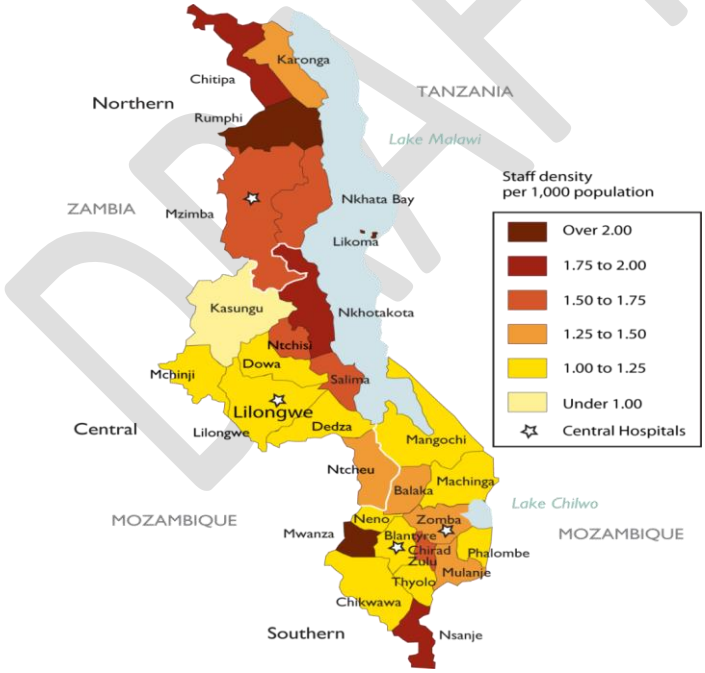
Ministry of Health

HUMAN RESOURCES FOR HEALTH STRATEGIC PLAN

2012-2016



Responding to the Malawi Health Sector Strategic Plan through

Rational Use of Human Resources for Health

2012

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ABBREVIATIONS & ACRONYMS

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AIDS	Acquired Immunodeficiency Syndrome
AIP	Annual Implementation Plan
ART	Antiretroviral Therapy
CHAM	Christian Health Association of Malawi
CoM	College of Medicine
CPD	Continuous Professional Development
DFID	Department for International Development
DHO	District Health Office
DPSM	Department of Public Sector Management
DIP	District Implementation Plan
EHP	Essential Health Package

EHRP	Emergency Human Resource Program
EPSTP	Emergency Pre-service Training Plan
GoM	Government of Malawi
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human Resources
HRD	Human Resource Development
HRH	Human Resources for Health
HRM	Human Resource Management
HRP	Human Resource Planning
HRTWG	Human Resources Technical Working Group
HSA	Health Surveillance Assistant
HSC	Health Service Commission
HSCS	Health Sector Communication Strategy
HSSP	Health Sector Strategic Plan
HSRG	Health Sector Review Group
HTI	Health Training Institute
IST	In-service Training
KCN	Kamuzu College of Nursing
M&E	Monitoring & Evaluation

M.Med	Master of Medicine
MCHS	Malawi College of Health Science
MCM	Medical Council of Malawi
ME&R	Monitoring, Evaluation & Research
MoH	Ministry of Health
MoU	Memorandum of Understanding
NGO	Non-governmental Organization
NMCM	Nurses and Midwives Council of Malawi
OPC	Office of the President and Cabinet
PMPB	Pharmacy, Medicines & Poisons Board
PoW	Programme of Work
PST	Pre-Service Training
SWAp	Sector-wide Approach
TA	Technical Assistance
TIMS	Training Information Monitoring System
ToR	Terms of Reference
TWG	Technical Working Group
UNDP	United Nations Development Program
UNV	United Nations Volunteer
VSO	Voluntary Services Overseas

WHO World Health Organization

Foreword

The public health sector has an obligation to contribute to the overall developmental goal of the Malawi Growth and Development Strategy and, from an international perspective, the Millennium Development Goals (MGDs). The attainment of both of these development agendas is dependent on the health status and productivity of the people of Malawi. This is in line with what US Secretary of State said recently Oslo Conference on "Charting a New Path in Global Health" that the stability of any nation is tied up to the well-being of its people. It is pleasing to note that as a country, Malawi continues to register positive strides in a number of health indicators since the inception of the 6-Year Program of Work (2004-2010) through the Sector Wide Approach. However, some of our vital indicators like the Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) are unacceptably high and must be tackled aggressively if we are to sustain the nation's stability. This will entail continued enhancement of the quality and access to health services for all segments of the population. The Ministry also recognizes that utilization of health services is critically dependent on what services are provided at each delivery point and the number and skills mix of human resources health that is available.

Like the first strategic plan, the major focus of this plan is to increase the level of training outputs and also consolidate and sustain gains made from the implementation of a 6_year Emergency Human Resources Plan based on an equitable availability of competent and motivated health workforce that is effectively contributing to improvement of health services accessed by the people of Malawi. The Ministry Health recognizes that this is only possible under a framework of pursuing common vision and priorities for all partners in the health sector to pull together in planning, development, deployment and utilization of human resources for complementarity and synergy.

Successful implementation of this HRH Strategy rests on true and honest partnerships, both within and outside the health sector including, but not limited to for- and not for-profit organizations, co-operating partners, etc. and that there is shared vision, mutual respect, transparency and recognition of contribution by all stakeholders.

I call upon everybody from the government, co-operating partners down to the community to work together and amicably implement the plan. I am aware of the many challenges that be there during the implementation phase, but I am confident that with the concerted efforts and sustained commitment from government and all of us, the needs of the population and those of the service providers can be addressed.

Minister of Health

ACKNOWLEDGEMENTS

The development of the Human Resources for Health Strategic Plan is a culmination of hard work by many people. The Ministry of Health is grateful to all of them and acknowledges that the quality of the plan is as a result of their commitment. The Ministry wishes to particularly acknowledge invaluable inputs from all key stakeholders.

Exceptional and lucid guidance by MoH Directors, other senior officers, the HRH Technical Working Group and the Steering Committee in ensuring that the plan attains this level of accomplishment is highly acknowledged and commended.

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Finally, I wish to appreciate individuals who worked on the final formatting and editing of this document.

Secretary for Health

Executive Summary

Continued shortage of trained health workforce remains the most significant constraint in improving the health status of Malawians and achieving the three health-related MDGs. The Malawi Government through Ministry of Health recognizes that Human Resources for Health (HRH) is the most important component of the health system especially that it is the biggest consumer of health budget, manages other resources, runs the health services system and is the major player in supporting other health service development goals. The Ministry is steadfast in ensuring that provision of health services is equitable, accessible, effective and efficient and encompasses community participation.

To this end, the Health Sector Strategic Plan (2011-2016), has set out HR strategies for the next 5 years for planning, management and training/development of the workforce in the health sector. However, to align to the aspirations outlined in the HSSP, the plan has a 4 year life-span

The strategic plan setting follows unified standards in health workforce development, deployment and utilization and ensuring widespread access to Essential Health Package to all people of Malawi with special emphasis to the vulnerable groups such as the under-5 children, mothers, physically challenged persons and the elderly. It will also build on the gains made from the implementation of the 6-Year Emergency Human Resources Plan; first HR strategic plan; other HR agendas; and mitigate some of the causal factors associated with attrition by giving due cognizance to existing and ongoing interventions by government and other key stakeholders in the health sector;

It also relates to the current situation of human resource and future health service needs, with emphasis on improving availability, efficiency and effectiveness in the use of the health workforce for good quality health care and optimal productivity. The HR strategic plan overall aim is:

> **To have a health sector with highly competent, motivated, adequate and equitably distributed Human Resources for Health that is effectively contributing to a healthy and productive life of the people in Malawi.**

Priority areas remain increasing production of health workforce focusing on eleven priority health cadres; fostering stakeholder coordination to achieve synergy in effective HR planning, management, training/development; and strengthening HR information system and research.

The plan has seven strategic objectives as outlined in the HSSP which are improved capacity for HRH planning in the health sector: strengthened Human Resource Management (HRM) for effective EHP delivery at all levels; improved retention of health care workers at all levels, particularly hard to staff/serve areas; improved HRH training and continued professional development; increased support for capacity building of health training institutions; strengthened capacities for HRH stewardship in policy, partnerships and monitoring and evaluation at national level; and strengthened capacity of the MOH to deliver the EHP through use of technical assistance

Under each of the above strategic objectives are key interventions and there are indicators to monitor progress.

CHAPTER 1: BACKGROUND

1.1 Putting HRH into Context

Human Resources for Health (HRH) is central to the overall health system's efficient and effective functionality and in Malawi this is very crucial because the public health sector and Christian Health Association of Malawi (CHAM), a not-for-profit conglomerate of hospitals belonging to several Faith-Based Organizations (FBOs) provide 97 per cent of health services.

Staffing at all levels of the health delivery system does not meet the minimum requirements and shortage is manifested nearly in all cadres of health workforce. This shortage is exacerbated by partly failure to produce adequate numbers and partly due to inability to retain those already in the system. Non-technical support personnel including Health Surveillance Assistants (HSAs) account for over 60 per cent of the Ministry' staff establishment. The country is also confronted with a heavy burden of diseases which is evidenced by high levels of child and adulthood mortality rates and high prevalence of diseases such as tuberculosis, malaria, HIV/AIDS and other tropical diseases. The escalating double burden of disease has worsened by the reported new HIV and TB cases and increasing rates of HIV & TB co-infection. All this is happening against a backdrop of continued large supply gap of trained health workers, a worrisome development in addressing the double burden of disease in the public health sector.

On service delivery, clinical officers, medical assistants and/or registered nurses or nurse/midwife technician (NMTs) are responsible for delivering most district health services that would normally be provided by fully qualified doctors or specialists. Health Surveillance Assistants too are providing health services that would ordinarily not be the case if government had trained adequate numbers of the health workforce.

There are capacity inadequacies for strengthening HRH planning, management, training/development, stewardship including structural, management and policy-related reforms, partnerships and monitoring and evaluation at all levels. For example evidence-based planning for the whole health sector remains as elusive as ever because of capacity constraints and HRH projections continue to be based on what is currently feasible and/or follows historical patterns. Only recently attempts have been made to project national requirements for nurses.

At structural level HRH challenges include rationalizing career structures through expansion of all health cadres while at the management level, evidence points to some trained health personnel being re-deployed to management-related jobs leading to a virtual complete loss in health technical capacity area. These re-deployments are invariably so because many technical health personnel view management posts as the only means by which they can achieve status and quick raise in the salary grade with resultant effect of shortage of frontline workers.

From a policy perspective, there is high concentration of health workforce at the central and district hospitals that are not providing primary or community-based services and yet 80 per cent of the population which comprises most of the vulnerable groups lives in the rural areas. Current expanded job description of the HSA is a clear manifestation of how absence of policy direction can lead to unrestrained task-shifting. While task-shifting may be deemed suitable given the critical shortage of trained health workforce, there is concern that this is done without reciprocal training skills, competencies and adequate supportive supervision, a development which compromises quality of services. Unfortunately this is the cadre that is not recognized by any of the regulatory bodies in Malawi although they are working in MoH facilities.

1.2 Policy Context

The strategic plan has been informed by a number of policy frameworks, both international and national and they include:

Millennium Development Goals

The World Health Report 2006 (http://www.who.int/whr/2006/en/index.html), estimates that countries with a density of fewer than 2.3 physicians, nurses and midwives per 1000 population generally fail to achieve targeted coverage rates for selected health care interventions set in accordance with the health-related Millennium Development Goals. The WHO has identified a threshold in workforce density below which adequate coverage of essential interventions, including those necessary to meet the health-related MDGs is unlikely. The health-related MDGs aim at reducing child mortality by two-thirds, maternal mortality rate by three-quarters and combat HIV/AIDS, malaria and other diseases. The strategic plan therefore intends to support strategies for meeting the MGDs by, among other things, ensuring the availability of adequate human resources for health.

Malawi Vision 2020

Vision 2020, is premised on the aspiration of the country that by the year 2020, Malawi as a God-fearing nation will be secure, democratically mature, environmentally sustainable, self-reliant with equal opportunities for and active participation by all, having social services, vibrant cultural and religious values and being a technologically driven middle-income economy. Adequate and well trained health workforce is the main asset for the realization of a vibrant social services component with respect to the health of people.

Malawi Growth and Development Strategy II

The Malawi Growth and Development Strategy II is the overarching strategy document because it articulates the overall agenda for the country on issues related to both economic growth and social development which are critical in providing essential health care and for strengthening health service delivery.

Draft National Health Policy

Malawi has been operating without a national health policy as guide for the health sector at the state helm, but in 2010 the Ministry with other key stakeholders developed the national health policy which is still in a draft form but currently undergoing refinement.

Malawi Health Sector Strategic Plan, 2011-2016

As the main health service provider, the Ministry of Health is responsible for providing strategic directions on the provision of health in the country and in 2011 the Ministry and its co-operating partners developed a 5-year Health Sector Strategic Plan for health sector which provides human resources for health strategic directions and key health interventions required to support delivery of quality EHP services. The overall goal of the HSSP is to improve the health status of Malawians by reducing the risk of illness and the occurrence of premature deaths, thereby contributing to the socio-economic development of the country.

1.3 Overall goal of the strategic plan

Overall goal is to increase training of health workforce and also build on the successes derived from implementation of the previous HR key intervention frameworks through improved human resource planning, management and development.

At the core a motivated workforce, human resource planning and management has to ensure that the health service has:

- the right number of appropriate staff matched with existing demands,
- in the right place,
- at the right time when they are needed,

- with the requisite knowledge and skills,
- with the right motivation and attitudes,
- at the right cost and,
- doing the work efficiently and effectively for which they are best trained

1.4 Process of Developing the HRH Strategic Plan

The Department of Human Resources in the Ministry of Health led the process of developing the current Human Resources for Health Strategic Plan, but the content of the plan reflects the collective thinking of a number of key stakeholders that were consulted throughout the development process. With technical support from USAID/Malawi, the initial stage involved hiring of an external consultant in February 2012 to help with the development of draft HRH plan Terms of Reference (ToRs) and road map which were presented to the HRH Technical Working Group and subsequently adopted after minor changes. The next stage involved identification of members to serve in the Steering Committee and a Task Force also known as Drafting Team to actually undertake the drafting exercise. The Steering Committee and the Drafting Team drew its membership from both the public and private health sectors. And to manifest the Ministry's highest commitment to the development of the strategic plan, members serving in these committee were duly appointed by the Secretary for Health.

Preliminary work in support of the HRH Strategic Planning process included:

- Collecting of key HR data/information, including validating and identifying gaps and other emerging issues.
- Undertaking consultations with key stakeholders such as Directors, Deputy Directors, Program Managers, Department of Public Service Management (DPSM), Faith-Based Organizations (FBOs), Non-Governmental Organizations (NGOs), health training institutions and professional associations.
- Snap evaluation of the previous HRH plan.
- Reviewing and, where appropriate, modifying some key HRH strategies and interventions highlighted in the Malawi Health Sector Strategic Plan to conform to emerging HR issues.
- Desk reviews.

1.5 Points of Departure

In developing the plan, the following have been identified as main points of departure from the previous strategic plan:

- That the HRH Strategic will be a central element for the realization of HR strategic priorities highlighted in the HSSP.

- That the HRH strategic plan remains an important vehicle for supporting delivery of expanded EHP services through the various platforms including acceleration on achievement of health-related MDGs.

- That although this plan is exclusively for the public sector, the private health sector may also use it as a guide in strengthening the planning, management and training/development of the HRH component of the health system.

1.6 Lay-out of the Strategic Plan

The plan is divided into nine. The first chapter mainly provides insights on current human resources challenges. It also outlines the plan's development process and points of departure. Chapter two describes the country's social structure, economy and health system while Chapter three outlines the policy framework contexts under which the plan has been developed, taking into consideration HR global and national perspectives. It also recounts the various frameworks including MDGs with special focus on health–related goals; Malawi Growth and Development Strategy (MGDS) II, Draft National Health Policy, Malawi Health Sector Strategic Plan; Essential Health Package (EHP) and other HR related policy documents. Chapter four provides a situational analysis giving the current HRH status in the public health sector. Chapter five presents the vision, mission, core values and broad strategic objective while purpose, strategic objectives, strategies and key interventions that underpin this plan are provided under chapter six. The seventh chapter outlines implementation arrangements with key assumptions for the plan's successful implementation. The budget component is briefly outlined in chapter seven with actual costing presented as annexes. The eighth chapter provides monitoring and evaluation framework and conclusion is provided in the final chapter nine.

CHAPTER 2. MALAWI'S SOCIO-ECONOMIC PROFILE AND THE HEALTH SYSTEM

2.1 Geographic and Demographic Features

Malawi is a small landlocked country found in Sub-Saharan Africa. It shares boundaries with Zambia to the North-West, Tanzania to the North and North-East, and Mozambique to the East, South and South-West. From North to South the country is 560 miles and the width varies from 50-100 miles. It covers an area of 118,484 Km^2 of which 94,276 Km^2 are land.

The country is divided into three administrative regions, namely, Northern, Central and Southern Regions. There are 28 districts which are further divided into Traditional Authorities (TAs) ruled by chiefs. Under the TA is a Group Village Head (GVH) who oversees several villages. At the GVH level is a Village Development Committee (VDC) responsible for development activities, including health issues.

The population is currently estimated at 14.4 million, rising from 8 million in 1987. It is expected that with a projected growth rate of 2.8, the population will reach 16.3 million by 2016 and this means the population will have doubled over a 20-year period. The implication of this high population growth is that the health sector will have to cater for over 2 million people.

2.2 Socio-Economic Determinants of Health

According to the National Statistical Office (NSO) 2009 Report, Malawi's Gross Domestic Product (GDP) per capita grew from less than $250 in 2004 to $313 in 2008 and the country witnessed remarkable economic growth rate of between 6% to 9% during the implementation of the Program of Work (2004-2010) with the net effect of a reduction in the proportion of Malawians living below the poverty line from 52% in 2004 to 39% in 2009. Notwithstanding, Malawi remains one of the poorest countries in the world and in 2010 it ranked 153rd of 177 countries on its human development index, which measures achievement in basic dimensions of human development.

Education, which is a key determinant of the lifestyle and societal status of individuals and the nation, is also strongly associated with health-related behaviours and attitudes. Against this background, Malawi introduced free primary education in 1994 and overall there has been progress in education attainment since then as the proportion of men and women with no education has decreased from 20% to 11% and 30% to 19%, respectively according to Demographic and Health Survey, 2010.

Malawi's economy is agro-based with agriculture as the predominant source of revenue, currently accounting for 35 per cent of the GDP. Major export cash crops include tobacco, tea and sugar. In 2009, the agricultural sector achieved a growth rate of 13.9 per cent following favourable prices that were offered at the auction floors in the 2008 marketing season. In 2010, however, the growth slowed to 1.3 per cent due to dry spells and heavy rains.

Public services are funded through taxes on personal income and company profits, trade taxes and grants from donors. The financing of public health services is inextricably linked to the aggregate of each of these revenue sources and external resources from donors, making the health budget highly vulnerable. In other words, if revenue collected is less and donor grants are reduced for whatever reason, funding for the public health sector is adversely affected.

Total budget for the public health sector, including funding channelled directly to the districts by the Treasury Department for the 2011/12 financial year is MK30.144 billion, representing 10 per cent of the national budget. However, this is below the Abuja target of allocating 15% of the national budget towards health. Table 1 below shows trends in government funding to the health sector for the last 7 years.

Table 1. 5-Year trend in Government budget allocation to the Health Sector

Quarters	GoM Total Budget (MK Bilion)	MoH Budget Allocation (MK Billon)	% Allocation
2007/08	162.9	25.1	15.4%
2008/09	229.2	31.1	13.5%
2009/10	244.0	32.9	13.5%
2010/11	285.8	36.4	12.7%
2011/12	300.0	30.5	10.2%

MoH, 2011 Mid-Year Review Report.

2.3 Epidemiological Profile

Malawi's health indicators remain among the worst in the world with communicable diseases making up a large proportion of the disease burden. Major causes of mortality are HIV & AIDS, followed by Lower Respiratory Infections (LRI), malaria, diarrhoeal diseases and conditions arising from perinatal conditions. Notwithstanding, the country's overall epidemiological profile has significantly changed in the last decade and that life expectancy has increased between from 40 to 48 years for men and 49 to 50 years for women between 2005 to 2010.

Table.... Selected health Indicators

Indicator	2000	2004	2010
Infant Mortality Rate	104/1000 live births (DHS 2000)	76/1000 live births (DHS 2004)	72/1000 live births (2010 DHS)
Under 5 Mortality Rate	189/1000 (DHS 2000)	133/1000 (DHS 2004)	112/1000 (2010 DHS)
Maternal	1120/100,000	984/100,000 live	675/100,000 live births

mortality rate	live births (DHS 2000)	births (DHS 2004)	(DHS, 2010)
Life expectancy at birth	40 years (DHS 2000)	-	49 years (Swap Progress Report 2010)

Source: HRH – Malawi Profile, 2010.

2.4 Burden of Disease

Malawi continues to witness increasing prevalence of Non-Communicable Diseases (NCDs) which has significant implication on HRH in terms of numbers and skilled health workers. The leading 10 risk factors and diseases and injuries, and NCD's prevalence are presented in tables 2 and 3 below.

Table 2. Leading 10 Risk Factors and 10 Diseases & Injuries in Malawi.

Top 10 Risk Factors			**Top 10 Disease/Injuries**		
	Risk Factor	**Total**	**Rank**	**Disease**	**% of deaths**
1	Unsafe sex	34.1	1	HIV/AIDS	33.6
2	Childhood and maternal underweight/ stunting	16.5	2	Lower Respiratory Infections	11.3
3	Unsafe water, sanitation and hygiene	6.7	3	Malaria	7.8
4	Zinc deficiency	4.9	4	Diarhoeal diseases	7.6
5	Vitamin A deficiency	4.8	5	Conditions arising from perinatal conditions	3.2
6	Indoor smoke from solid fuels	4.8	6	Cerebrovascular disease	2.8

7	High blood pressure	3.5	7	Ischaemic heart disease	2.6
8	Alcohol	2.0	8	Tuberculosis	2.4
9	Tobacco	1.5	9	RTA	1.3
10	Iron deficiency	1.3	10	Protein energy malnutrition	1.0

Table 3. Prevalence of Non-Communicable Diseases

Disease/condition	**Prevalence**	**Data sources**
Hypertension	32.9%	NCD STEPS Survey, 2009
Cardiovascular diseases (using cholesterol as a marker)	8.9%	NCD STEPS Survey, 2009 (N=3910, Age 25-64 years)
Injuries other than RTA	8.5%	WHS Malawi, 2003 (N=5297, age >=18 years)
Diabetes	5.6%	NCD STEPS Survey, 2009
Asthma	5.1%	WHS Malawi 2003 (N=5297, age >=18 years)
Road Traffic Accidents (RTA)	3.5%	WHS Malawi 2003, (N=5297, age >= 18 years)

2.6 Regional and National HRH Perspectives

Human resources in the health sector are critical because of the high recurrent costs in the provision of health care. At regional level key HR management challenges include, among others, finding ways to increase employee satisfaction and productivity despite understaffing; inadequate resources leading to uncompetitive salaries; poor and inaccurate data to conduct effective workforce planning; unavailability of health workers with needed skills and competencies in the face of reduced staffing levels caused by AIDS; migration of health professionals because of lack of attractive retention strategies; attrition caused by deaths and other multiple push factors and weak organizational advocacy.

At the sub-regional level, health workers/population ratios remain unacceptably low when compared to recommendations from World Health Organization. Table … shows comparisons on health workers per 100,000 population in some selected countries in the SADC region.

Table… . Number of health professionals per 100,000 population.

Country	Year	Physicians	Year	Nurses/ Midwife	Year	Pharmacists	Year	Laboratory technicians
Tanzania	2006	1.0	2006	24.0	2006	1.0	2006	1.0
Malawi	2009	2.0	2010	36.8	2009	1.7	2009	2.9
Uganda	2005	12.0	2005	131.0	2005	3.0	2004	6.0
South Africa	2004	77.0	2004	408.0	2004	28.0	2004	4.0

Source: World Health Atlas…..

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CHAPTER 3: SITUATIONAL ANALYSIS

3.1 SWOT Analysis

An internal and external environmental scan to identify strengths and weaknesses, opportunities and threats was undertaken with the supposition is that through a scanning process using a SWOT analysis, the Ministry will take competitive advantage of its strengths and opportunities to overcome or minimize weaknesses and threats. Outcome of a SWOT analysis is summarized below.

STRENGTHS	WEAKNESSES
• Political will at the highest level. • Improved availability of Senior HR Officers at all district and central hospitals. • Creation of a fully-fledged HR Department/ Directorate to strategically champion implementation of HR Strategic Plan. • Expansion/operationalization of HRMIS at all central and district hospitals. • Goodwill and understanding of current HRH challenges and strong partnership among key stakeholders. • Availability of some consistent resource providers in HRH training.	• Insufficient funding for human resource activities including training and staff development. • Inadequate capacities at all levels in HR Department at HQ including unfilled positions of Director and Deputy Director to provide human resources for health strategic directions. • Bureaucracy - lack of flexibility in decision making in such matters as obtaining "authority to recruit" resulting in delayed recruitments/promotions etc. • Failure to operationalize HRH Development Policy. • Inability to retain qualified staff in rural health centres, to inadequate incentive programs targeting hard to staff/serve areas.
OPPORTUNITIES	**THREATS**
• Malawi Growth and Development Strategy (2011-2016) which provides national development agenda. • Government's continued commitment to improving HRH as reflected in the HSSP 2011-2016. • Existence of Health Donor Group and various Technical Working Groups. • Improved staffing levels especially for nurses and doctors. • Existence of HRH policies.	• High disease burden with high population growth putting pressure on the health sector. • Glaring poverty is an important health determinant. • Fragile HR strategic capacities at management level. • Shortage, unequal distribution and attrition of skilled health staff due to various factors such as resignations, retirements and deaths mainly due to impact of HIV/AIDS on health workers. • Inadequate funding to deliver the EHP to all citizens. • Unattractive incentive package to attract human resources specifically for hard to reach/serve areas. • Economic uncertainty, weak accountability and donor fatigue. • Unsustainable 52 per cent top up allowances retention strategy payable to 11 priority health cadres supported by donors.

3.2 Department of Human Resources for Health

The Ministry has a fully-fledged department anchored in the headquarters and is responsible for HR planning, management and development with a headship at the level of Director but which is currently unfilled. Notwithstanding decentralization, management of HRH is still centrally managed although this is contrary to Government's Decentralization Policy. Currently the department is not sufficiently staffed to undertake the range and scale of HR strategic initiatives necessary to achieve significant improvements in HR planning, management and development that can conversely contribute to health systems strengthening. Capacity deficiencies range from inadequate number of senior officers, including turnover of skilled staff to lacking HR strategic skills. Table 6 shows current staffing in the department.

Table 6. Staffing levels at MoH Human Resources Department

Position	Grade	No	Filled/Not filled
Director	D	1	NOT FILLED
Deputy Director	E	1	Not filled
Chief HR Management Officer	F	1	Filled
Chief Human Resource Planning Officer	F	1	Not Filled
Chief Human Resources Development Officer	F	1	Not Filled
Principal Human Resources Development Officer	G	1	Filled
Principal Human Resources Planning Officer	G	1	Filled
Principal Human Resources Management Officer	G	1	Filled
Human Resource Development Officer	I	1	Filled
Human Resource Planning Officer	I	1	Filled
Human Resource Management Officer	I	2	1 x Filled
Senior Assistant HR Management Officer	J	0	2 x Filled
Assistant HR Management Officer	K	10	Filled
Stenographer	K	3	1x filled
Senior Clerical Officer	L	7	Filled
Clerical Officer	M	15	8 x filled
Copy typist	M	7	5 x filled
Messenger	P	3	3 x filled
Drivers	N	3	3 x filled

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3.2.1 HR Technical Working Group

The HR TWG is a multi-composed structure responsible for providing support to the Ministry of health on all human resources issues and the HR Department is the Secretariat.

3.3 Workforce Population and Distribution

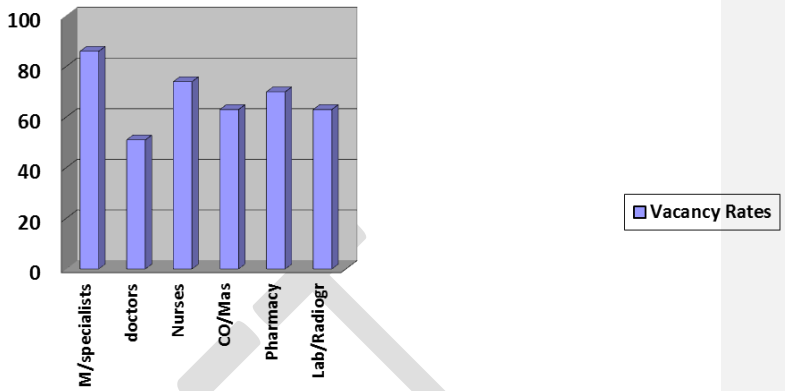
3.3.1 HRH Population

The exact number of the health workforce at national level, especially from the private-for-profit sub-sector is unknown without conducting another comprehensive human resources census. The last HRH census was conducted in 2008. However, by December 2012, the public health sector had 27,474 positions filled against the establishment of 42,052 giving a vacancy rate of 65%. The 2010 Emergency Human Resource Plan Evaluation Report has indicated an overall increase in the number of number of trained health workforce following the implementation Pre-Service Human Resources Training Plan. Notwithstanding, the high vacancy rate follows the revising of the staff establishment in 2007 and variation of vacancy rates exists in all the different health professional cadres. Table 1 and Figure 1 show MoH staff establishment and summary of vacancy rates for some selected health cadres.

Table 1….. Establishment vs. Filled Posts

Post description	Established Posts	Filled	Vacancy rate
All positions	**42309**	20365	52%
Planning and Policy Development	626	76	88%
Preventive Health Services	7553	5136	32%
Nursing Services	13669	3545	74%
Pharmacy	545	161	70%
Allied Health Technical Services	1143	381	67%
Allied Health Services-Clinical Officers	4491	1643	63%
Medical Speciallists	228	32	86%
Medical Officers	344	168	51%
Internal Audit	16	7	56%
Accounting Services	421	315	25%
Administration	6732	4261	37%

Figure …. Vacancy rates of selected health cadres as at ~~December 2011~~June 2010 (source MOH)



3.3.2 HRH Distribution

There is disparity in the distribution of health workforce at various levels with greater concentrations registered in the health facilities located in the cities, district headquarters and semi-urban areas. The shortage is more severe in rural facilities and yet there is where the majority of the population live. The shortage is further exacerbated by the expanded population, HIV & AIDS pandemic, increased cases of malaria, tuberculosis and other diseases.

Comparisons of urban/rural health workforce distribution with the health worker/population ratios at the national level are provided in Tables …. and …… in the Annex.

3.4 HRH Planning

The HR Planning Division overall function is analytical and strategic function within the generic functions of Planninmg. Specifically, the mandates, in a bullet form are as follows:

- Initiating development and review of HR policies and Workplans
- Maintaining HRH information systems
- Advocacy, Change management, and Organisation development
- HRH research and development

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- Establishment control and Functional Reviews
- Job Analysis, review and job description writing; and
- Career planning and Management.

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3.5 HR~~H~~ Management

The HR Management Division overall function is analytical and strategic function within the generic functions of Management. Specifically, the mandates, in a bullet form are as follows:

- Industrial relations, grievance and dispute handling
- Performance Management system
- Staff welfare
- Recruitment, Deployment and promotions
- Salary and leave administration
- Interpretation of conditions of service and Government procedures
- Processing of Terminal Benefits
- Staff Discipline and Ethics; and
- Registry and File Management.

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3.5.1 Recruitment of health workers

In 2002 the Government of Malawi established the Health Service Commission through an Act of Parliament. The Commission is responsible for setting conditions of service and recruitment of the health workforce for the public sector. However, the Commission has been unable to exercise its full functions especially on setting conditions of service for the health workforce because this functionality because of other Acts such as the Public Service Act and Local Government Act.

Commented [WU3]: When was the Act enacted?

3.5.2 Retention of the Health Workforce

Evidence shows that shortage of health workers is also exacerbated by failure to retain those that are in the system due to a number of push factors which include, among others, low remuneration package, shortage of accommodation especially in hard to reach/serve areas. Therefore, the Ministry is implementing a number of financial and non-financial incentives for its health workers in order to attract, motivate and retain them in the health sector. The main monetary incentive is the 52 per cent top-up allowances payable to 11 priority cadres of health professions and a 26% payable to Health Surveillance Assistants. Table ….. below shows current number of professional health workforce receiving 52 per cent top up allowance and HSAs receiving 26 per cent.

Table…… Number of health workers receiving top up allowances

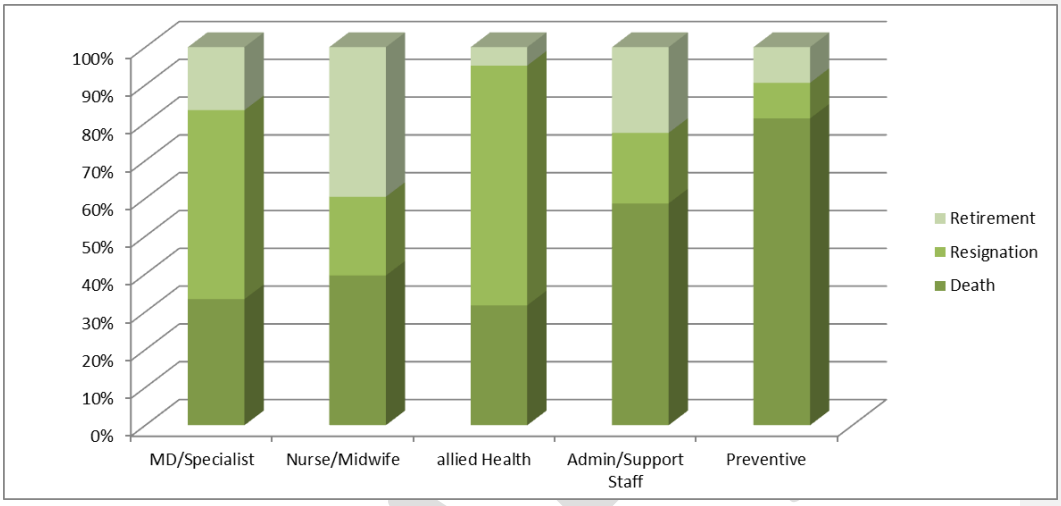
Cadre	**No.**
Physicians	
Nurses including community midwives	
Clinical Officers	
Medical Assistants	
Pharmacy Technicians	
Radiography Technicians	
Laboratory Technicians	
Dental Therapists	
Environmental Health Officers	
Physiotherapists	
Medical Engineers	
Health Surveillance Assistants	

Currently some of non-monetary incentives include establishment of career schemes to improve professional opportunities for all cadres; free post-graduate training, free hot meals for night duty health workers in hospitals; houses including renovations of old staff houses.

3.5.3 HRH Attrition

Attrition of health workers contributes to the shortages and in 2011 attrition of allied health professional was the highest followed by nursing personnel. Deaths among health care workers represent the highest percentage of the causes of attrition. Figure 3 below shows causes of attrition among health workforce.

Figure 3. Attrition among Health Workforce



3.5.4 Technical Assistance

Periodically, the Ministry engages technical assistants to provide specialized services, train local personnel in those services and in some instances as an interim gap-filling measure. Some technical assistants are recruited on fiduciary basis. Current human resources for health key technical assistance support is mainly from partners including United Kingdom's Department for International Development (DFID), World Health Organization, Germany Technical Cooperation (GIZ) the Chinese Government, Japanese International Cooperation Agency (JICA), United Nations Development Program (UNDP), UNFPA, etc. Figure 2 and table …. In the Annex show current status of technical assistance.

3.5.5 Human Resource Management Information System and Research

The Human Resource Information System is still not well formalized to inform decision making. The HRIS was established to provide a snapshot of existing human resources for health situation and should form a foundation for making human resources projections and estimations but this is not the case because of software limitation. Currently human resources information is generated by cost centres who then submit the information to the District Health officers (DHOs) for updating. At the end of every month, all cost centres submit their information to HR Department at the Ministry through a network system. Where the system is not working cost centres submit their data using memory sticks.

The HRIS faces numerous challenges and that quality of data has always been the center of contention and this is further exacerbated with inadequate computer skills among HRH personnel at all levels of the health system making it difficult to update the database; delays by cost centers to send their data to Ministry headquarters, failure by managers to use data/information at their cost centres for evidence-based decision-making, and inadequate supervision from DHOs. There are instances where the numbers of professional health workers registered by the regulatory bodies are different from those from the Ministry.

3.5.5.1 Research

HRH research programs have mainly been initiated from outside the Ministry by key stakeholders such as GIZ, DFID, CHAM and the academia including and Centre for Social Research. Following the National Health Research Agenda, there is a shift of focus in that all research programs will now be initiated by the Ministry based on identified needs and that partners will only come in to provide technical support. This will not only help in capacity building but also align to the principles of country ownership.

The HR Development Division

The HRDevelopment Division overall function is analytical and strategic function within the generic functions of training and Development. Specifically, the mandates, in a bullet form are as follows:

Management of Training and Staff Development

Staff Counselling and Mentoring

Undertaking Training needs assessment (TNA)

Maintaining inventory of external and internal training institutions

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Training and Education

Malawi has a total of 13 Health Training Institutions (HTIs) producing around ..... graduates per annum. There is growing concern on the quality of training being offered by some of these colleges because many of these institutions, especially those under CHAM have inadequate training materials and tutors, the facilities are small and require expansion if the country is to meet its supply projections. Training institutions shown under table 11 also run upgrading programs for health workers.

Commented [WU4]: MoH Training Section – provide latest data, i.e. as of 2011.

College or Institute	Public	Private	Total
College of Medicine	1	0	1
Kamuzu College of Nursing	1	0	1
Malawi Polytechnic	1	0	1
Malawi College of Health Sciences	1	0	1
Mzuzu University	1	0	1
Dae Yang College of Nursing	0	1	1
CHAM			
• Ekwendeni School of Nursing	0	1	1

• St. Johns School of Nursing	0	1	1
• Trinity School of Nursing	0	1	1
• Mulanje School of Nursing	0	1	1
• Nkhoma School of Nursing	0	1	1
• Holy Family School of Nursing	0	1	1
• St. Joseph School of Nursing	0	1	1
• St. Luke's School of Nursing	0	1	1
• St. Johns of God School of Nursing	0	1	1
• Malamulo College of Health Sciences	0	1	1
Total	3	10	13

3.4.1 Pre-Service Training

The function of pre-service training for health workers is the responsibility of the Ministry of Education. However, the Ministry of Health takes special interest and supports pre-service training because of the influence human resources for health have on delivery of health services.

Table 12. Graduates from training institutions by ownership 2007-2011

HTI	Cadre	2007	2008	2009	2010	2011	TOTAL
CHAM	Nurse (+ Midwives)	376	379	406	519	523	
	Clinical Officer	26	25	34	33	30	
	Medical Assistant	25	68	33	68	60	
	Laboratory Technician	0	15	28	14	17	
Total CHAM		**427**	**487**	**501**	**633**	**690**	
KCN	Nurse (+ Midwives)	166	155	138	129	171	
COM	Physicians	40	46	31	33	37	
	Laboratory Technician	0	14	18	0	0	32
	Pharmacy Technician	0	0	8	0	0	8
Total COM		**40**	**60**	**57**			
MCHS	Nurse (+ Midwives)	126	169	155	164	179	
	Clinical Officer	86	66	126	92	124	

	Medical Assistant	114	117	120	120	126	
	Laboratory Technician	45	13	85	24	29	
	Pharmacy Technician	17	19	17	39	38	
	Radiography Technician	19	24	18	48	54	
	Dental Therapist	9	8	12	10	14	
	Physiotherapist	0	0	0	0	0	
	Environmental Health Officer	21	19	16	45	48	
Total MCHS		**437**	**435**	**549**			
TOTAL		1,070	1,137	1,245			6,316

Commented [WU5]: MoH Training Section to update data up to 2011 .

Table 12: Current Number of Students in Health Training Institutions

Institution	Cadre of Students	1st year Enrollment	Continuing Students	Total	Graduating Students
College of Medicin	MBBS	105	286	391	0
	B.Sc. Pharma	30	26	56	0
	B/Lab Tech	36	35	71	0
	M/Med	19	13	32	0
Kamuzu College o Nursing	BSN	195	322	517	84
	MSN	24	16		10
CHAM	DCM	17	20	37	0
	CCM	27	3	30	
	NMT	495	484	979	
	Lab Tec	0	57	57	
St. John of God School of Nursing	BSc. Pysch	62	0	62	11
	Counselors	15	0	15	
Mzuzu University	BSc. Nursing	49	78	127	31
Malawi College of Health Sciences	DCM	0	297	297	

Institution	Cadre of Students	1st year Enrollment	Continuing Students	Total	Graduating Students
	DipRN	0	133	133	
	CCM	0	240	240	
	Lab Tec	0	35	35	18
	Pharm Tec	0	68	68	15
	Dent Ther	0	39	39	18
	Rad. Tech	0	38	38	18
	AEHO	0	87	87	28
	Opto. Tech	0	10	10	
	NMT	0	130	130	53
	Pys. . Nurse	0	0		13
	DipRM	0	0		49
	TOTALS	924 (+ 120)	2130		348

Source: MoH Mid-Year Performance Report, 2012

Table 13. Increase in annual numbers of graduates by cadre from 2004-2011

Description	2004	2011	% Change
Physician	18		
Nurse (+ Midwives)	575		
Clinical Officer	80		
Medical Assistant*	156		
Laboratory Technician	26		
Pharmacy Technician	22		
Radiography Technician	9		
Dental Therapist	9		
Environmental Health Officer	22		
Total	**917**		

Source: MoH, Training Section, 2012

Commented [WU6]: MoH Training Section to provide latest data to-date.

3.4.2 Post-Basic Training

There are a number of members of staff undergoing long term post-basic training in various disciplines under sponsorship of the Malawi Government, co-operating partners and some cases self.

Table 14. Members of staff on long-term post-basic training in various disciplines, 2012

PROGRAM	NO. OF TRAINEES	SPONSOR
Internal Medicine	2	DFID/MoH
Ophthalmology	1	Sight Savers
Obstetrics & Gynaecology	3	MoH
Radiation Oncology	2	MoH
Pediatrics	1	MoH
Plastic Surgery	1	Taiwan/MoH
General Surgery	2	Taiwan/MoH
Diagnostic Radiology	1	MoH
Master in Public Health	5	Self /JICA/USAID/GAVI/MOH
MSc, Community Health	6	MoH
Diploma in Physiotherapy	2	MoH
Higher Diploma in Clinical Medicine	1	MoH
Surgery ENT	1	MoH
MSc in Public Health	3	Australian Government
MSc in Nursing	7	MoH
MSc in Environmental Health	1	MoH
MSc in Business Administration	1	MOH
MSc in Bio-Medical Sciences	3	MOH
MSc Dental Public Health	1	MOH
MA, Procurement Management	1	MoH

Commented [WU7]: Comments from WHO: Does MoH have evidence-based gap analysis on specialists needs and are these areas a priority for government to direct its meager resources?

MA, Maternal and Child Health	1	MoH
MA, Reproductive Health	3	MoH
MSc, Health Economics	3	GAVI
Postgraduate Diploma in Transfusion Medicine	1	MoH
Total	53	

Sources: MOH, Training Unit, 2012

Commented [WU8]: MoH, Training Section to update the above table to include latest data, if available.

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3.6 Regulatory Bodies

Malawi has three regulatory bodies established as specific Acts of Parliament. These are Medical Council of Malawi, Nurses and Midwives Council of Malawi and Pharmacy, Medicines and Poisons Board.

3.6.1 The Medical Council of Malawi

This is a non-profit making statutory body wholly sub-vented and established by the Medical Practitioners and Dentists Act No. 17 of 1987. The overall objective is to set and maintain standards of health care in relation to registration of practitioners, as well as the qualifications and credentials of personnel employed at health establishments including their behaviour and conduct towards patients and clients; inspection of premises, equipment and supplies.

3.6.2 Nurses and Midwives Council of Malawi

Established in 1995, ~~t~~he Nurses and Midwives Council of Malawi is mandated to regulate training, education and practice of all nursing and midwifery services, including registration and conducting licensure examinations for nurses and midwives. In liaison with the Ministry of Health, the Council also advocates for increase of nurses and midwives in the country to ensure provision of quality nursing and midwifery services.

3.6.3 The Pharmacy and Poisons Board

The Pharmacy, Medicines and Poisons Board is responsible for regulating, registering, and control the quality of drugs in Malawi. The Board is also responsible for the registration, ethical control and training

of pharmacy professionals. The Board has a Medicines Committee for scheduling and registration of drugs. Drug registration, quality control testing and inspection service were introduced after an assessment of the medicines and poisons.

3.7 HRH Stakeholders in Malawi

The Ministry is working with many stakeholders drawn from various constituencies on areas specifically to improve the situation of human resources for health in Malawi. Detailed list of key HR stakeholders including specific focus areas is presented below.

Name	Category/Constituency	Area of Interests
Ministry of Health	Public sector	HRH policy, planning, management & development, data and information management for decision making.
Ministry of Education	Public sector	Policies, supervision
Parliamentary Committee on Health	Legislature	Advocacy for increased funding for the health sector
Ministry of Local Government & Rural Development	Public sector	Service provision
Ministry of Finance	Public sector	Funding health services, salaries
Christian Health Association of Malawi	Faith-Based Organization	Service provision, training
Department of Public Sector Management	Public sector	Policies, setting of Conditions of Service for public servants
Health Service Commission	Public sector	Recruitment, promotions, setting Conditions of Service
University of Malawi, College of Medicine	Academia	Training, research
University of Malawi, Kamuzu College of Nursing	Academia	Training, research
University of Malawi, The Polytechnic	Academia	Training, research
Mzuzu University	Academia	Training, research
Malawi College of Health Sciences	Academia	Training
Medical Council of Malawi	Regulatory body	Licensing and registration of physicians, clinical officers, medical assistants and allied health professionals. Accreditation of training institutions and health facilities.
Nurses and Midwives Council of Malawi	Regulatory body	Licensing and registration of nurses, technicians, administration of licensure examinations; curricula development.
UNICEF	Multilateral	Health system support, training of midwives and HSAs initial training, research and

		advocacy.
World Health Organization (WHO)	Multilateral (with a focus in the health sector)	Technical support in various areas in the health sector including norms, standards, capacity building, policy planning and strategy development in areas such as Human Resources for Health.
US Government USAID, CDC and Health Resources & Services Administration (HRSA)	Development partner	HRH training bursaries, curricula development and review; training institution capacity building including infrastructure development; in-service training across all EHP technical areas and HR systems; leadership and management strengthening at MoH, zone, district and facility levels through the following organizations: CHAM, ITECH, NEPI/ICAP, GAIA, Abt Associates and College of Medicine.
Pharmacy, Medicines & Poisons Board	Regulatory body	Licensing and registration of pharmacists, Supervision of pharmacists
For-profit health service providers	Private sector	Provision of services
Clinton Health Access Initiative (CHAI)	INGO – donor	Increasing nurse training institution capacity; optimization of health worker distribution; costing of pre-service training of health workers.
German International Corporation (GIZ)	Development partner	Human resources studies, technical assistance
Management Sciences for Health (MSH)	INGO	EHRP Evaluation, HRH Country Profile & Health Systems
Save the Children (USA)	INGO	Human resources for Maternal Health
MSF- Belgium	INGO	Research and advocacy and HRH for ART
United Kingdom Department for International Development (DFID)	Development poor partner	Technical assistance, HR support including EHRP evaluation.
Malawi Health Equity Network	CSO umbrella body	Advocacy.
Japan International Cooperation Agency (JICA)	Development partner	Technical assistance, short and long-term training
KFW/CIM	INGO – donor	Provision of doctors under Technical Assistance Agreement
Community	Client	Service consumer
Health workers	Provider	Service provision
Global AIDS Interfaith Alliance	INGO	Training of nurses
Norwegian Embassy	Development partner	Poor donor to Health SWAp which includes support to human resources for health
Norwegian Church Aid	Development partner	Infrastructure and management development
Global Fund	Donor	Health systems strengthening
Volunteer Service Organization	INGO	Placement and management of VSO volunteers

Commented [WU9]: Circulated to Leonard - MSH for their input.

United Nations Development Program	Multilateral	Management and placement of UN volunteers including specialists, general doctors and ART supervisors at public health institutions.
UNFPA	Multilateral	Health systems support, training of midwives and postgraduates (KCN & CHAM), in-service training e.g. HSAs in DPMA training, research and policy advocacy.
National Organization of Nurses and Midwives of Malawi	Union	Advocacy for increased nurses. Nursing and midwifery standards, development and review of nurse/midwives syllabi.
District Councils/DHOs	Public	
National Commission of Science and Technology (HRCSI)	Parastatal/research	Research, training
African Development Bank	Development partner	Infrastructure development
National AIDS Commission	Discrete partner	Salary top-ups

CHAPTER 4: VISION, MISSION, CORE VALUES ~~&~~ STRATEGIC GOAL AND OBJECTIVES

4.1 Vision Statement

The Ministry of Health vision with regard to HRH is derived from Vision 2020 which is to have a health sector with highly competent, motivated, adequate and equitably distributed Human Resources for Health that is effectively contributing to a healthy and productive life of the people in Malawi by 2020.

4.2 Mission Statement

To provide sound leadership and direction in the planning, development and management of human resources by ensuring that the health sector has the right number of health workers with the requisite competences and motivation to effectively and efficiently provide quality health care services in Malawi.

4.3 Core Values

The formulation of this HRH Strategic Plan is guided by a number of fundamental core values based on various international agreements including Aid Effectiveness signed in Paris, Accra and Abuja. These include:

Leadership and Accountability	There will be strong leadership which will be accountable at all levels to support human resources for health.
Partnerships	Strong partnerships with HR key stakeholders including development partners, other government sectors, private sector and the community to build and strengthen the health workforce.
Equity	Equitable delivery of health services in all zones through the deployment of adequate numbers of competent motivated and

	managed health workforce
Innovation	Innovative approaches will be used in the training, deployment and management of health workforce.
Human rights based approach & Gender Equality	The health sector will apply a rights-based approach. This will include commitment in the principles of gender equality, non-discrimination, accountability, empowerment and participation by all. The health sector will safeguard the rights of employees with disabilities and ensure that no employee is discriminated against on the basis of assumed or known HIV status and physical challenges.
Evidence-based decision -making	HRH interventions shall be based on proven and cost-effective best practices.
Efficiency & Effectiveness	Insofar as use of resources is concerned, priority will be given only where the greatest benefits to the largest number of health workers is envisaged. Furthermore, priority will be given where the objectives of the Ministry of Health Human Resources will be achieved fully.
Decentralization	HRH management and provision shall be in line with the Local Government Act of 1998 which entails devolving health service delivery to district councils.

4.4 Strategic Goal

To attract, develop and retain adequate numbers and well distributed health workers with the necessary skills, attitudes and experiences for efficient and effective achievements of the Ministry of Health's strategic vision, mission, goals and objectives.

45.52 Strategic Objectives

The HRH Strategic Plan is guided by seven key strategic objectives in ensuring that human resources for health are adequate, properly trained and remunerated, motivated and capable of effectively delivering the EHP to the Malawi population. Specific strategies and interventions are grouped into specific action areas of human resources planning, management and development. The seven strategic objectives are:

SOB 1: Improve the capacity for HRH planning in the health sector.

SOB 2: Strengthen Human Resource Management (HRM) for effective EHP delivery at all levels.

SOB 3: Improve retention of health care workers at all levels, particularly in hard to staff areas.

SOB 4 : Strengthen HRH training and continued professional development.

SOB 5: Support capacity building agendas of health training institutions.

SOB 6: Strengthen capacities for HRH stewardship in policy, partnerships and monitoring and evaluation at national level.

SOB 7: Strengthen the capacity of the MOH to deliver the EHP through use of technical assistance.

5.3 STRATEGIES AND KEY INTERVENTIONS

5.3.1 Improve the capacity for HRH planning in the health sector.

Key Interventions:

- Establish evidence-based staffing norms for all levels of human resources for health based on workload analysis.
- Expand, maintain and integrate HRMIS with existing management databases, enable greater coverage of other cadres and facilitate its use with other relevant organizations such as CHAM and the private sector.
- Develop innovative approaches for knowledge management regarding human resources policies, planning, data management and dissemination for evidence-based decision-making by Directors and Managers at all levels.
- Improve data management capacity to provide accurate and timely information on numbers, cadres, qualifications, deployment, transfer and attrition of health staff in order to make effective HR decisions.

5.3.2 Strengthen Human Resource Management (HRM) for effective EHP delivery at all levels.

Key Interventions:

- Recruit staff according to staffing norms for all cadres.
- Lobby DPSM for filing of strategic HR positions at all levels.
- Create and clarify job descriptions and career paths for all health cadres.
- Generate evidence-based needs through HRH research.

- Develop/review policies/guidelines on management of locum, relief and other incentive schemes to ensure equity and cost-effectiveness.
- Review and standardize policy on scope of work for HSAs.
- Strengthen health systems management at all levels on effective HRM practices.
- Institutionalize performance based management tool (leveraging an effective appraisal system, merit-based processes and supportive supervision) at all levels.
- Develop a robust, effective and efficient HRM system that mitigates effects of HIV & AIDS on human resources for health.
- Lobby for the increase of 2 per cent Other Recurrent Transactions (ORT) towards HIV & AIDS interventions for human resources for health.
- Strengthen implementation modalities for the Care of Carer Policy at lower levels of the health system.

5.3.3 Improve retention of health care workers at all levels, particularly in hard to staff areas

Key Interventions:

- Lobby for sustainable approach for top-up allowances for existing priority cadres and support a phase-in strategy to integrate top-up allowances into salaries.
- Review existing incentive scheme and identify implementation challenges.
- Link performance appraisal system to Performance Based Initiative.
- Lobby for improved staff welfare and amenities including housing, infrastructure, and public transport and recreation facilities in all areas prioritizing hard to reach/staff areas.

5.3.4 Strengthen HRH training and development.

Key Interventions:

- Increase the number of key health workers being trained at HTIs.
- Increase the number of tutors and clinical instructors being trained.
- Lobby for establishment of a loan scheme to support student fees and institute policy/guidelines to enforce bonding mechanism for tracking of students funded by government and other donor partners.
- Support regulatory bodies in the rolling out of continuing professional development programs for various cadres including tutors and clinical instructors.
- Develop continuing professional development programs targeting HR support staff.
- Lobby for expansion of an internship program for all health workers.

- Review existing in-service training scheme, develop and pilot the scheme to ensure transparency.
- Scale up the training of specialists for human resources for health.
- Support implementation of training program on leadership, management and professional development for training institution staff.
- Strengthen cost-effective training through innovative areas such as e-learning, distance learning, applied and part-time learning.
- Scale up the training of key human resources for health in the use of HRMIS at all levels.
- Identify priority areas for implementation of the National Nurse/Midwife Training Operational Plan over five years to double training capacity at nursing and midwifery training institutions, as a specific response to the significant shortage of nurse/midwives.

5.3.5 Support capacity building of health training institutions

Key Interventions:

- Support training institutions in developing cost-effective interventions to increase student intakes.
- Explore cost-effective and continuation mechanisms for equitable incentive packages for tutors, taking into consideration placement (e.g. urban vs. rural).
- As key stakeholder, participate in the reviews of the curricula for training of health workers to address the needs of the MOH.

5.3.6 Strengthen capacities for HRH stewardship in policy, partnerships and monitoring and evaluation at national level.

Key Interventions:

- Review existing HR Acts and Policies giving priority to Acts/Policies that inconsistent with HR national policies.
- Develop National HR Policy.
- Identify and implement innovative approaches to capacity building of key HR functions at all levels.
- Review the management and coordination of technical assistants (regional and international) at all levels.
- Promote multi-stakeholder cooperation through a Human Resources Observatory and other platforms.
- Strengthen partnership agreements with other health service providers (e.g. CHAM, private sector).

- Advocate for the strong presence of Human Resources Department in decisions relating to HTIs and students fees.
- Promote the sustainability and growth of gains made in EHRP, i.e. pre-service training, recruitment and retention.
- Advocate for decentralization of HR management at central and district hospital levels.
- Lobby recipient countries of migration CF WHO CODE OF PRACTICE ON MIGRATION
- Mobilize adequate resources for effective HR planning, management and sector development, using a comprehensive capacity development approach that embraces the organizational context and the institutional environment.

5.3.7 Strengthen the capacity of the MOH to deliver the EHP through use of technical assistance.

Key Interventions:

- Finalize and implement Technical Assistance Strategy.
- Engage short term technical assistance in priority areas to support delivery of EHP as a stop gap measure.

5.4 Implementation Arrangements

C~~HAPTER 6~~: IMPLEMENTATION ARRANGEMENTS

The Department of Human Resources in the MoH is the lead department for providing strategic direction in the planning, management and development of human resources for health in the public sector. This is done through various consultations with other Departments in the Ministry and through other frameworks such as the HRH Technical Working Group (TWG). The latter is multi-sectoral and essentially provides technical guidance on human resource issues. The Health Services Commission is responsible for the recruitment of health workers for the public health sector, a role that is envisaged to continue during the implementation of this plan. The Ministry will also work collaboratively with other key public stakeholders including the Ministry of Education, Science and Technology especially in areas of human resource training program, Ministry of Finance and the Department of Public Sector Management under the Office of the President and Cabinet.

To ensure maximum benefit of technical assistance to the health sector, the draft TA strategy will be finalized under the leadership of the tutelage of HRH TWG. The strategy recommends the provision of counterparts for the proposed TA for proper transference of skills. The HRH TWG will monitor progress by the TA in their fields of specialty and ensure the continuous availability of counterparts.

6.1 Key Assumptions

The eight strategies in the strategic plan are meant to address the identified HRH challenges. It is assumed that these strategies will help to achieve the broad objective spelled out in the document. Notwithstanding, successful implementation of the plan is based on a number of key assumptions/risks. This is premised on the understanding that there can be some factors within and outside the health sector that may impede or slow the progress in the achievement of the broad objective and strategies highlighted in the plan.

6.1.1 Policymakers will continue to commit themselves to making HRH a priority area for the Ministry of Health, by among other things, sustaining payment of top up allowances for priority cadres, developing innovative ways of reducing red-tape when addressing HRH issues.

6.1.2 Policymakers will mobilize and ensure that adequate resources are available to implement strategies/interventions to ensure effective and efficient delivery of EHP services.

6.1.3 All stakeholders will use this plan as the basis for rational use of HRH in the country.

6.1.4 Decentralization/devolution of functions will not negate equity in the health system.

6.1.5 Ensure availability of skilled health workers in hard to reach/serve areas through implementation of a cost-effective incentive package for human resources for health.

6.1.6 Our co-operating partners/donors will continue to support strategic interventions geared towards improving/strengthening HRH planning, management and development.

Timelines for implementation of key interventions is shown in Annex……

CHAPTER 5~~7~~6: FINANCING HUMAN RESOURCES FOR HEALTH

7.1. Financing **HRH Training**

Implementation of the Human Resource Strategic Plan is a major undertaking of the Ministry of Health and will require massive budget allocation. Projected HRH needs which will therefore be the basis for costing and financing the plan.

Using intermediate projection model in 2007, and assuming that the population growth remained constant, authorized staff establishment operationalized, health workforce outputs from health training institutions increased and other variables remaining constant, an attempt was made in 2007 projecting HR requirements for both public and private health sectors for the 10-year period as shown below.

Table 19. 10 Year health workforce requirements projections

Cadre	2017 Public	2017 Private	2017 Total
Specialized doctors	192	17	209
General doctors	295	76	371
Dentists	106	7	113
Pharmacists	102	13	115
Pharmacy Technicians	426	223	649
Clinical Nurse Specialists	175	3,808	3,983
Nurse Professional (Registered)	2,137	697	2,834
Nurse/Midwife (Technicians)	10,884	9,207	20,091
Specialized Clinical Officers	245	121	366
General Clinical Officers	2,081	1,160	3,241
Dental Therapists	253	157	410

Medical Assistants	2,881	1,351	4,642
Environmental Health Professionals	253	294	547
Allied Health Professionals (Diagnostics)	1,690	1,069	2,759
Senior Administrators/Managers	155	37	192
Skilled Degree Holders (Non-Medical)	315	88	403
Health Related Degree Professionals	234	361	595
Support staff (Clinical)	560	222	782
Health Surveillance Assistants	56,691	1,176	57,867
Other Support Staff	3,433	644	4,077

These projections are now considered unattainable due to various underlying reasons including inadequate financial resources for training and space challenges at health training institutions to meet the targets. Therefore, projected needs of the health workforce are premised on the factors mentioned above and staff establishment for specialists training.

7.1.1 Projections for specialists training

Cadre	**2012/13**	**2013/14**	**2014/15**	**2015/16**
Medical Specialists	3	2	2	2
Surgical Specialists	3	3	3	3
Gynaecologists	3	3	3	3
Paediatric Specialists	3	3	3	3
Anaesthetists	2	1	1	1
Orthopaedic Specialists	1	1	1	1
Ophthalmologists	3	2	2	2
Radiologists	1	1	1	1
Histopathologists	2	2	2	2
Total per year	**21**	**18**	**18**	**18**

7.1.2 Projections for post-basic nursing training

Program	2012/13	2013/14	2014/15	2015/16
B.Sc in Nursing & Midwifery	25	25	25	25
University Certificate in Midwifery	4	4	4	4
Master's Degree in Midwifery	2	3	3	3
Master's Degree in Community Health Nursing	2	2	3	3
Master's Degree in Maternal Neonatal Health Nursing	2	2	2	2
Master's Degree in Paediatric Nursing Science	2	2	2	2
Master's Degree in Clinical Nursing (Medical/Surgical Adult Nursing)	2	3	3	3

7.1.3 Projections for Pre-Service Training at Malawi College of Health Sciences

Program	Year	2012/13	2013/14	2014/15	2015/16
Diploma in Nursing & Midwifery Technician (NMT)	1	165	165	165	165
	2	125	165	165	165
	3	49	125	165	165
Diploma for Allied Professionals (clinical officers, environmental health, pharmacy, dental, radiography, Optometry, ophthalmology, laboratory technicians)	1	275	275	275	275
	2	240	275	275	275
	3	185	240	275	275
Certificate programs for Nursing Midwife Technician	1	31	31	31	31
	2	0	31	31	31
Certificate programs for Allied Professionals (medical assistants, pharmacy, laboratory and radiography, technicians)	1	221	221	221	221
	2	116	221	221	221
	3	61	116	221	221

Commented [WU10]: Total number includes MAs for 2-year certificate program. Vincent to provide breakdown on programs and number for each program

7.1.4 Pre-Service Training – CHAM Health Training Institutions

Program	Year	2012/13	2013/14	2014/15	2015/16
Diploma in Nursing & Midwifery Technician (NMT)	1	540	540	540	540
	2	879	540	540	540
	3	238	879	540	540
Diploma for Allied Professionals (C0s, Pharmacy, Laboratory Technicians)	1	107	107	107	107
	2	121	107	107	107
	3	133	121	107	107
Certificate for Allied Professionals (Medical Assistants)	1	80	50	80	
	2		80	50	80

Source: MoH, Training Section, 2012

Commented [WU11]: Total number includes MAs for 2-year certificate program. Vincent to provide breakdown on programs and number for each program

Commented [WU12]: Actual figures will be provided through addressing comment WU15 above.

7.1.5 Projections for in-service/upgrading development programs – professional technical staff

Program	2012/13	2013/14	2014/15	2015/16
MBBS (incl. those in Cuba)	16			
MPH Immunology (Kenya)	1			
B.Sc. in Physiotherapy	10			
B.Sc. in Renewable Energy	4			
B.Sc. in Dental Technology	2			
B.Sc. in Radiography	1			
B.Sc. in Dental Surgery	4			
B. Tech Diagnostic Radiography	5			
B. Tech Biomedical Sciences	6			
B.Sc. Dental Surgery	5			
B.Sc. Pharmacy	6			
B.Sc. in Nursing	20			
B.Sc. in Mental Health (Clinical and Nursing)	20			
Medical Laboratory Technology	6			
Diploma in Clinical Ophthalmology	5			
University Certificate in Midwifery	50			

Diploma in Community Health Nursing	15			
Diploma in Psychiatric Nursing	15			
Diploma in Registered Nursing	20			
Medical Assistants/HSAs	60			
Pharmacy Assistants	30			
Upgrading - School of Anaesthesia	20			

Commented [WU13]: Patrick/Vin: What are the projections for the subsequent years?

7.1.6 Projections for in-service/upgrading management development programs for support staff

Program	2012/13	2013/14	2014/15	2015/16
Diploma in Human Resources Development	4	4	5	5
Bachelor's degree in Human Resources Development	1	3	2	1
Master's degree in Human Resources Planning	0	1	0	1
Bachelor's degree in Management & Leadership	0	3	0	4
Master's degree in Human Financial Management	0	2	0	0
Bachelor's degree in Procurement	0	2	0	0
Master's Degree in Health Planning/Economics	0	1	0	1
Master's Degree in Monitoring & Evaluation	0	1	0	
Master's Degree in Health Services Management	4	0	4	0
Bachelor's degree in Health Services Management	0	2	0	1
B.Sc. in Quantity Surveyor	1			
In-service training for support staff: clerical officers, Secretaries; office	20	25	30	35

assistants, drivers, etc.				
Total	**30**	**44**	**41**	**48**

7.2 Implications on the recurrent cost of providing health services.

The costs of providing health care services will continue to escalate as more people demand quality health care and likewise more health workforce will have to be trained to keep pace with human resource costs for health care providers and other supporting staff as each facility requires maintenance budgets, medical and laboratory supplies, and bed and lines.

Although the HSSP has provided the ideal and actual HRH costs under outcome 2, the recent devaluation of the Malawi Kwacha means the stakes are high for the successful implementation the strategic plan. Table … in the Annex shows the ideal and actual costs for implementing HR strategies.

CHAPTER 68 MONITORING & EVALUATION

8.1 Monitoring and Evaluation Framework for Human Resources for Health

Like in the previous plan, the MoH is committed towards improving existing HRH capabilities and responsiveness by establishing and maintaining robust systems to support the development and monitoring of HRH strategic plan and line with HSSP M & E matrix

Effective monitoring and evaluation of key strategies and interventions is therefore paramount to building evidence to support implementation of the Malawi Health Sector Strategic Plan. While HR indicators in the HSSP, M & E matrix will remain the central focus for assessing progress in the implementation of HR interventions, some indicators in the previous HR strategic plan will be reviewed and taken on board and, where found appropriate, additional indicators will be developed to support the implementation of Annual Implementation Plans (AIPs) for MoH headquarters, Central Hospitals Implementation Plans (CHIPS) and District Implementation Plans (DIPs) for central and district hospitals, respectively.

HRH Monitoring & Evaluation Indicator Matrix is presented as Annex….

Commented [WU14]: STA M & E will assist in identifying indicators for the plan in addition to the ones in the HSSP.

Commented [WU15]: Consider nesting Output/ process indicators for interventions in AIPs/CHIPS/DIPs

ANNEXES

Annex…….: Implementation timeline of key strategic interventions

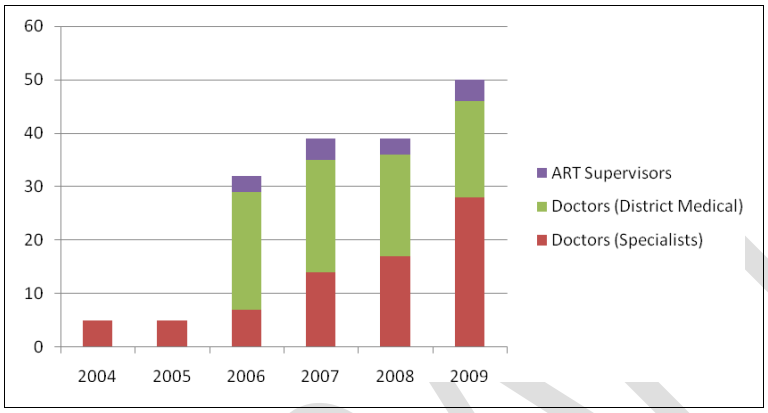
Strategic Objective 1: Improve the capacity for HRH planning in the health sector				
Strategic actions	**2012/13**	**2013/14**	**2014/2015**	**2015/2016**
Establish evidence-based staffing norms for all levels of human resources for health based on workload analysis.				
Expand, maintain and integrate HRMIS with existing management databases, enable greater coverage of other cadres and facilitate its use with other relevant organizations such as CHAM and the private sector.				
Develop innovative approaches for knowledge management regarding human resources policies, planning, data management and dissemination for evidence-based decision-making by Directors and Managers at all levels.				
Improve data management capacity to provide accurate and timely information on numbers, cadres, qualifications, deployment, transfer and attrition of health staff in order to make effective HR decisions.				
Strategic Objective 2: Strengthen Human Resources for Health Management (HRM) for Effective EHP delivery at all levels.				
Recruit staff according to staffing norms for all cadres.				
Lobby DPSM for filing of strategic HR positions at all levels.				
Create and clarify job descriptions and career paths for appropriate health cadres.				
Develop/review policies/guidelines on management of locum, relief and other incentive schemes to ensure equity and cost-effectiveness.				
Review and standardize policy on scope of work for HSAs.				
Strengthen health systems management at all levels on effective HRM practices.				
Institutionalize performance based management tool (leveraging an effective appraisal system, merit-based processes and supportive supervision) at all levels.				
Develop a robust, effective and efficient HRM system that mitigates effects of HIV & AIDS on human resources for health.				
Lobby for the increase of 2 per cent Other Recurrent Transactions (ORT) towards HIV & AIDS interventions for				

human resources for health.				
Strengthen implementation modalities for the Care of Carer Policy at lower levels of the health system.				
Strategic Objective 3: Improve retention of health care workers at all levels, particularly in hard to staff areas				
Lobby for sustainable approach for top-up allowances for existing priority cadres and support a phase-in strategy to integrate top-up allowances into salaries.				
Review existing incentive scheme and identify implementation challenges.				
Link performance appraisal system to Performance Based Initiative.				
Lobby for improved staff welfare and amenities including housing and recreation facilities in all areas prioritizing hard to reach/staff areas.				
Strategic Objective 4: Strengthen HRH training and development				
Increase the number of key health workers being trained at HTIs.				
Increase the number of tutors and clinical instructors being trained.				
Lobby for establishment of a loan scheme to support student fees and institute policy/guidelines to enforce bonding mechanism for tracking of students funded by government and other donor partners.				
Support regulatory bodies in the rolling out of continuing professional development programs for various cadres including tutors and clinical instructors.				
Develop continuing professional development programs targeting HR support staff.				
Lobby for expansion of an internship program for all health workers.				
Review existing in-service training scheme, develop and pilot the scheme to ensure transparency.				
Scale up the training of specialists for human resources for health.				
Support implementation of training program on leadership, management and professional development for training institution staff.				
Strengthen cost-effective training through innovative areas such as e-learning, distance learning, applied and part-time learning.				
Scale up the training of key human resources for health in				

the use of HRMIS at all levels.				
Strategic Objective 5: Support capacity building of health training institutions				
Support training institutions in developing cost-effective interventions to increase student intakes.				
Explore cost-effective and continuation mechanisms for equitable incentive packages for tutors, taking into consideration placement (e.g. urban vs. rural).				
As key stakeholder, participate in the reviews of the curricula for training of health workers to address the needs of the MOH.				
Strategic Objective 6: Strengthen capacities for HRH stewardship in policy, partnerships and monitoring and evaluation at national level.				
Review existing HR Acts and Policies giving priority to Acts/Policies that inconsistent with HR national policies.				
Develop National HR Policy.				
Identify and implement innovative approaches to capacity building of key HR functions at all levels.				
Review the management and coordination of technical assistants (regional and international) at all levels.				
Promote multi-stakeholder cooperation through a Human Resources Observatory and other platforms.				
Strengthen partnership agreements with other health service providers (e.g. CHAM, private sector).				
Advocate for the strong presence of Human Resources Department in decisions relating to HTIs and students fees.				
Promote the sustainability and growth of gains made in EHRP, i.e. pre-service training, recruitment and retention.				
Advocate for decentralization of HR management at central and district hospital levels.				
Lobby recipient countries of migration CF WHO CODE OF PRACTICE ON MIGRATION				
Mobilize adequate resources for effective HR planning, management and sector development, using a comprehensive capacity development approach that embraces the organizational context and the institutional environment.				
Strategic Objective 7: Strengthen the capacity of the MOH to deliver the EHP through use of Technical Assistance.				
Finalize and implement Technical Assistance Strategy				
Engage short term technical assistance in priority areas to support delivery of EHP as a stop gap measure.				

ANNEXES

Figure 6: UNV Deployment, 2005 – 2009



Source: UNDP Malawi Office, 2011.

Table ….: CIM Experts - 'German Doctors', and their Specialization

Specialization	Numbers in 2009	Location
Gynaecology and Obstetrics	2	KCH, ZCH
Surgery	2	COM, QECH
Anaesthesia/ICU	1	COM/QECH
Registrar	1	KCH
Internal & Tropical Medicine	2	ZCH, COM/QECH

Table ….. Urban/rural distribution of health workers

Occupational category/cadre	Total Number	% Urban	% Rural	HW/1000 Pop. in Urban	HW/1000 Pop.
Generalist medical practitioners	190	77%	23%	0.1	0.02
Specialist medical practitioners	67	95%	5%	0.04	0.006
Nursing professionals	2928	71%	29%	1.6	0.3
Nursing associate professionals	968	60%	40%	0.5	0.09
Midwifery professionals	-	-	-	-	-
Midwifery associate professionals	-	-	-	-	-
Paramedical practitioners	1881	79%	21%	1.0	0.2
Dentists	-	-	-	-	-
Dental assistants and therapists	211	56%	34%	0.1	0.02
Pharmacists	-	-	-	-	-
Pharmaceutical technicians and assistants	293	58%	42%	0.2	0.03
Environmental and occupational health & hygiene workers	318	75%	25%	0.2	0.03
Physiotherapists and physiotherapy assistants	9	78%	22%	0.005	0.0008
Optometrists and opticians	8	87%	13%	0.004	0.0007
Medical imaging and therapeutic equipment operators	102	79%	21%	0.06	0.009
Medical and pathology laboratory technicians	473	63%	37%	0.3	0.04
Medical and dental prosthetic technicians	-	-	-	-	-
Community health workers	10,055	21%	79%	5.4	0.9
Health management workers/Skilled administrative staff.	2931	70%	30%	1.6	0.3
Other health support staff	11,726	70%	30%	6.4	1.04

Table 7. Health worker/population ratios at national level

Occupational categories/Cadres	2008	Ratios	2010
	Number of HW	HW/1000 population	No. of HW from Regulatory Bodies

Generalist medical practitioners	190	0.01	232
Specialist medical practitioners	67	0.005	102
Nursing professionals	2,928	0.2	-
Registered Nurses and Midwives	-	-	3350
Midwifery professionals	-	-	
Associate Nursing professionals	968	0.07	
Nurse/midwifery Technicians/enrolled nurse midwives	-	-	5757
Associate Midwives professionals	-	-	
Paramedical practitioners	1881	0.14	1,145
Dentists	-	-	19
Dental assistants and therapists	211	0.02	58
Pharmacists	293	0.02	77
Pharmaceutical technicians and assistants	-	-	204
Environmental and occupational health & hygiene workers	318	0.02	67
Physiotherapists and physiotherapy assistants	9	0.0006	26
Optometrists and opticians	8	0.0006	7
Medical imaging and therapeutic equipment operators	102	0.0070	54
Medical and pathology laboratory technicians	473	0.03	193
Medical and dental prosthetic technicians	-	-	3
Community health workers (HSAs)	10,055	0.77	-
Health management workers/skilled administrative staff.	3,072	0.23	-
Other health support staff	333	0.03	-
TOTAL	20,908		

Table…. Ideal and Actual costs for implementing HR strategies

Broad Strategy: Improved availability of Human resources for health sector	**Ideal Costs**	**Estimated Budget MK (000,000)**						**Total**
Broad Activities /actions	**2011-16**	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**Total**	**US$m**

Broad Strategy: Improved availability of Human resources for health sector		**Ideal Costs**	**Estimated Budget MK (000,000)**						**Total**
2.1.1	Pre-service training	20,455	353	354	387	405	478	**1,978**	12
2.1.2	Tutors	0	0	0	0	0	0	**0**	0
2.1.3	Post graduate training	15,641	2,293	2,453	2,680	2,809	3,313	**13,549**	82
2.1.4	Recruit and pay staff at all levels	84,450	11,719	13,125	15,009	16,465	20,328	**76,646**	451
2.1.6	Capacity Building	2,916	0	0	0	0	0	**0**	0
2.1.8	HR Planning and management	1,945	219	235	257	269	317	**1,297**	8
	Subtotal HR	125,407	14,585	16,168	18,333	19,948	24,437	**93,470**	**553**

GENERAL COMMENTS

WHO:

1. **Which ones are the medium, intermediate, or long-term interventions?**

UNFPA

1. **Consider improving HRH management department to be able manage resources more efficiently and link use of resources to the Ministry's expected results.**
2. ~~1.~~3.

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