- HRH in Poverty Reduction Strategy Papers and World Bank-IMF Joint Staff Assessments
- HRH in Development Policy Loans – Poverty Reduction Support Credits
- Conclusions
Changing Strategic Context

- Early attention in 1970s only in relation to population
- Global views: WDR93 and 1997 global HNP sector strategy
- WB HNP Strategy in Africa – From ‘Better Health in Africa’ to ‘Strategic Options’
- Joint Learning Initiative
- Africa Action Plan – HRH important but marginal
HRH in WB Operations in Africa Database: Types of Instrument and Years covered

- SAL's
- PRSP's
- PRSC's

HRH in WB Africa Operations, APHA December 2005
HRH in WB Operations in Africa Database: Number of Countries and Financial Commitments by Instrument

Number of Countries with WB Support, by Instrument

- HNP: 34
- SAL: 32
- PRSP: 19
- PRSC: 10

Financial Commitments in Billions of Dollars, by Instrument

- HNP: 1.8
- SAL: 5.28
- PRSC: 1.7

HRH in WB Africa Operations,
APHA December 2005
HRH in Health, Nutrition and Population (HNP) Investment Operations

- Data set
- Results
- Examples
- Conclusions on HRH under investment operations

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Results for HNP Operations:
Training dominates HNP Investment

Health Workforce Agenda

Breakdown of Cost Data by Health Workforce Activity

- Training: 60%
- Institutional Strengthening and Technical Assistance: 12%
- Consultant Services: 13%
- Manpower Development: 15%
Results, cont: Remarkable Breadth of HRH Activities under HNP Operations

- Health care worker census
- Computerized personnel and training files
- Health workforce plans and staffing norms
- Health workforce mgt capacity building in MoH
- Recruitment, deployment, developing, and retention planning and implementation
- Evaluation and/or accreditation of training institutions
Notable Characteristics of HRH in HNP Projects

- Almost exclusively under MOH authority
- Almost no involvement of health care workers
- Relatively little but some beginning engagement on health care workforce reform
- Nearly one half of projects had covenants relating to HRH, mostly relating only to project-specific issues
- Over half of ICRs contained no data relevant to HRH workforce planning and projections
- Focus on nurses and auxiliary personnel, little attention to MDs
- About half of ICRs conceived of HRH as a standard issue in development and expansion of health facilities and services
- Little attention to HRH in context of macroeconomic environment
Conclusions on HRH under Investment Operations

- Wide but not deep engagement
- Little involvement in agenda that has emerged in recent years with JLI and other initiatives - major issues of pre-service and in-service training of whole categories of personnel, and recruitment, deployment, migration, remuneration, development and career management
- Agenda focused on training
- Little involvement with HRH in relation to civil service reform and the emerging world-wide health care labor market, despite the Bank’s deep involvement in public sector reform and in fiscal ‘right-sizing’
- Why?
HRH under Structural Adjustment Loans (SALs)

- What and why SALs; actions and actors
- Derivation of issues of concern in examining HRH under SALs
- The agenda: public expenditure, including wage bill, numbers of employees, institutional and policy changes relevant to public employment
- Results?
Results on HRH under SALs: Public Expenditures

- Public expenditures addressed under every one of the operations
- Where health expenditures covered, many more increases than decreases
- Frequent concern to increase non-wage share in total public spending on health
- > 60% of ICRs address wage bill, almost exclusively w/o reference to sectors, under theme of containing the wage bill for macro stability
- Wage bill expansion in 19 ICRs, wage bill contraction in 14
- Few formal wage bill conditionalities
- Nearly half of SAL ICRs address numbers of public employees, with wide variation in treatment
- Little treatment of public sector health care provider numbers
HRH & SALs: Institutional and Policy Changes Relevant to Public Employment (32 countries)

<table>
<thead>
<tr>
<th>Category</th>
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<tbody>
<tr>
<td>Legislation</td>
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<td>Org. &amp; Staff Plans</td>
<td>9</td>
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<tr>
<td>Personnel Mgmt</td>
<td>15</td>
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<tr>
<td>Pay Reform</td>
<td>8</td>
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<tr>
<td>Contractual Employment</td>
<td>4</td>
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</table>

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HRH and SALs: Skills Development, relevant to HRH, in Public Agencies (10 countries)

- Plans and Programs: 2
- Review of Curricula: 2
- Job Skills: 7
- Training on Rights and Responsibilities: 1
- Ethics Training: 1

HRH in WB Africa Operations, APHA December 2005
Conclusions on HRH under SALs

- Main theme - managing public budget through wage bill and/or staffing constraints
- Treatment as macro issue, with little attention to health sector consequences
- At sector level, limited attention, focus on adequacy of non-wage expenditures in a highly constrained budget environment and concern government priority to protecting employee numbers squeeze routine operating expenditures, make services non-operational, and compress the wage scale with highly demotivating results for higher level staff
- Some attention to positive agenda in connection with public sector/civil service reform but little focus on health-sector specific applications or consequences
HRH under Poverty Reduction Strategies

- PRSP concept and evolution
- PRSP data base
- Approach to capturing an understanding of HRH in PRSPs
HRH Contents of PRSPs

- HRH problems identified in PRSPs
- HRH spending and financial issues
- HRH policy changes
- Some particular activities on HRH in PRSPs
HRH Problems Identified in PRSPs:
Type of Problem, by Country

- Spending and Finance
- Individual Performance Mgmt
- Deployment
- Shortages

Benin  Burk  Camer  Chad  Ethiop  Gambia  Ghana  Guinea  Madagas  Malawi  Mali  Maurit  Mozam  Niger  Rwanda  Senegal  Tanzan  Uganda  Zambia

HRH in WB Africa Operations,
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PRSP Material on HRH Spending and Financial Issues (19 countries)

[Graph showing HRH spending and financial issues in 19 countries]

HRH in WB Africa Operations,
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PRSP Material on HRH Policy Change
HRH Particular Activities in PRSPs

[Bar chart showing deployment, recruitment, and training/devp activities for countries in Africa.]

HRH in WB Africa Operations,
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HRH under WB-IMF Joint Staff Assessments (J SAs)

- Nature of the J SA
- HRH contents of J SAs
HRH under WB-IMF JSAs

HRH in WB Africa Operations,
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HRH under Poverty Reduction Support Credits (PRSCs):
10 Countries, 19 Operations

- Problem statements
- HRH spending and financial issues
- HRH-related policy change
- Particular activities
HRH Problems Identified in PRSCs (10 countries)

- Shortages: 8
- Deployment: 6
- Performance Mgmt: 8
- Budget & Financial: 5
HRH Spending in PRSCs (No. of Program Documents)

- Increase Spending: 8
- Decrease Spending: 1
- Funds for HRH Dvlp: 5
- Funds for Hiring: 2
- Funds for Training: 1
- Wage Policy Review: 2
- Pymt & Incentive Systems: 4

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PRSC Material relating to HRH Policy Change (10 countries, 19 operations)

Policy Devel.
- Improv. Pers. Mgt
- Staffing norms
- Contracts
- Train. Instit. & Curric
- Increase HRH
- HRH devel Plans
- Incentive System
- Rationalize HRH

HRH in WB Africa Operations,
APHA December 2005
PRSPs and PRSCs Compared: Problem Identification, by Share of Countries

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<tr>
<th>Category</th>
<th>PRSP</th>
<th>PRSC</th>
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<tr>
<td>Personnel shortages</td>
<td>26%</td>
<td>80%</td>
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<tr>
<td>Deployment</td>
<td>68%</td>
<td>60%</td>
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<tr>
<td>Performance management</td>
<td>53%</td>
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<tr>
<td>Financial</td>
<td>26%</td>
<td>50%</td>
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PRSPs and PRSCs Compared: HRH Financial Issues, by Share of Countries

- Spending Increase
  - PRSP: 50%
  - PRSC: 42%

- Spending Decrease
  - PRSP: 6%
  - PRSC: 10%

- Funds for HRH staff development
  - PRSP: 37%
  - PRSC: 20%

- Funds for hiring additional HRH
  - PRSP: 20%
  - PRSC: 16%

- Compensation policy review mentioning HRH
  - PRSP: 20%
  - PRSC: 16%

- Payment and incentive systems
  - PRSP: 20%
  - PRSC: 16%
PRSPs and PRSCs Compared: Policy Change affecting HRH, by Share of Countries

- **HRH policy devp:** PRSP 26%, PRSC 60%
- **Performance management:** PRSP 68%, PRSC 70%
- **HRH development plans:** PRSP 11%, PRSC 10%
- **Staffing norms:** PRSP 16%, PRSC 30%
- **Contracting HRH:** PRSP 21%, PRSC 30%
- **Payment and incentive systems:** PRSP 39%, PRSC 70%
- **HRH training and curricula:** PRSP 21%, PRSC 30%
Conclusions on HRH in past World Bank Operations in Africa

- Many actions, many missed opportunities

- Past agenda under investment operations largely training oriented, little systematic attention to overall strategies

- The SAL concerns related to HRH reflect the agenda of the time, with particular attention to budget management, and relatively little forward looking attention to a wider HRH agenda

- Striking growth in attention in recent years, reflected in PRSPs and PRSCs
Why so little attention until recently? Possible explanations for past WB HRH agenda in Africa

- Until recently, the HRH ‘problem’ in Africa was widely perceived and conceived as numbers of para-medicals

- Health professions reluctant to engage

- Answers to the problems on the new agenda hard to identify, harder to implement, extraordinarily political

- Most of new agenda requires intensive inter-ministerial collaboration - challenging in most countries and especially difficult in Africa
Way Forward on HRH in World Bank Operations in Africa

- Different uses of different instruments - investment and development policy lending

- Important potential in development policy lending to facilitate action on central HRH issues in Africa

- A new priority today, globally and in World Bank, but Bank only beginning to integrate HRH issues into its work

- Trust fund support for a broadened agenda

- Continuing competition for attention of policy makers within Bank and within countries - increases challenge, may increase credibility
THANK YOU!

aelmendorf@worldbank.org