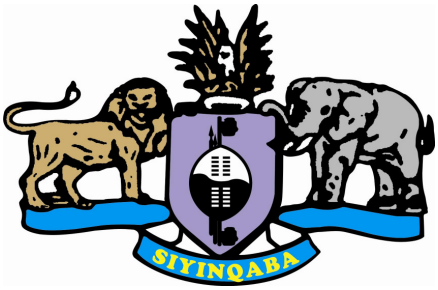

KINGDOM OF SWAZILAND

MINISTRY OF HEALTH

HUMAN RESOURCES FOR HEALTH

STRATEGIC PLAN

2012-2017

OCTOBER 2012

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
ART	Anti Retroviral Treatment
ARV	Anti Retroviral Medicine
BNSc	Bachelor of Nursing Sciences
CBO	Community Based Organization
CPD	Continuing Professional Development
CSC	Civil Service Commission
DFID	Department For International Development
DHS	Demographic and Health Survey
EHCP	Essential Health Care Package
ECSA-HC	East Central and Southern Africa Health Community
ERS	Economic Recovery Strategy
EU	European Union
EPI	Extended Programme of Immunization
FAR	Fiscal Adjustment Roadmap
FBO	Faith Based Organization
GDP	Gross Domestic product
GNP	Gross National product
GoS	Government of Swaziland
HIV	Human Immunodeficiency Virus
HCD	Human Capacity Development
HMIS	Health Management Information System
HQ	Headquarters
HR	Human Resources
HRH	Human Resources for Health
HRIS	Human Resources Information System
I-CAP	International Centre for AIDS Care and Treatment Programmes

IMCI	Integrated Management of Childhood Illnesses
ITN	Insecticide Treated Net
IYCF	Infant and Young Child Feeding
MDG	Millennium Development Goal
MDR-TB	Multiple Drug resistant TB
MICS	Multiple Indicator Cluster Survey
MOET	Ministry of Education and Training
MOF	Ministry of Finance
MOH	Ministry of Health
MOLSS	Ministry of Labour and Social Security
MOPS	Ministry of Public Service
MOEPD	Ministry of Economic Planning and Development
MSF	Medicines sans Frontieres
NERCHA	National Emergency Response Council on HIV and AIDS
NHSSP	National Health Sector Strategic Plan
NGO	Non-Governmental Organization
PEPFAR	President's Emergency Plan for AIDS Relief (USA)
PHC	Primary Health Care
PMS	Performance Management System
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV
PPP	Public Private Partnership
PSMP	Public Services Management Programme (in MOPS)
RFM	Raleigh Fitkin Memorial (Hospital)
RHM	Rural Health Motivator
RHMT	Rural Health Management Team
RHO	Regional Health Offices
SACU	Southern African Customs Union
SADC	Southern African Development Community
SID	Strategic Information Department

SMDC	Swaziland Medical and Dental Council
SNC	Swaziland Nursing Council
TB	Tuberculosis
UN	United Nation
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

FOREWORD

It gives me great pleasure to present the first Human Resources for Health Strategic plan. This plan is a culmination of great ideas and input from MOH officials and stakeholders in the health sector. It provides a much needed framework to develop and retain human resources critical to the delivery of quality health services.

This strategic plan is a grand initiative and marks the beginning of a more structured and systematic response to the HRH challenges faced in the health sector. The provision and delivery of quality healthcare services is very much dependent on the availability of an adequate and competent health workforce. For the past five years, the Ministry of Health has been fundamentally reshaping its approach to providing appropriate services at the right time. However, HRH shortages coupled with uneven distribution has continued to undermine the noble intentions of a number of interventions.

There is an urgent need therefore to focus on a broader range of issues and measures that will enable the production of adequate numbers of healthcare workers to meet the rising demand for healthcare. The ever-changing disease burden landscape has resulted in the introduction of 'new cadres' to better respond to the healthcare needs of the Swazi populace. As such, means will be considered to sustain such cadres so that service provision is not interrupted and the MOH continues to provide a full continuum of care. It has also been critical for staff already employed in the health sector, to update their skills and knowledge on several clinical and non-clinical areas so that they can respond effectively to patient cases.

The heath sector, at some point in time, witnessed an unprecedented outward migration of healthcare workers. Even today, health workers continue to migrate even though comparatively to a lesser degree. Nonetheless, measures will be put in place to retain healthcare workers and to ensure that they remain satisfied whilst serving in their respective workstations. It is also important to acknowledge that quality healthcare services are dependent on various factors, amongst them, the performance of healthcare workers. A dynamic performance management system is therefore an important feature of HRH management. Focus will therefore be on introducing versatile systems that will take into consideration the diversity of the healthcare workforce and thus ensure that each individual performs to the best of their ability.

The Government of the Kingdom of Swaziland will continue prioritizing the health sector amid the current financial challenges. I therefore implore all concerned parties to devote time and resources in ensuring that this strategic plan is fully implemented and its goals and objectives achieved within the set timeframes.

BENEDICT XABA
HONOURABLE MINISTER FOR HEALTH

ACKNOWLEDGEMENTS

The Ministry of Health recognizes and appreciates all stakeholders including MOH officials and development partners who made significant inputs into the development of this strategic plan.

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DR STEVEN V. SHONGWE

PRINCIPAL SECRETARY

EXECUTIVE SUMMARY

Swaziland still faces challenges related to the adequacy of skills and numbers of healthcare workers. As such, the country is classified by WHO as an 'HRH crisis country' amongst 35 countries in Africa and 57 countries in the world. WHO recommends a minimum staff-population ratio of 2.5 (doctors, nurses and midwives) per 1000 people. The staff-population ratio in Swaziland is 1.69: 1000 falling below the recommended minimum (HRH Rapid Assessment, 2009). As such, the country can be considered as facing an HRH crisis since the ratios fall under the recommended minimum.

The shortage of Human Resources for Health (HRH) coupled with increased attrition rates has also affected the full implementation of the PHC strategy as well as provision of specialist care. Other challenges include; insufficient capacity for HRH planning and making decisions in a collaborative manner to address HRH requirements; lack of staffing standards and/or staffing norms; Unclear (or absence of) policies to address employee benefits and manage staff employed in donor funded projects; long and complex process for recruiting and deploying staff; limited capacity for management and leadership of the health system; poor working environment continues to be a push factor for doctors; lack of succession plans; insufficient numbers of key health workers (doctors, laboratory technicians, paramedics and pharmacy technicians) and ; lack of capital funding to expand existing training institutions.

The HRH strategic plan which covers a period of five years (2012-2017) provides a framework for the systematic response to the HRH challenges focusing on the planning, development and management aspects of HRH. It has been developed following the formulation of the HRH policy (2011) and basically translates the policy into actionable items with clear realistic targets and goals. The ultimate goal is to have the adequate numbers of a motivated and performing health workforce with the proper skills and knowledge to tackle current and future health challenges. This is also in line with the National Health Policy and National Health Sector Strategic Plan (2009) whose strategic objective 1.3 is "To strengthen the human resources management systems and capacity and realize at least 75% of the minimum staffing norms at each level of the health system by 2013".

The increase in the disease burden over the past ten years has had a negative impact on human resources for health in the country. The Demographic Health Survey (2007) estimates that 26% of the Swazi Population are now living with the HIV and the annual case notification rate of (TB) cases has risen almost fourfold from 236 per 100 000 population in 1996 to 1257 per 100 000 population in 2010. In addition there are emerging cases of Multi Drug Resistant TB (MDR-TB) involved new and retreated cases estimated at 7.3% and 33.4%, respectively**.** According to the Multiple Indicator Cluster Survey (MICS) 2010, the infant mortality rate is 79/1000 whilst under five mortality rate is 104/1000. Both indicators reflect a slight improvement since

according to the DHS (2007), infant mortality was 85/1000 and under five mortality was 120/1000. The maternal mortality ratio of 589/100,000 live births is much higher than the average for lower middle income countries at149/100,000.

The impact of the disease burden on the overstretched health workforce may result in Swaziland failing to attain its MDG targets by 2015 unless concerted efforts are made to increase HRH stock levels to the required minimum standards.

It may be stated however, that there are notable achievements realized over the years in improving public health such as immunization coverage, elimination of polio, reduction of malaria incidence, skilled birth attendance and improved contraceptive prevalence.As such it is crucial to ensure the availability of adequate and skilled healthcare sustaining some of the above achievements and scaling up successful interventions. The existence of a conducive policy and legal environment is also important for the successful implementation of the strategic plan. It is imperative that policies and Acts which will provide an enabling environment for the successful implementation of the strategic plan are in place.

The Strategic plan essentially addresses three pillars; Planning, Development and Management. HRH Planning involves having mechanisms to for projections of future health workforce requirements, determining numbers and skills to be recruited, monitoring entry and exit of the workforce and managing human resources information systems. Whilst HRH Development deals with pre-service and in-service education, HRH management is concerned with matters related to personnel, performance, work environment and conditions, and task shifting.

Within this Plan and over the next five years, the strategies being proposed are as follows;

a. HRH Planning

- Developing Capacity for HRH planning across the sector
- Develop Data Bases to hoard information for HRH Planning
- Develop a Staff Distribution Plan that will ensure equity in human capital across the health sector
- Develop system for generation of data and provide Information that will be used to ascertain health workforce needs
- Develop a reliable electronic database on Health Workforce
- Develop systems for data analysis, interpretation and regular reporting
- Revive and Upgrade the Human Resources Information System

b. HRH Development

i. Pre-service

- Strengthen the coordination and strategy formulation of pre-service training
- Improve physical and organizational/operational capacity of training institutes
- Establish preceptorship program
- Strengthen the regulation and quality assurance system for pre-service trainings

ii. In service

- Strengthen coordination of in-service trainings
- Develop evidence informed and need based training plan
- Ensure quality of in-service trainings

c. HRH Management

- Strengthen recruitment and deployment procedures
- Implement the Task Shifting Framework
- Reduce staff migration and turn over
- Improve job satisfaction, employee relations, employee retention, working and living conditions
- Work hand in hand with MOPS to implement the new PMS under development by MOPS
- Implement the supportive supervision and mentoring framework
- Improve HR management capacity of HR department
- Strengthen the structure and functions of HR management at MOH
- Decentralize HR functions to Regions

The Ministry of Health will take the lead in the implementation of the strategic plan with the active involvement of other key agencies from government, UN agencies, donor community, private sector and Civil Society. Monitoring and Evaluation of the strategic plan will be guided by a framework with a specific set of indicators related to the three HRH pillars.

CHAPTER 1: BACKGROUND AND INTRODUCTION

1. Rationale of the Plan

In Swaziland, similarly to other countries in Sub-Saharan Africa, health service delivery continues to be hindered by shortage of Human Resources for Health (HRH).The World Health Organization (WHO) recommends a minimum staff-population ratio of 2.5 (doctors, nurses and midwives) per 1000 people. The staff-population ratio in Swaziland is 1.62 per 1000 in the public sector falling below the recommended minimum standard (MOH, 2011). As such, the country can be considered as facing an HRH crisis since the ratios fall under the recommended minimum.

The MOH articulated policies to provide equity of access to health services in the National Health Policy (2007). However, the lack of qualified health personnel in several areas has inadvertently led to inequitable service provision mostly due to the unequal distribution of health care workers across the country. The shortage of HRH coupled with increased attrition rates due to a dissatisfied health workforce has also affected the full implementation of the Primary Health Care (PHC) strategy as well as provision of specialist care. Many factors have contributed to the critical shortage of health workers including insufficient capacity for HRH planning and making decisions in a collaborative manner to address HRH requirements; lack of staffing standards and/or staffing norms; Unclear (or absence of) policies to address employee benefits and manage staff employed in donor funded projects; long and complex process for recruiting and deploying staff; limited capacity for management and leadership of HRH across the sector; poor working environment which continues to be a push factor for doctors; lack of succession plans; insufficient numbers of key health workers (e.g doctors, laboratory technicians, paramedics and pharmacy technicians) and ; limited capacity of training institutions to produce graduate health workers in numbers that are commensurate with the needs of the health system

Kobe and Van Damme (2006) also noted that emigration and attrition due to HIV/AIDS significantly reduced the health workforce. This situation has denied the ordinary Swazi access to quality health care. Unfortunately, this has also occurred at a time when the disease burden is increasing especially due to the advent of HIV/AIDS, TB and other infectious and non-infectious diseases. On the other hand, the increasing burden has led to heavy workloads resulting in staff suffering 'burn out' and getting frustrated due to the inability to provide quality care (Masango et al, 2008).

Since the formulation of the HRH Policy (2011), it has thus become imperative to develop a strategic plan that would provide a framework for the systematic response to the HRH challenges focusing on the planning, development and management aspects of HRH. The strategic plan covers a five year period (2012-2017) and translates the HRH policy into actionable items with

clear realistic targets and goals. The ultimate goal is to have the adequate numbers of a motivated and performing health workforce with the proper skills and knowledge to tackle current and future health challenges. This is also in line with the National Health Policy and National Health Sector Strategic Plan (2009) whose strategic objective 1.3 is "To strengthen the human resources management systems and capacity and realize at least 75% of the minimum staffing norms at each level of the health system by 2013".

The strategic plan has been developed through wide consultations with stakeholders who contributed to its structure and content including consensus on priority areas, appropriate strategies and activities to operationalize core strategic interventions. The consultations which were done on a one-to-one basis and multi-stakeholder workshops involved MoH officials, labour unions, regulatory bodies, Civil Society and Cooperating Partners. Their contributions were incorporated into the Plan and informed the background, situation analysis and strategic interventions.

2. Country Profile

2.1 Geographical Context

The Kingdom of Swaziland is a landlocked country located in Southern Africa. It shares borders with the Republic of Mozambique to the east and with the Republic of South Africa on the south, north and west. The county is divided into four ecological and topographic zones` namely: the highveld, middleveld, lowveld and the Lubombo plateau and covers an area of 17,364 square kilometers. Swaziland is further divided into 55 constituencies known as *Tinkhundla* with 360 chiefdoms.

2.2 Demographic Context

According to the 1997 census, the population of Swaziland was 929 718 with an annual growth rate of 2.9% per annum. In 2007 (according to the 2007 CSO census) the population was 1 018 449 with a significant drop in the growth rate to 0.9% per annum. The country has a very young population with 39.5% younger than 15 years of age and 52.0% younger than 20 years. The median age is 17.6 years. An estimated 3.7% of the population is 65 years of age or over. There are more women than men in Swaziland, with a sex ratio of 89.7.The majority of the population in the country (78.9%) is rural.

The pattern of a larger number of females than males is observed in both rural and urban areas, although the imbalance is larger in rural areas (88.9 males per 100 females) than in urban areas (92.9 males per 100 females). Though the population of Swaziland is evenly distributed throughout the four regions; Manzini has the largest population of 319 530 (31.4%) and the smallest being Lubombo with 207 731 (20.4%).

2.3 Socioeconomic Context

Swaziland is classified as a lower middle-income country because its per capita income is estimated at around US$ 2280. The GDP growth rate deteriorated from a high of 9% per annum during the period 1986–1990 to an average of 2.4% in the last six years. The projected GDP growth for 2011 was 1%.

Overall, the country's economy faces serious challenges. In many respects, most of the economic indicators point to a fragile economy. Swaziland is largely dependent on Southern African Customs Union (SACU) revenues from which it derives 60% of the total revenue. According to the Budget Outlook paper (2011), SACU receipts declined by 13.1% in 2009/10 and 50.5% in 2010/11. The country's official reserves' are forecasted to be negative over the medium term as a result of the decrease in revenue flows. In response to the crisis, government developed the Fiscal Adjustment Roadmap (FAR) and the Economic Recovery Strategy (ERS). The FAR proposes to bring the fiscal position to sustainable levels through revenue enhancement and expenditure control particularly reducing the large wage bill while creating space for government's commitments to increase spending to the health and education sectors. However, these efforts need to be doubled to fully implement these strategic documents with a view to normalize the situation over the medium term.

Swaziland's classification as a lower middle-income country denies Swaziland the much-needed concessional resources appropriate for addressing the country's many socioeconomic challenges such as high poverty and HIV/AIDS prevalence rates. While the GDP per capita places the country among lower middle-income developing countries, its income distribution is unevenly marked with a Gini index of 51% (MEPD, 2005). In 2008, unemployment was estimated at 28.5% (Swaziland Labour Force Survey, 2010/11) and this reflects a minimal increase from 28.2% in 2007.

According to the Ministry of Economic Planning and Development (MEPD) Poverty Reduction Strategy and Action Programme (PRSAP) (2006), 69% of the country's population is living below the upper poverty line of E 71.07 per capita, per month. This is aggravated by high food and energy costs as well as by the severe impact of the HIV/AIDS pandemic. At national level, 29% of children under five years are stunted (32% male, 26% female) according to the Demographic and Health Survey of 2006–2007 (Central Statistical Office & Macro International Inc, 2008).

Overall, the declining economic performance continues to compromise the country's capacity to pursue policies that increase expenditure on social services such as basic health, safe water and safety nets that benefit the poorest and most vulnerable groups. In order to achieve the Millennium Development Goals (MDGs), economic growth of 7% per annum is required. The

current growth rate of 1.8% per annum therefore falls far short of the annual GDP growth rate required to meet the national commitments to combat poverty and provide essential social services to the people of Swaziland.

2.4 Epidemiological Context

The Demographic Health Survey (2007) estimates that 26% of the Swazi Population are now living with HIV. The Government of Swaziland has continued to step up efforts in fighting the epidemic, ensuring that the population has access to treatment and care and putting up programmes to prevent further infections. Also, there have been several programmes set up to mitigate the effects of the epidemic especially targeting orphans and vulnerable children.

The annual case notification rate of (TB) cases has risen almost fourfold from 236 per 100 000 population in 1996 to 1257 per 100 000 population in 2010 (Service Availability Mapping, 2010). Also there is an increase in TB related deaths because of increasing cases of HIV infection in the country. The prevalence of HIV among adults with TB was approximately 82% in 2010 In addition there are emerging cases of Multi Drug Resistant TB (MDR-TB) involved new and retreated cases estimated at 7.3% and 33.4%, respectively (MOH Annual Statistical Bulletin, 2010) Measures to deal with the TB epidemic have included; countrywide implementation of DOTS strategy within the general health sector and strengthening national capacity to diagnose Multi Drug Resistant (MDR) TB. This has, in recent years, resulted in improvement in the treatment success rate and case detection rate. The country also has a dedicated a hospital for TB patients**.**

The country achieved the Abuja Target of reducing malaria morbidity and mortality by 50% in 2010. Indoor residual spraying of households stands at 98% coverage. The distribution of Insecticide Treated Nets (ITN) has been scaled up since 2002 with pregnant women and children under 5 year being given ITNs at Maternal and Child Health (MCH) clinics. It is estimated that 11% of households own at least one mosquito net (MICS 2010).

According to the Multiple Indicator Cluster Survey (MICS) 2010, the infant mortality rate is 79/1000 whilst under five mortality rate is 104/1000. Both indicators reflect a slight improvement since according to the DHS (2007), infant mortality was 85/1000 and under five mortality was 120/1000. The maternal mortality ratio of 589/100,000 live births is much higher than the average for lower middle income countries at149/100,000.

Nonetheless, the adoption of the PHC strategy in 1978 has resulted in tremendous achievements in the country as it gave birth to key child survival programmes comprising: Expanded Programme on Immunization (EPI), Integrated Management of Childhood Illnesses (IMCI), Infant and Young Child Feeding (IYCF), Sexual Reproductive Health (ANC, PMTCT, & Family

Planning), Pediatrics AIDS, Environmental Health & Safe water supply and Rural Health Motivation (RHM). Some of the achievements realized under these programs include:

- reduction in infant mortality rate from 156/1000 live births in 1986 to 79/1000 live births in 2010;
- significant reduction of vaccine preventable diseases such as whooping cough and measles;
- increase in routine immunization coverage from 8% in 1980 to 90% for DPT and 80% for measles in 2011;
- attainment of polio free status in 2005;
- exclusive breast feeding rate has increased from 8% in 1986 to 44% in 2010;
- Contraceptive Prevalence rate among all women has increased from 4% in 1986 to 49% in 2010;
- 97% of pregnant women attend ANC at least once during pregnancy
- 82% of pregnant women are delivered by skilled health worker and 89% of pregnant women attending ANC test for HIV.
- PMTCT coverage is 87%

The availability of adequate and skilled healthcare workers is thus crucial for sustaining some of the above achievements and scaling up successful interventions. However, the health workforce has also suffered the brunt of the rising disease burden.

2.4.1 Impact of high disease burden on HRH

The impact of the disease burden on HRH can be discussed from two different perspectives. Firstly, the inability of health workers to meet the rising demand for health care and secondly, health workers themselves being directly affected by diseases.

According to a study conducted by Masango et al (2004), respondents unanimously agreed that the increasing disease burden mostly due to HIV/AIDS and consequent increase in demand for healthcare has over-stretched the health system. Respondents further indicated that the capacity of the health system to adequately respond to current health needs has been reduced. Increased utilization rates at facility level meant that more health workers had to improvise in order to provide the much needed services. This has been largely due to the creation of new programmes such as PMTCT, VCT and HIV Chronic care to respond to the high disease burden. The creation of new programmes has inadvertently resulted in staff being stretched between existing units to run new programmes created. This has resulted in some health workers suffering 'burn-out' and opting to leave.

While new programmes and units have been established the supply of health workers or health workers entering the system has remained almost constant over the years whilst at the same time some health workers have been exiting the system. It was estimated that 4 to 5 nurses were

exiting the workforce between 2003 and 2004 (Kober and Van Damme, 2006). Health workers have also been directly affected by HIV/AIDS and TB among other diseases. The study conducted by Kober and Van Damme(2004) estimated that losses due to AIDS would be 3% or 4% on an annual basis over a period of five years. The effect of HIV/AIDS, TB and Non Communicable Diseases (NCDs) on health workers has also manifested itself in higher absentee rates morbidity, mortality resulting in higher attrition rates. In order to mitigate this situation, in 2008 the government introduced Public Sector HIV/AIDS Coordinating Committee (PSHACC), a workplace program under the Ministry of Public Service to ensure the health and productivity of the over 36,000 employees including those from the Ministry of Health. Subsequently, the MoH established a Workplace Wellness Policy and Program to help address the issue of care among its health workers. The Ministry in partnership with the Swaziland Nursing Association (SNA) also opened the first comprehensive Wellness Centre for health care workers and their families in Manzini in 2006.

The impact of the disease burden on overstretched health workforce may result in Swaziland failing to attain its MDG targets by 2015 unless concerted efforts are made to increase HRH stock levels to the required minimum standards. .

2.5 Health System Context

2.5.1 Organization of Health Services

Functionally, the public health system is decentralized from the central MOH to the four Regional Health Offices (RHO) in Hhohho, Lubombo, Manzini and Shiselweni. The MOH performs executive and administrative functions, as well as providing strategic guidance on the delivery of the essential health-care package at all levels of service delivery. At the regional level, it is the responsibility of the regional health offices to implement national health policies and plans. The RHO is supported by the Regional Health Management Team (RHMT) whose mandate is to provide technical leadership in executing MOH policies.

At the community level, there is a network of community health workers, including rural health motivators (RHMs), to promote community participation in health activities in their areas. There are also community health committees that assist in the general management of health facilities.

Health services provided by NGOs, including FBOs and the private sector, are regulated and closely monitored by the MOH.

The health service system consists of three main levels: primary, secondary and tertiary. At the primary level, there are community-based health-care workers, such as 4700–5000 RHMs and various HIV and AIDS programme volunteers, 162 clinics (24 clinics with maternity services and 138 clinics without them) and 187 outreach sites run by nurses. The secondary level comprises five health centres which offer both outpatient and inpatient services (with 20–40 beds) and eight public health units for referral. The health centres also serve as referral points for the primary level. The tertiary level comprises four regional hospitals – one in each of the four regions (Hhohho, Lubombo, Manzini and Shiselweni). The country also has two specialized hospitals (a national referral psychiatric hospital and a national referral TB hospital), both of which are in the Manzini region.

There are two nonprofit (mission) hospitals in two regions (Good Shepherd hospital in Lubombo and Raleigh Fitkin Memorial Hospital in Manzini), both receiving subsidies from the MOH. There are also 73 other mission facilities, including health centres, clinics and outreach services. There are 22 industry-supported health centres and clinics, 53 private clinics and four NGOs providing health care.

Table 1: Distribution of Health Facilities across Regions by type

Facility type	Hhohho		Lubombo		Manzini		Shiselweni		Total	
	#	%	#	%	#	%	#	%	#	%
National Referral hospital	1	33.3%	0	0.0%	2	66.7%	0	0.0%	**3**	**1.1%**
Regional hospital	1	20.0%	1	20.0%	2	40.0%	1	20.0%	**5**	**1.9%**
Hospital	2	50.0%	1	25.0%	1	25.0%	0	0.0%	**4**	**1.5%**
Health centre	2	40.0%	1	20.0%	0	0.0%	2	40.0%	**5**	**1.9%**
Public health unit	2	25.0%	1	12.5%	2	25.0%	3	37.5%	**8**	**3.0%**
Clinic with maternity	4	16.0%	12	48.0%	7	28.0%	2	8.0%	**25**	**9.4%**
Clinic without maternity	49	26.3%	33	17.7%	76	40.9%	28	15.1%	**186**	**70.2%**
Specialized facility	10	34.5%	4	13.8%	14	48.3%	1	3.4%	**29**	**10.9%**
Total	**71**	**26.8%**	**53**	**20.0%**	**104**	**39.2%**	**37**	**14.0%**	**265**	**100.0%**

Source: MoH (2011) Service Availability Mapping

2.5.2 Access to healthcare services

Currently, up to 85% of the population lives within eight kilometers of a health facility (MoH 2010 Service Availability Mapping Report). However, the quality and availability of health services is affected by the allocation of resources. There is ample evidence to suggest that the allocation of health resources tend to favour urban populations over rural ones. Furthermore, although physical access to health services appears quite reasonable compared to other African countries, the quality of care provided remains a challenge due to, among other things, the heavy disease burden, a chronic shortage of human resources in the public sector, deteriorating infrastructure, inadequate budget allocations and weak supportive supervision systems (World Bank 2009). Several specialist services such as urology, dermatology and highly specialized surgeries are not currently offered in the country due to critical shortage of specialists and medical equipment. Patients requiring these services are either transferred to hospitals in South Africa under the Phalala Special Care Medical Aid Fund, or are treated in Swaziland by visiting specialists under special bilateral technical assistance arrangements with the South African Department of Health (MOH, 2007).

Utilization of skilled health workers and health infrastructure requires better coordination and planning. There are incidences where midwives are deployed to facilities without maternity services. Similarly, there are facilities with maternity services and theatres that do not have midwives and medical doctors deployed to work there. Consequently, patients served by these facilities requiring maternity or theatres services end up being referred to other facilities that have a combination of maternity or theatre facilities and midwives or medical doctors.

2.5.3 Healthcare Financing

The government allocation to the health sector has maintained an average of 7.1% (MOF, 2005) and has recently begun to rise, reaching 9% in 2009/10 and 8% in 2010/11(MoH 2012). However, despite the recent increase in the government allocation to the health sector, this still falls short of the 15% of the national budget that is recommended by the Abuja Declaration of April 2001 especially in view of the increasing disease burden. Per capita health spending by the government declined steeply by 38% between 1998 and 2003, from US$54 to US$39 (World Bank, 2006). However, since 2007 it has shown a significant increase and in 2009–2010 it reached US$129 (Central Bank of Swaziland, 2009).This is higher than the recommended minimum per capita expenditure of US$34 recommended for developing countries.

The allocation of public health expenditures is biased in favour of less cost-effective urban-based curative health interventions, and central administration. Approximately 72% of the national health budget is absorbed by curative services despite a call by the 1983 National Health Policy for increased investment in preventive and promotive health activities (World Bank, 2006). As a result, donors heavily support preventive health programmes such as HIV/AIDS, sexually transmitted infections, the expanded programme of immunization (EPI), TB, malaria and sexual and reproductive health, whereas the government has been consistently unable to meet the need.

3. Policy and Legislation

The existence of a conducive policy and legal environment is crucial for the successful implementation of the strategic plan. It is imperative that policies and Acts which will provide an enabling environment for the successful implementation of the strategic plan are in place.

In addition the Public Health Act (1969), Nursing and Midwives Act (1965) exist but are being reviewed and updated. The table below reflects the objective of each of the policy and legal instruments and their relevance to the HRH strategic plan.

Name of Policy or Legal instrument	**Objective (s)**	**Relevance to HRH Strategic Plan**
Task Shifting Framework (Draft of 2012)	1. To ensure appropriate distribution of task among health cadres. 2. To provide frameworks that will enhance the uniform implementation and coordination of the task shifting interventions in the health sector. 3. To ensure the provision of quality services at all levels where task shifting is being implemented. 4. To legalize/ formalize the existing task shifting that has proved its effectiveness in enhancing access to health services.	Task shifting, with adequate distribution of tasks among health cadres including those at peripheral health system level, will improve universal access to health care in the country.

Staffing Norms (Draft of 2012)	1. To help in determining how best to improve the current staffing situation by serving as the basis for setting better priorities for allocating new staff or transferring existing staff. 2. To determine the best way to allocate new functions and transfer existing functions to different health worker categories. 3. To determine how many extra staff would be required in a particular cadre to achieve staffing standards to enhance performance. 4. To facilitate planning for future staffing of health facilities. 5. To examine the impact of different conditions of employment on staff requirements.	Staffing norms will enable the health system to attain the human resources for health goal which is to have the right number of people with the right skills in the right place at the right time with the right attitude doing the right work at the right cost with the right work output.
Swaziland Nursing Council Bill of 2008 (reviewed Nursing Act of 1965 and submitted to parliament)	1. Provide for the regulation of nursing education and practice and protecting the public from unsafe health practices 2. Establish the Swaziland Nursing Council and to define the powers and function of the Council 3. Promote, preserve and protect the health, safety and welfare of the community by and through effective control and regulation of nursing education and practice 4. Ensure that a person practising or offering to practice nursing as defined in this Act, or using the title of registered nurse, nurse specialist, enrolled nurse or nursing assistant after the effective date of this Act, within the country shall, before entering upon practice, be licensed as provided in this Act 5. Repeal the Nurse and Midwives Act of 1965; and	Regulation of nursing practice in Swaziland Control of Nursing Education and Training (ensuring quality education) Establishment of a Secretariat to (amongst other functions) maintain an information system on nurses in the country

Public Service Bill 2009	6. Provide for other matters incidental to the above objects 1. Provide for administration of public service 2. Provide for public service values and a public officers code of conduct 3. Prescribe criteria for public appointments and provide for the discipline, removal, etc of officers in the public service 4. Provide for the termination of appointment and for retirement of officers in the public service 5. Provide for performance management in the public service; and 6. Provide for matters incidental thereto	Relevant to the management of HRH in the health sector
Public Health Act (1969) **Public Health Bill of 2012 - review of the Public Health Act of 1969 and submitted to Parliament**	1. Promote public health within the country and to provide for measures directed at preventing, controlling and treating diseases and conditions; 2.Provide an enabling environment by establishing facilitative structures in the form of advisory and Management health committees; 3. Define duties and responsibilities of health personnel in the public health sector; 4. Provide for the establishment of a Health Service Commission that will be responsible for appointing officers in the public health sector; 5. Repeal the Public Health Act, No. 5 of 1969; and 6. Providing for other incidental matters.	Establishment of the Health Service Commission Management of health workers and the sector as a whole through establishment of relevant management bodies

Pharmacy Bill of 2012	1. Provide for the establishment of a Medicines Regulatory Authority and to provide for its functions; 2. Provide for the registration of medicines and medical devices; for the control of medicines and scheduled substances, and to provide for matters incidental thereto.	Availability of drugs and medicines crucial to performance of healthcare workforce

CHAPTER 2: HEALTH WORKFORCE SITUATION

This chapter presents the situation analysis related to HRH Planning, Development and Management. For each of the three areas, the background, current situation and key issues are discussed, forming the basis for the strategic direction discussed in the next chapter.

2.1. HRH PLANNING

HRH planning involves the evaluation and identification of human resources requirements for meeting organizational goals. It requires an assessment of the availability of the qualified resources that will be needed to ensure effective delivery of services and anticipate staffing needs. For instance, the MoH must implement innovative strategies that are designed to enhance their employee retention rate and recruit fresh talent into the organization. Human resources planning is one way to help MoH develop strategies and predict the needs in order to meet its health goals and vision. HRH planning is therefore an important component of HRH management and development because:

- It will ensure that MOH has a clearer picture of how much HR is required It will enable MoH to foresee the employee attrition and make the arrangements for minimizing turnover and filling up of consequent vacancies
- It will help to minimize imbalances caused due to non-availability of human resources by ensuring that health worker deployment is prepared to send the right kind, and right number of health workers to the right place at the right time
- It will help managers to foresee the impact of new programs or health technology on work, existing employees and future human resources requirements

The three key elements of the HR planning process are forecasting labor demand, analyzing present labor supply, and balancing projected labor demand and supply.

2.1.1. Capacity for HRH Planning

Health Workforce planning is a fundamental function of the Ministry of Health in Swaziland in the overall management of its workforce because it allows the Ministry to systematically review workforce requirements to ensure that the required numbers of health workers with the right skills are available when and where they are needed. Staff profiles and personnel in the MoH HRH department however seem to be more heavily skewed toward HRH operational management and administration than HRH policy and planning. These functions seem to be scattered between the planning Unit and other departments. For instance there is no officer within the HRH department responsible for planning and information management. Consequently, the major challenge for MoH headquarters over the years has been the skewed balance between the routine personnel administrative management function and the broader mandate of HRH policy and planning. At the region and facility levels, there is no human resource capacity to undertake HRH planning.

As a result, there is insufficient technical expertise for the development of appropriate tools, methodologies, and processes to support HRH policy, planning and development

consequently planning for the Health Workforce is based on rudimentary methods which are not evidence based. Due to lack of a systematic HRH planning culture in the health sector, the health system is laden with attrition of core health workers, staff shortages and imbalances in the distribution of staff.

Workforce planning should become an integral part of health system planning. It must be mainstreamed at all levels of the health system. Efforts will thus have to be made towards the acquisition and retention of the requisite capacities for HRH policy formulation and planning within the sector. Continued emphasis on operational personnel management and administration may discourage effective policy and planning. A lack of emphasis on policy and planning may explain, in part, why information from the Human Resources Information System is not utilized for key decision making with regard to health workforce management and development across all levels of the health sector.

The coordination of inputs by the key agencies of Government that are involved in HRH planning, management and development especially the Ministry of Public Service, Civil Service Commission, Ministry of Finance, Ministry of Education and the HRH Unit in the Ministry of Health requires strengthening and this is evidenced by delays in recruitment of key health personnel and retired staff although no longer on the payroll, perpetually remain on the establishment and thereby preclude new entrants into the workforce.

2.1.2. Human Resources for Health Plans

HRH Plans, which are then consolidated by the regions and submitted to the centre for inclusion in the annual budget estimates, are developed by the facilities using a template developed by the Planning Unit at MoH. These plans are meant to guide the development of MoH Personnel Requirement Submission to MOPS based on the entire needs of the sector. However, it is apparent that these plans are developed to merely meet the requirements of the MoH Headquarters and are not in any way management and workforce development tools for regional and facility based HRH planning. A review of HRH plans could not provide any meaningful information on the HRH gaps and how the gaps could be filled through the provision of adequately trained staff. This is mostly due to poor data on HRH. There is also a general discontentment by those preparing HRH plans and budgets that although efforts are made to plan for HRH, resources are not allocated to support implementation of the plans which renders the whole exercise a paper activity.

2.1.3. Information for Planning

Available information is not adequate to inform comprehensive planning. The Human Resources Information System (HRIS) is supposed to provide information for planning. However it has limited information parameters as it merely captures information on approved establishment posts, filled and vacant posts, and place of work, title and nationality. The system does not provide information that is cardinal for planning such as attrition rates, professional career development, skills available in the sector against need, equity in distribution of staff, productivity of staff and staff undergoing specialist training.

A significant impediment to health workforce planning is the lack of an electronic data base with information that can inform planning, management and development of the health workforce. All information that formed the background for the strategic planning process was gathered as a "once off" activity. There is need to develop in the interim a depository where all information can be stored within the MoH. The Strategic Information Department (SID) will be an ideal setup for that. In the long term, a national data base must be created which should have information arranged according to various health system themes such as:

- Service delivery
- Pharmaceutical
- Capital
- Human Resources for Health
- Priority diseases
- Health Management Information Systems

2.1.4. Stock and Profiles of HRH

Compared with neighboring low middle income countries in sub-Saharan Africa, the aggregate number of medical doctors and nurses is low in both number and density. As indicated in table 2, only Angola fairs worse than Swaziland at 8 medical doctors and 115 nurses per 100,000 population. The estimates for Swaziland are 13 medical doctors per 100,000 population excluding the for profit private sector and 150 nurses per 100,000 population excluding the for profit private sector. Some low income countries such as Zimbabwe fare better than Swaziland with regard to the doctor to population ratio at 16 per 100,000 population. When numbers for the for profit private sector are factored in, the staff to population ratios increases significantly to 23 Medical Doctors per 100,000 population and 186 nurses per 100,000. The figure for nurses is beyond the WHO benchmark of 173 nurses per 100,000.

Using the WHO bench mark for the total workforce to the population ratio, Swaziland falls short of the recommended benchmark to reach the MDGs. Estimates from the 2010 HRIS indicate a total workforce of 3,684 which translates to a total workforce to population ratio of 3.7per 1000 population which is below the WHO benchmark of 4.1 per 1000.The WHO has further recommended a benchmark of at least 2.5 health workers (defined as doctors and nurses) per 1000 population to provide the minimum public health and essential health care package. The WHO also suggests a ratio of 0.55 medical doctors and 1.73 nurses per 1000 (Scheffler et al, 2008). Swaziland is far below the benchmark for essential health workers which is estimated at 1.6 per 1000 population for the public, not for profit Non Governmental Organizations (NGO) and Faith Based Organizations (FBO). It is equally far below the benchmark for medical doctors which is estimated at 0.13. It fares much better for nurses which is estimated at 1.5. When for profit private sector are factored in, the ratio for health workers increases from 1.6 per 1000 population to 2.1 per 1000 population. Similarly, the ratio for medical doctors increases slightly from 0.13 per 1000 population to 0.24 per 1000 population and 1.9 per 1000 population for nurses.

Based on these ratios, it may be concluded that Swaziland is not an HRH crisis country because its health workforce to population ratios are close to the WHO benchmarks. However, when projecting the health workforce requirements based on workloads due to HIV/AIDS and computing the health workforce to population ratios based on the projected figures, it is clear that Swaziland is still faced with a critical shortage of health workers required to meet the MDG targets.

It is clear from these projections that although Swaziland appears to be getting closer to the WHO benchmarks for doctors (0.24/1000 against a benchmark of 0.55) and has surpassed the benchmark for nurses (1.9/1000 against a benchmark of 1.73), the projected workforce requirements based on workloads clearly shows that Swaziland is a unique country due to its high HIV/AIDS prevalence rates estimated at 26% of the population which demands for a higher doctor and nurse to population ratios than the WHO benchmarks..

In addition, given that 69% of the population live below the poverty datum line, we can safely state that only 30% of the population can afford health care in the for profit private care facilities. The remaining 70% will seek care in the public sector facilities and FBOs. Therefore, because the health worker to population ratios are close to the WHO benchmarks when we include the number of health workers in the for profit health facilities, it will be important to consider the public health sector workforce to population ratios only when deriving strategies under this plan in view of the fact that the majority of the population (70%) will seek health care at public facilities only. As indicated above, the staff to population ratios in the public sector facilities falls far below the WHO benchmarks and appropriate strategies to prop up the ratios towards the WHO benchmark must be developed and successfully implemented.

Table 2: Global Indicators of Human Resources for Health in Southern Africa

Country	**Population**	**Doctors/100,000**	**Nurses/100,000**	**Total Medical doctors and Nurses/100,000**
Lesotho	2.1	5	62	67
Malawi	15.9	2	59	61
Mozambique	20.9	2	21	36
Tanzania	39.3	2	37	39
Zambia	13	12	174	186
Zimbabwe	12.3	16	72	88
Total Low Income	99.7	**5**	**92**	**97**
Angola	12.2	8	115	127
Botswana	1.8	40	265	305
Namibia	2.0	30	306	336
South Africa	44.0	77	408	485
Swaziland*	1.02	13 (23*including for profit private	150 (186* including for	163 (209* including for

		sector)	profit private sector)	profit private sector)
Total Low Middle Income	**61.1**	**59**	**337**	**396**

***Figures includes the for profit private sector**

Source: WHO (2008) Global Indicators of Human Resources for Health in Southern Africa

Table 3: Health Workers per 1000 Population in Swaziland against International Benchmarks

CADRE	TOTAL NUMBER	HEALTH WORKER PER 1000 PEOPLE	BENCHMARK TO ACHIEVE MDGs (PER 1000 PEOPLE)
Medical	126	0.126 (2.1 including for profit private sector)	0.55 Scheffler et al 2008
Nursing	1,505	1.5 (1.9 including for profit private sector)	1.73 Scheffler et al 2008
Dental	71	0.071	
Environmental Health	122	0.122	
Health Education	29	0.029	
Laboratory	114	0.114	
Administration	224	0.224	
Medical Imaging	47	0.047	
Biomedical Engineering	35	0.035	
Nutrition	77	0.077	
Other Paramedical	78	0.078	

Pharmaceutical	60	0.060	
Physiotherapy	30	0.030	
Psychology	11	0.011	
Social Welfare	3	0.003	
Support Staff	1,152	1.2	
GRAND TOTAL	**3,684**	**3.68**	**4.1 WHO Benchmark**

Source: (MoH 2010 Annual Statistical Bulletin)

Of the total health workforce employed in the public sector in Swaziland, more than half (62%) can be classified as direct or clinical health service providers while the rest (38%) are in administration or provide support services. Nurses represent the largest share comprising 41% of the total workforce, followed by Environmental Health Officers at 3.7% and Medical Doctors who comprise 3.5% of the total workforce.

Expatriates make up a significant proportion of HRH in Swaziland's public health system. Table 4 below shows a progressive increase in expatriate staff particularly among the medical doctors which registered a 60% increase for General Medical Doctors between 2006 and 2008, while Medical Specialists registered a significant percentage increase of 83% between 2006 and 2009. Nurses registered a modest increase at 32%.

The health workforce situation presents an alarming picture when we compute the percentage contribution of expatriate health workers to the total workforce for key cadres such as medical doctors, pharmacy technicians, laboratory technicians and medical imaging cadres. Expatriates contribute 65% of the total medical doctors, 46% of laboratory technicians, 43% of medical imaging and 35% of pharmacists. The percentage contribution further increased in 2011 to 72% for medical doctors, 67% for pharmaceutical, 50% for medical imaging and 62% for laboratory.

Table 4: Foreign Medical Doctors and Nurses in the Swaziland Health Care System

Cadre	**Post Code Description**	**1/12/2006**	**10/12/2007**	**5/9/2008**
Medical Doctors	Clinical Superintendent		2	2
	Medical Officer	29	67	72
	Medical Specialist	4	20	24
	Ophthalmologist		1	1
	Optometrist		1	1
	Expatriate Total	33	91	100
Nurses	General Staff Nurse	14	20	19

	Nursing Assistant	2	2	2
	Nursing Sister		1	1
	Staff Nurse			
		1	3	3
	Expatriate Total	17	26	25

Source: MoH (2008) Human Resources for Health Rapid Assessment

Table 5: Percentage Contribution of Selected Expatriate Health Workers to the Total Workforce

Cadre	**Nationality Not stated**		**Swazi**		**Non-Swazi**		**Total**	
	2008	2011	2008	2011	2008	2011	2008	2011
Laboratory	7	0	24	39	26 (46%)	65 (62%)	57	104
Medical	18	5	50	65	126 (65%)	168 (72%)	194	238
Medical imaging	0	0	16	18	12 (43%)	18 (50%)	28	36
Nursing	257	97	1276	1180	93 (5.7%)	620 (34%)	1626	1897
Pharmaceutical	2	0	31	23	18 (35%)	48 (67%)	51	71
Total clinical staff	**291**	**102**	**1476**	**1,325**	**289 (13.9%)**	**39%**	**2084**	**2,346**

Source: MoH (2008; 2011) HRIS

It is important to plan for any sudden emigration of expatriate health workers should the economic situation improve in their countries of origin.

2.1.6. Distribution of Health Workforce

The Health Workforce is distributed according to the public and private sector settings, geographical location which includes regions, facilities and gender.

2.1.6.1. Distribution by Sector (Public and Private)

The number of medical doctors working in the private sector is reported to be significant in Swaziland. The European Commission HRH Survey of 2008 estimates that 43% of General Medical Doctors were working in the public sector while 57% were in the private sector. There are equally more Specialist Doctors working in the private sector estimated at 72% with only 27% working in the public sector, while 51% and 49% of Paramedics work in the private and public sector respectively. The trend somehow changes with the nursing and environmental health cadre. Approximately 65% of nurses worked in the public sector with

only 34% working for the private sector, while 97% and 3% of Environmental Health Officers worked in the Public and Public Sector respectively.

From these estimates it can be assumed that doctors are more attracted to work in the private sector than in the public sector. The explanation for this observed trend could be that medical doctors foresee high financial gains to be realized from the private sector than the public sector. This is explained by the high percentage contribution of private health facilities owned by medical doctors estimated at 21%, second to government facilities estimated at 40% as indicated in figure 1.

Table 6: Distribution of Health workers by Sector (Public/Private)

Occupational category/cadre	Total Number	% Public sector	% Private sector, including FBOs (Missions)
Generalist medical practitioners	140	43.57%	57.14%
Specialist medical practitioners	33	27.27%	72.73%
Nursing professionals (including midwives)	1164	65.98%	34.02%
Nursing assistants	462	73.16%	26.84%
Paramedical practitioners	45	48.89%	51.11%
Dentists (Dental officers)	13	76.92%	23.08%
Dental assistants and therapists	30	33.33%	66.67%
Pharmacists	20	45.00%	55.00%
Pharmacy technicians	31	54.84%	45.16%
Environmental and occupational health & hygiene workers	116	97.41%	2.59%
Physiotherapists and physiotherapy assistants	14	85.71%	14.29%
Optometrists and opticians	4	75.00%	25.00%
Medical imaging and therapeutic equipment operators	28	57.14%	42.86%
Medical and pathology laboratory technicians	57	33.33%	66.67%
Medical and dental prosthetic technicians	16	87.50%	12.50%
Community health workers			
Health management workers/Skilled administrative staff.	254	62.99%	37.01%
Other health support staff	1222	83.14%	16.86%

TOTAL	**3649**	**71.72%**	**28.28%**

Source: MoH (2009) Statistics of the Distribution of Health Workers between Public and Private sector

The private sector (for profit and not for profit) has grown in recent years. For instance in the early 1990s, private clinics accounted for less than 2% of the total health facilities. In 2010, private clinics owned by medical doctors accounted for 21.5% of the total facilities in Swaziland. (MoH 2010, Service Availability Mapping Report). Figure1below shows that the not for profit and for profit private sector accounts for 60% of health facilities in Swaziland (MoH 2010: Service Availability Mapping). The growth of vertical programs to fight against HIV/AIDS, TB and Malaria during the last decade has created lucrative job opportunities for doctors and nurses in the NGO sector.

Consequently, there is anecdotal evidence that more health workers are moving from the public sector to the private sector particularly medical doctors and nurses. Health workers entering the private sector are attracted by better pay packages including better equipped facilities which are not available in the public sector. On the contrary however, recently there is evidence that improvements in government conditions of service such as superior overtime and on call allowances and high pension payments have attracted staff from Faith Based Organization (FBO) (not for profit) to government facilities.

2.1.6.2. Geographical Distribution

Health workers in Swaziland are distributed across geographical locations such as regions, rural and urban areas. The distribution of health workers across regions is uneven. According to the 2007 Swaziland Demographic and Health Survey Manzini and Hhohho have the highest economic status while Lubombo and Shiselweni have the lowest with Shiselweni fairing the worst. Similarly the 2010 Swaziland Household Income and Expenditure Survey present a similar pattern in regional economic status. Manzini and Hhohho have a rich economic status while Lubombo and Shiselweni have a poor economic status.

The distribution of health workers follows the regional economic status. Regions presenting a high economic status namely Manzini and Hhohho have a high distribution of health workers than Lubombo and Shiselweni. For instance, using medical doctors and nurses as a proxy as indicated in Table 7 which uses 2006 figures, Manzini and Hhohho have a better doctor to population ratio of 17/100,000 and 10/100,000 respectively while Lubombo and Shiselweni only have 6/100,000 population and 5/100,000 population respectively. A similar pattern emerges with the nursing cadre. Manzini and Hhohho have 57/100,000 population and 70/100,000 population of nurses while Lubombo and Shiselweni have 52/100,000 population and 41/100,000 population. The status is even worse for midwives. Hhohho and Manzini have 72/100,000 population and 80/100,000 population respectively while Lubombo and Shiselweni have 47 midwives/100,000 population and 46 midwives/100,000 population respectively.

A similar pattern emerges when we compute 2011 figures. Hhohho and Manzini register high doctor to population ratios which are nearly four times more than Lubombo and Shiselweni. Equally for nurses they register a high ratio which is nearly more than 80 nurses than Lubombo and Shiselweni per 100,000 population.

Further analysis shows that Hhohho and Manzini surpassed the WHO benchmark for nurse to population ratios by 2011. The WHO has set 173 nurses per 100,000 as a benchmark to meet the Millennium Development Goals. Manzini reported a nurse to population ratio of 189 nurses per 100,000 population while Hhohho reported 183 nurses per 100,000. The disadvantaged regions of Lubombo and Shiselweni on the other hand faired far below the benchmark with Lubombo and Shiselweni reporting a ratio of 136 and 109 per 100,000 population respectively. The national aggregate for all four regions is also below the WHO benchmark at 154 per 100,000. Furthermore all four regions did not meet the WHO benchmark for medical doctors set at 55 per 100,000 population with Hhohho reporting a much better ratio (34 per 100,000 population) followed by Manzini (23 per 100,000). Lubombo and Shiselweni reported a deficit of nearly 47 medical doctors against the WHO benchmark.

Table 7: Distribution of Medical Doctors and Nurses across Regions

Region	**Year**	**Population**	**Doctor's Ratio/ 100 000**		**Nurses Ratio/ 100 000**	
			Available	WHO Benchmark	Available	WHO Benchmark
Hhohho	2006		17	55	70	173
	2011	331 734	34	55	183	173
Lubombo	2006		6	55	52	173
	2011	249 153	10	55	136	173
Manzini	2006		10	55	57	173
	2011	360 228	23	55	189	173
Shiselweni	2006		5	55	41	173
	2011	241365	8	55	109	173
Total	2006		10	55	56	173
	2011	1,182,480	18	55	154	173

Source: MoH (2011) Human Resources Information System

It is clear from the analysis above that the distribution of health workers favours rich urban regions and towns. The poor and rural regions and Tinkhundlas are deprived of key health personnel. The general inequitable rural/urban distribution of health workers in Swaziland may be explained by low entry of graduates or transfers into rural areas and high exit from rural health facilities.

2.1.6.3. Gender Distribution

A significantly larger proportion of health workers in urban and rural facilities are female. This is mainly due to the fact that the nursing cadre, which is predominantly female, contributes 41% to the total health workforce. In the medical profession less than 9% are female, while the rest, about 90% are male.

2.1.7. Need versus Staff Availability and Projections

Using the approved establishment as a gauge for health workforce requirements based on need, we can firmly state (using the 2010 and 2011 HRIS reports) that the current workforce had a total deficit of 19% in 2010 and 22% in 2011 for all cadres. Analysis of vacancies across cadres shows noticeable gaps in core health cadres. Laboratory Technicians had the highest deficit of 175% in 2010 and 187% in 2011, followed by Psychologists at 175% in 2010 and 120% in 2011; Medical Imaging at 147% in 2010 and 124% in 2011, Physiotherapy had a deficit of 138% in 2010 and 114% in 2011. Medical Doctors and Nurses positions in the establishment were almost fully occupied with vacancies of 21%and 22% respectively in 2011.

It must be stated however that the staff establishment does not determine the need for health workforce requirements because it was developed without taking into account demographic growth and change; disease burden; staffing norms and relevant quality standards; public demand and expectation. Currently staffing norms are being developed. They will set a more realistic basis for revising the staff establishment. The development of the revised establishment must also be informed by a skills audit which will determine the requisite skills required to provide the essential package of care. For instance Swaziland lacks specialists in Obstetrics and Gynecology, Pediatrics, Internal Medicine, Surgery, Psychiatry and Ophthalmology. The exact numbers required per level of care can only be determined through a skills audit and staffing norms.

Table 8: Distribution of Established and Vacant Posts in the Ministry, Swaziland – 2010 and 2011

POSITION	FILLED POSTS on ESTABLISHMENT		VACANT POSTS		% VACANT	
	2010	2011	2010	2011	2010	2011
Administration	165	166	38	44	23	26.5
Biomedical Engineering	32	31	3	4	9.3	13
Dental	46	45	23	26	50	58
Environmental Health	115	107	5	15	4.3	14
Health Education	13	14	16	15	123	107
Laboratory	40	38	70	71	175	187

Medical	83	105	43	22	52	21
Medical Imaging	19	21	28	26	147	124
Nursing	1187	1235	212	273	18	22
Nutrition	62	62	15	15	24	24
Other Paramedical	23	66	15	18	65	27
Pharmaceutical	30	28	30	31	100	110
Physiotherapy	13	14	18	16	138	114
Psychology	4	5	7	6	175	120
Social Welfare	2	2	1	1	50	50
Support Staff	1071	1094	31	68	2.9	6.2
GRAND TOTAL	**2905**	**3041**	**555**	**655**	19	22

Source: MoH (2010 and 2011) Human Resources Information System

Analysis of vacancy rates by regions shows that the better off regions of Hhohho and Manzini have high vacancy rates on the establishment register compared to the economically challenged regions of Lubombo and Shiselweni despite these regions reporting poor staff to population ratios. For instance, Hhohho (34/100,000) and Manzini (23/100,000) have 7 vacant positions each for medical doctors while Shiselweni which has a doctor to population ratio of 8 per 100,000 population only has one vacant position. The same pattern is observed for pharmacy and nursing cadres. This explains the inherent inequity in allocation of vacant posts to the regions by the central agencies which tend to favour the richer regions at the expense of the poor regions.

The WHO has developed methods for projecting workforce requirements which includes the workforce to population ratio methods; health needs method; service demand methods and the service target methods. It will be important that the MoH develops and institutionalizes a methodical approach to projecting workforce requirements based on any of the four methods indicated above. This will require capacity building of Health Economists and HRH Planners on preparing data sets and various parameters which will be used to compute workforce projections.

For the purposes of projecting workforce requirements under this plan, the HIV/AIDS WISN model was used to estimate the staff requirements. The HIV/AIDS model attempts to use the Full Time Equivalent (FTE) HIV/AIDS staffing requirements to project staffing needs. The model calculates target figures of patient loads eligible for Anti Retroviral Treatment (ART) and the actual time that various cadres will spend providing services to each patient.

Table 9 below shows that Swaziland will require a total of 294 Medical Doctors in 2013 and 453 by 2018. A total of 2,942 nurses will be required in 2013 and 4,527 by 2018. This would

translate to a doctor to population ratio of 0.29 per 1000 population in 2013 and 0.44 per 1000 population by 2018.The projected nurse to population ratio is 2.9 per 1000 population in 2013 and 4.4 per 1000 population by 2018. The total ratio for health workers (defined as medical doctors and nurses) is 3.2 per 1000 population in 2013 and 4.9 per 1000 population by 2018.

Table 9: Projections for health workforce requirements for the coming years

Cadre/ Year	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Medical Doctor	270	294	321	350	381	415	453	493	538	586
Nurse/ Midwives	2699	2942	3207	3496	3810	4153	4527	4935	5379	5863
Pharmacist	39	43	46	51	55	60	66	71	78	85
Pharmacy Technician	139	151	165	180	196	214	233	254	277	302
Dispenser	260	284	309	337	367	401	437	476	519	565
Data Processing Clerk	191	208	227	247	269	294	320	349	380	415
Logisticians	116	126	137	150	163	178	194	211	231	251
Record Clerks	174	189	206	225	245	267	291	317	346	377
Lab Technologists	152	166	180	197	214	234	255	278	303	330
Dental Therapist	130	142	155	169	184	200	218	238	259	283
Mental Health Officer	390	426	464	506	551	601	655	714	778	848
Nutritionist	130	142	155	169	184	200	218	238	259	283
Counsellor	449	490	534	582	634	691	753	821	895	976
Community Health Workers*	898	979	1067	1163	1268	1382	1507	1642	1790	1951
Phlebotomist	456	498	540	591	642	702	765	834	909	990
Total	6764	7374	8034	8760	9546	10407	11344	12365	13478	14699

Projections of the current available cadres (doctors, nurses, and pharmacy and laboratory staff) indicate significant deficits across all cadres against the standard requirements. If the current conditions continue unchecked, the staff availability in each cadre will continue to decline. For example, if the current situation does not change, the number of doctors will decline to 74 against requirements of 586 by 2021. This situation needs an urgent response.

Nurse production must be increased to keep up with staff requirements. This may require scaling up training through increasing the capacity of training institutions to churn out more graduates to meet the staffing requirements. Training of Pharmacy Technicians and laboratory Technicians must be introduced locally in the long term. In the interim, there must be an aggressive recruitment program of both foreign and local Swaziland nationals. Similarly, the current plan of producing certificate-level laboratory staff (phlebotomists) needs to continue in the short term.

Table 10 below illustrates the gap in key health personnel (medical doctor, nurses, pharmacists and pharmacy technicians and laboratory technicians) which must be filled through recruitment of qualified foreign professionals and Swaziland nationals in the short term and training of Swaziland nationals who will be absorbed into the health workforce in the long term.

Table 10: Estimate of Numbers to be recruited annually to meet the Workload Due to HIV/AIDS

Cadre	**Available as per 2011 HRIS**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Medical Doctors	238*	32	24	27	29	31	34	38	40	45	48
Nurses	1897	802	243	265	289	314	343	374	408	444	484
Pharmacy Technicians	60	79	12	14	15	16	18	19	21	23	25
Laboratory Technicians	114	38	14	14	17	17	20	21	23	25	27

In order to meet the workforce projections a combined effort of recruiting staff in the foreign and local workforce market and introducing locally based training programs for pharmacy technicians and laboratory technicians who will immediately be absorbed into the health system must be embarked on. The biggest numbers required are in the first and second years. For instance, in the first year there is a need to recruit 32 medical doctors. Assuming that attrition will be at 7.9%, Swaziland will only have to recruit 24 extra medical doctors in year two, 27 in year three, 29 in year four and 48 in year ten. The requirements for nurses are quiet high. In year one and two, the health system will have to recruit 802 and 243 nurses respectively. In year three 265, year four 289 and 484 in year ten nurses should be recruited. These requirements can be met from the local training schools if capacity is increased to scale up training. The system will have to recruit approximately 79Pharmacy Technicians in year one and 14 in year two. In year ten a total of 25 pharmacy technicians should be recruited. A total of 38 and 14 laboratory technicians must be recruited in years one and two respectively. In year ten 27laboratory technicians will have to be recruited.

2.1.8. Human Resources Information Systems (HRIS)

2.1.8.1. Status of the HRIS

The Human Resources Information System (HRIS) was installed in 2006. The system collects health workforce data on the approved staff establishment, filled and vacant posts. It has two data sets: Public establishments and Non Public establishment. The HRIS includes names, place of work, post, title, code and nationality. It is confidential and protected. The system operates on an access data base which was developed in house and was tested by a software developer. Staff within the HRH department at the MoH has been trained on how to operate the system. Equally, other key staff within the MoH such as the Chief Nursing Officer has been trained on how to operate the system. The system has been decentralized to the Regional Health Offices and Tertiary Hospitals and was rolled out to public and private facilities such as RFM and Good Shepherd Hospitals.

A Strategic Information Department (SID) was established to manage strategic information. This includes collection and generation of data for the Health Management Information System (HMIS), the HRIS and managing the overall monitoring and evaluation function of the MoH. Nearly all employees in the SID are not on the government payroll as most are paid by the Global Fund. The failure to put all employees on the government payroll is not sustainable in the long term as it may result in disruption of key HRIS functions due to loss of staff.

The HRIS system was developed on an access based program which could not handle a high volume of data. Due to this limitation, the system crashed in early 2012 and it has not been revived since then. Efforts are however underway to migrate data from the Access database to an SQL database.

2.1.8.2. Analysis of Various Components of the HRIS

2.1.8.2.1. Classification of Health Workers

Any health workforce analysis requires precise definition of health workers. The HRIS has classified health workers into various categories ranging from administration, medical, environmental, medical imaging, nursing and paramedical. The system however does not disaggregate the different types of cadres further into sub categories. Instead it generalizes each cadre. For instance medical doctors are merely classified as medical.

This classification does not take into account the various categories of medical doctors such as general practitioners and specialist medical doctors. The presentation of medical doctors under one category does not give more insight into the available specialist positions against need which is necessary for undertaking a skills audit. Similarly nurses must be coded into registered nurses, registered midwives, psychiatric nurses, theatres nurses etc in order to present a complete depiction of the required nursing competences and skills mix to enable HRH Planners undertake a comprehensive skills audit and make appropriate projections for the nursing cadre based on need.

2.1.8.2.2. Definition of Core Indicators to Monitors Health Workers

The HRIS does not have a core set of indicators which can be tracked routinely with periodic targets for analysis in terms of change and progress over time. Effective monitoring and

evaluation of HRH will require agreement upon a core set of indicators at the sub national, national and international levels such as indicators of staff attrition, skills mix, stock and density of the health workforce, number of education places available per cadre and existence of institutional models for projecting , monitoring and evaluating staffing requirement. Consistent measurement of these indicators will allow monitoring of how HRH-related programmes and policies are being implemented. Once the baseline data have been generated, an evaluation framework can be established with realistic targets for analysis which will inform policy and developing strategic interventions to ensure tangible progress in HRH management.

2.1.8.2.3 Competences and Capacity to Manage the HRIS (Human and Financial)

The major challenge facing the MoH is the limited human capacities to collect, compile, analyze and interpret workforce data to inform HRH policy formulation and strategic HRH decision making. The limited human, technical and financial resources have contributed to the current poor status of information and evidence on the health workforce situation.

The lack of qualified expertise in epidemiology, demography and health informatics at the national level coupled with the poor information and communications technologies (for example computer hardware and software applications for the manipulation and communication of information) needed for implementing a comprehensive HRH information system is a major concern.

For instance due to lack of expertise in Information Technology or demography within the HRH department at MoH, the HRIS has not been updated with workforce data that is submitted monthly from the regions and facilities which renders the information generated outdated for decision making. Although competences are available within the SID to perform this function issues around confidentiality restricts them from accessing the data base to make any changes because the mandate to do that is with the HRH department in MoH.

While it has been acknowledged that strengthening HRH information systems means attention to each of its components – not just the infrastructure and technology, but also the persons needed to capture and use the data, dedicated health information staff is not available at the national, regional and even at larger facilities for data collection, processing, reporting and analysis. Training may be required among those providing information to decision-makers to strengthen analytical and presentation skills. Training among policy-makers and their subordinates should also be targeted at helping them to better identify and use high-quality data on HRH.

With regard to budget allocations for Monitoring and Evaluation in general and HRIS in particular, there is no specific budget allocation to support implementation and strengthening of HRIS. Consequently, there are no resources available to buy HRIS infrastructure, train HMIS Specialists on data collection, analysis and interpretation. Training is also required for users of HRIS information.

2.1.8.2.4. Linkages with other HRH Information Systems within Government

Ideally, the HRIS should be integrated into one comprehensive information system, whereby routine administrative records are complemented with regularly conducted population-based and facility-based surveys and censuses. Data and evidence are necessary to inform discussion,

prioritization and decision-making among key stakeholders involved in HRH management across various government sectors particularly the Ministry of Public Service, Civil Service Commission, Health Training Institutions and the Ministry of Education.

The HRIS is linked and interfaces with Ministry of Public Service database to upload and share information on recruitment, retirement and updating the establishment register. However there is no platform for a direct link between the HRIS and the Regional Health Offices and the facilities. All updates are done manually by facilities and the Regional Health Offices and submitted to MoH for entry onto the database. There is equally no interface between the HRIS and training institutions to share information on health workforce supply data to ensure effective planning to absorb the new entrants into the health workforce within the MoH.

As upgrades and redesigns of the HRIS are undertaken, it will be important to pay particular attention to creating a common platform through which the HRIS can interface with databases at regional, facility, training institutions and health professional bodies.

2.2 HRH DEVELOPMENT

HRH development covers three phases of health care workers training and development namely: basic education (pre-service training), postgraduate education (specialization) and continuing professional development (in-service training and continuing medical education).

2.2.1. Pre-service Training

Scaling up educational programmes to produce multi-disciplinary service delivery teams, which include a carefully balanced mix of clinicians, community health workers and health managers, is clearly urgent and essential for Swaziland. However, simply increasing the numbers of workers will not be enough. The shortage of health workers in Swaziland is compounded by the fact that their skills, competencies, clinical experience, and expectations are often poorly suited to the health needs of the populations they serve.

A concerted effort by all stakeholders is crucial to finding answers for scaling up the health workforce to increase the quantity, and to improve the quality and relevance of health workers to meet the needs of the health sector and contribute to better population health outcomes.

2.2.1.1 HRH Production

There are three main sources of health man power for the Swaziland health sector. The first is the in-country production of nurses, midwives and nursing assistants and environmental health workers. The second source is international scholarships, which is the main supply source of medical officers. The third is active international recruitments, which is the main source for medical specialties, pharmacy, laboratory, radiology and other scare skill areas. .

2.2.1.1.1 In-Country Production

There are three health professional training institutes in the country which train nurses, nursing assistants, midwives, psychiatric nurses and environmental health workers. The institutions are responsible for recruitment of students and make decisions on the volume of entrants for each category of cadre based on their capacity. Availability of these training institutes and their increasing expansion and production of health cadres to respond to the increasing demand is an

opportunity for the escalating human resource need of the health sector. For example, in addressing the critical skill shortages in laboratory and pharmacy, Nazarene Faculty of Health Sciences has initiated a diploma program in laboratory technology and will start the pharmacy program in the next academic year. The Faculty of Health Sciences also has a plan to initiate training in these programs. But the in-country training institutions have no plans to cater for the other scare skill areas like radiology, nutrition, biomedical science and other allied health professionals.

Table 11. Number of entrants and graduates from in-country training institutes by year

Program	Number of entrants					Total Input	Number of graduates					Total output
	2008	2009	2010	2011	2012		2007	2008	2009	2010	2011	
Diploma in general nursing	126	140	133	137	138	674	121	126	127	128	130	**632**
Post graduate diploma in midwifery	40	57	91	93	122	403	36	39	39	58	85	**257**
Post graduate diploma in mental health nursing	0	3	3	1	4	11	0	0	0	3	1	**4**
Bachelor of Nursing			0		48	48						**0**
Bachelor of environmental health			0		77	77						**0**
Nursing assistants	21	20	46	46	47	180	34	21	48	46	46	**195**
Diploma in environmental health	26	29	51	46	46	198	19	20	36	28	35	**195**
Total	**213**	**249**	**324**	**323**	**482**	**1591**	**210**	**206**	**250**	**263**	**297**	**1283**

Sustainable funding from government to forge ahead with the increasing demands of the schools is going to be a challenge. Physical and organizational/operational capacity of schools are not compatible with the increasing demand for HRH, including classrooms, offices, laboratory, hostels, equipment, pedagogical tools, lecturers etc. The reduction of student allowances for accommodation has also affected the teaching learning process as students are forced to stay far away from schools. Because of this, students were not able to practice at night and it is presumed that this will have a negative effect on the attitudes of students to work on night duties after graduation.

Table 12. Perceived intake projections of the in-country training institutes 2012-2017

PROGRAMME	2012	2013	2014	2015	2016	2017	Total
Bachelor of Nursing Science	50	50	50	50	50	50	**300**
Year 4 Nursing	40	40	35	35			**150**
Year 4 Environmental	30	30	30	30	20		**140**
Bachelor of Environmental health	80	80	80	80	80	80	**480**
Post-Diploma Midwifery	90	90	90	90	90	90	**540**
Post-diploma Mental Health	4	6	6	10	10	10	**46**
Pharmacy assistant	20	20	20	15	15	10	**100**
Nursing assistants	30	30	30	30	30	30	**180**
Diploma in General nursing	90	90	90	80	80	80	**510**
Laboratory technician					30	30	**60**
Pharmacy technician			30	30	30	30	**120**
Critical care nursing				15	15	15	**45**
Anesthetics				15	15	15	**45**

The other key issue in the work force production effort in the country is the lack of a pre-service education strategy and plan. The production plans of training institutes are not informed by projected health workforce needs or staffing norms of the health sector. Moreover, there is no clear mechanism to coordinate the workforce production planning among key stakeholders, such as the training institutes, Ministry of Education and Training (MoET), Ministry of Labour and Social Security (MOLSS), and MOH.

The involvement of MoET in standard setting, need identification, career guidance of students, curriculum review, accreditation and quality improvement is not as strong as expected from its mandate. The training schools would take initiative and lead the process as there is no system put in place to monitor quality of education. Medical qualification authority to assess registration and accreditation of medical training institutes is non-existent. Currently the Swaziland Nursing Council assists in curriculum reviews and accreditation of the nursing schools.

2.2.1.1.2 Pre-service Scholarship Program

The award of scholarships to school-leavers for pre-service training is the mandate of the MOLSS. Pre-service training of health professionals in country and out of country are funded either directly by MOLSS (50% student loan) or through agreements between other donors and a number of international development assistance arrangements. The ministry develops a three year human resource profile for the country based on identified priority program areas through consultations with respective agencies, including MOH. However, the availability of funding determines the number of scholarship granted each year.

The recovery of the 50% loan from students has been way below expected as the process was voluntary. Currently the Ministry is planning to establish a revolving loan fund facility through strengthening recovery of loans by updating data and opening an account in a local commercial bank.

Doctors are trained in South Africa or other countries and receive government scholarships each year, but few or none return to work in the public sector. In general, there is no obligatory mechanism put in place that commits graduates to work in the public sector. There is also no career guidance and follow up mechanisms in place to assess the performance and conditions for scholarship students after leavening the country. Due to an incomplete database it is impossible to generate historical data on the number of scholarship granted and status of graduates. On the other hand, the coordination with MOPS to create posts for students attending scholarship is very weak.

In response to the high attrition of Swazi medical officers and to cater for other scarce skills, the Government of Swaziland in partnership with African Continent Mission (ACM) have launched the establishment of Swaziland Christian University. Although the construction is not advancing as expected, it is planned to start function in June, 2013. There is a concern that the process in curriculum development and securing the required human resource is not progressing hand in hand with the construction work.

2.2.2 In-service Training

2.2.2.1 Planning and Coordination

In service training of MOH personnel is coordinated by the MOH training unit in the HR department. Divisions and sections within MOH play a major role in the actual design and conduct of relevant local training activities. The MOH training unit prepares annual long term training plan by compiling requests from facilities and regions. As there is no established staffing norm in the facilities and there is no proper system for training needs assessment or skills audit the current long term training plan could not be responsive to the needs of the sector.

MOH personnel may be funded by MOH or nominated for funding by other agencies for participation in short-term in service training out-of-country. Post-basic and post-graduate and continuing education activities in-country are funded either directly by MOPS or under agreements between MOH, other government agencies and a number of international development assistance arrangements. However, due to shortage of funding not more than 10% of the proposed trainings are granted scholarship.

Local workshops, seminars and short courses in-country are offered by the University of Swaziland (UNISWA), Southern Africa Nazarene University (SANU), Swaziland Institute of Management and Public Administration (SIMPA), Eastern and Southern African Management Institute (ESAMI) and Institute of Development Management (IDM). The coordination of short-term in-service training for health workers in the country is very weak. Most of the time, same groups of health professionals are targeted as audience of similar training courses which differ only in the mode of delivery or organizing body. Moreover, a system for monitoring standardization of local short term training activities is not in place.

Data on in-service training are unavailable, as there is no documentation system and data base. The HRIS at MOH do not capture data related to in-service training.

MOPS has drafted in-service training policy for public servants employed under the Public Service Act. The purpose of the policy is to establish clear and effective national norms and standards with reference to training principles, priorities, and practices. However, MOH has no in-service training policy or strategy tailored to the health sector.

2.2.2.2. Continuing Medical Education

Continuing medical education program is nonexistent for any of the health care workers, except for a recent initiative by the Swaziland Nursing Council. The Swaziland Nursing Council has developed a continuing professional development (CPD) framework and is in preparation for the launch. Nurses registered with Swaziland Nursing Council will be expected to undertake at least 10 hours of continuing professional development each year prior to renewing their practising license. Participation in the CPD program for nurses in Swaziland is currently voluntary in nature although there is a requirement in the Swaziland National Health Policy for all health professionals in the country to engage in continuing education as a prerequisite to the renewal of their practising license.

It is anticipated that in the future there will be a legislated requirement for nurses to participate in a specified amount of CPD each year. The CPD program needs support in materialising its plan and improving its current initiative. Establishing a formal linkage with pre-service training program is one of those essential steps. The SNC should also develop a resource centre that provides a tailored continuing nursing education program, which could either be web based or using other realistic modes of delivery.

2.3. HRH MANAGEMENT

Personnel management for the health sector is regulated by the Ministry of Public Services (MOPS) and carried out by MOH, other Central Ministries and the Civil Service Commission (CSC) as follows:

- MOPS - setting and regulating recruitment, selection, promotion and terms and conditions for public servants as shown in the general orders and regulations; setting the government establishment register
- CSC – carrying out recruitment, promotion, discipline, retirement, according to the public service general orders and regulations
- MOH – day to day HR management, short listing and submitting requests to CSC for recruitment, promotion, and transfer.
- Other Central Ministries: MOEPD, Ministry of Finance, MOPS – recruitment, promotion and transfer of planners, accounts officers and HR officers and other admin cadres respectively.

The regulations and procedures for all public sector HR management are documented in the General Orders (1973) and the Civil Service Board (General) Regulations, which specifies post titles and grades. The General Orders are being revised to be consistent with current labour laws, the national constitution and other relevant policies and legislation.

2.3.1 Recruitment and Deployment

The current process of recruitment is considered cumbersome and long. On average it takes about 4-6 months to complete the recruitment process, and this slow process forces health workers to go to the private sector or NGOs or leave the country. The delay particularly affects employing scarce professionals amid competitive international recruitments. Due to recent communication between MOPS and MOH, the recruitment of graduating nurses and medical officers has been fast tracked.

Once staff are employed and allocated posts, it usually takes a long time, at times over four months, to receive first pay. Moreover, the process of defining and grading new posts is lengthy and sometimes inconsistent, and this has become one of the reasons for staff attritions or migrations.

The current practice of orientation/induction of new employees to the Civil Service regulations needs improvement. Program orientation is offered for new employees, but the emphasis on MOH strategic direction, values and performance standards is not strong enough. Continuous formal induction is necessary for significant cost savings by ensuring that new employees have the training they require in policies and procedures so that they can undertake their role effectively.

Deployment of workers is based on existing vacancy and request of health facilities, regions and departments. The Ministry does not have staffing norm and career progression system to guide deployment and successions. Currently the HRIS is not functioning optimally hence vacancies are tracked and posted through information obtained from health managers at facilities.

Large numbers of health cadres working for MOH are paid by development partners. Absorption of this workforce is currently a challenge as MOPS was not engaged at the initial stages to create and approve posts.

2.3.2 Transfers and Promotions

The public services procedures tend to treat employees uniformly but without consideration of the specialist needs of unique sectors, such as health. One example of this has been highlighted by the HRIS, whereby promotion is done within Post Code (the code identifying the category or sub-cadre). All "double-qualified" nurse posts - that is all the nurse specializations such as Community Health, Mental Health, Intensive Care - have the same Post Code. In some cases when a manager has requested a senior grade post to be filled, the CSC have promoted a nurse with a different specialization because they have long service but who is not appropriate for the job.

The processing of transfers and promotions is cumbersome as it is done by separate memoranda from manager to HR office and then to MOPS and back again. Health personnel may be transferred from one facility to another but their post still remains with the original facility and is recorded as filled.

Length of service continues to be used by the CSC as the top criterion for promotion; seniority is given more weight than qualifications or performance. This can happen despite MOH recommendations on selected candidates. However, some senior technical posts have been filled by the MOH directly, using competitive interviews, and this has resulted in appointment of well qualified candidates.

These problems related to recruitment, deployments, transfer and promotions are attributed to limited HR capacity at MOH and weak communications between the two agencies (MOH and CSC/MOPS). The MOH is committed to setting up a Health Service Commission to take over and improve the recruitment, deployment, promotion and development of health professionals, as stated in the HR Policy document. However, there are differing views from other government bodies and individuals that the problem with HRH management could be addressed through improving the communication between Central Government agencies and MOH and strengthening the HRH management system at MOH by capacitating the HR unit in terms of proper staffing, staff development, and improving HRIS.

2.3.3 Work Environment and Retention

Pay and working conditions in the health sector have been substantially improved in the past 10 years, particularly salary increases, access to loans and overtime payments. This has been important in retaining staff in the health services. Transfer in from NGO and Private health services, has been an important source of staff for the Ministry over the past few years, since improved salaries, benefits and allowances were introduced in 2004 and 2008, especially for nursing cadres. Some nurses are even coming back from abroad due to improved benefit packages. However there are continuing complaints for shortages of staff housing and inadequacy of housing allowances. As the on call allowances for doctors are not standardized, there are differences in the total gain from pay working at health centers and referral hospitals. It

was attested that doctors in health centers get greater number of on calls since they are few in numbers compared to doctors working in referral hospitals.

Financial incentives can contribute to retention of health workers, but to be sustainable, schemes must be complemented by non-financial incentives (improved working conditions and human resources management). In the current scenario, lack of non-financial incentives contributes significantly to the intentions of health workers to leave their jobs. Key non-financial incentives that are considered missing are recognition of efforts and good performance, supportive supervision with feedback, lack of career progression, shortage of essential equipment and tools, and threats to safety of employees. Among providers, it was strongly felt that HR managers at all levels are not well oriented to the basic principles of industrial relations. Managers need to show employees they are valued and treat them with respect as professionals.

Poor working conditions are considered the most important factor for job dissatisfaction and migration, particularly for doctors. This includes shortage of equipment and medical supplies, and proper housing. Other issues include limited attention to workplace safety (particularly TB infection prevention), increasing workload and burnout due to increasing burden of disease particularly HIV/AIDS and TB, lack of maintenance and replacement plan for equipment and lack of security in rural health clinics.

There are discriminatory inducement policies for doctors and paramedical staff recruited from other countries, who get 10% of their annual salary paid as a lump sum on recruitment and 25% at the end of their two-year contract. Locally recruited doctors and paramedical staff do not get these inducements.

Loss of staff due to death is a significant problem, which is estimated at 2.6% according to the 2004 report by MOPS. Since 2006, the Swaziland Nurses Association have been running a Wellness Centre for health workers in Manzini with a nurse and nurse/counsellor, and have publicised this widely. The Centre was strongly associated with HIV testing and treatment, rather than comprehensive health care, and were not very accessible to anyone outside Manzini city. Since 2009, the wellness centre has expanded to 15 facilities throughout the country and begun to provide comprehensive health and psychosocial counselling services. A workplace health and wellness program coordinator is assigned in the HR department to coordinate the wellness program. An HIV/AIDS workplace policy for health workers in the health sector was developed and a strategic plan was also drafted. However, the wellness program has challenges in mainstreaming the program in the overall MOH strategy and functions, including in the HRH system.

2.3.4 Performance Management

The Ministry of Public Services is the lead agency in terms of developing a Performance Management System (PMS) and guiding its implementation. The Civil Service Commission is responsible for using the results of existing performance appraisals during transfers, promotions or discipline staff, on the advice of the relevant Ministry, including MOH.

The current application of PMS at MOH has a number of deficiencies. Staff performance appraisal is currently carried out annually, but is seen to be inadequate to deal with poor quality

of health services. Supervisors and managers do not see the performance appraisal as related to the performance of their staff and the achievement of the services they are responsible for. They see it rather as a bureaucratic form filling exercise related to increments and promotion. The tool being used to appraise staff is the same across cadres and there are no checks and balances in the appraisal process. The system does not include a jointly developed and agreed performance plan with staff and the supervisor. Moreover, oftentimes supervisors and departments fail to submit appraisal reports in time.

The existing job descriptions are not a true reflection of current practice. They are also not up-to-date and very general, lacking specifics to respective cadre's job responsibilities and productivity. There are established lines of authority, but the supervisors' role and functions is not understood and little supportive supervision takes place.

A new Performance Management System is under development by MOPS. It is designed to address the problems of poor performance and to overcome the constraints inherent in the current staff performance appraisal system. It is envisaged to enhance the communication between an officer and his/her immediate supervisor. The system has in place a reward or/ and acknowledgement mechanisms for rewarding outstanding performance and remedies for unsatisfactory or poor performance. The PMS as related to the health sector is being investigated and developed taking into consideration the unique features of the sector. The implementation of the new PMS is planned to commence in 2011/12 financial year through a phased approach and to be in full operation in the next five years.

With the intention of improving quality health care delivery and improved health outcomes, the MOH in partnership with the WHO country office, developed a supportive supervision and mentoring framework, which is one of the conditions for the successful implementation of PMS. It is also envisaged that the development of this framework will support the implementation of the recent initiatives including the development of the Essential Health Care Package (EHCP), Task Shifting implementation framework and standard treatment guidelines.

2.3.5 HRH Leadership and Coordination

The key component of a strong HR management system is professionally prepared and competent HR managers who are able to perform the HR functions, namely Workforce Planning; HR recruitment, hiring and deployment practices; Ensuring conducive work environment and conditions, HR information management; and Performance management, leadership and staff development. However, MOH currently lacks institutional arrangements and capacity to lead HR planning, management and development. Some of these functions are scattered in different departments. For example the planning function has been partially fulfilled by the HR department as there is currently no structure responsible for this activity. Moreover, HR functions are centralized, and this is considered to aggravate inefficiencies in HR management at health facilities and regions.

The department is highly constrained by limited HR management capacity. The majority of the HR personnel are not HRH trained and the assignment of these personnel by MOPS did not consider required qualifications and experiences to discharge HR management functions, including workforce planning, staff training and development, intra and inter-ministerial

coordination, HRIS, etc. This problem is further aggravated by high rate of staff turnover in the department. The HR Department also has weak material capacity, such as computers, IT support for HRIS system, printers, photocopiers and communication materials.

The parent Ministry for the HR Department is MOPS. Hence recruitment, promotion and in-service training of the department are the responsibility of MOPS. Due to this administrative arrangement there is a high rate of turnover within the ministries and the challenge remains to keep experienced and trained staff in the HR department. This can be positive in providing broad experience and continuous career pathways for the staff, but also can be negative if skills that have been developed within the HR department by the respective Ministry are lost.

In 2010, the MOH developed a new MOH organisational structure and it proposes a director of Administration and HR reporting directly to the Principal Secretary. The new structure also reorganises positions to strategically address HRH pillar functions, such as HR planning, HR management, HR training and development, and human relations. An HR Officer in each Regional Administration has also been proposed. A phased approach to implementation is being considered due to the current fiscal challenges faced by the government. Open communication and close working relationship with MOPS is essential for smooth implementation of the envisaged structure.

2.3.6 Task Shifting

It is anticipated that the implementation of the Essential Health Care Package may face challenges, particularly with regard to the shortage of human resources at all levels. Efforts are being made to produce additional human resources, such as, increasing intake in the existing training institutions and introduction of training for new cadres but it may take longer to get the required human resources in place. To that end Task-Shifting should be considered as a short and medium term solution, taking advantage of lessons learnt from other countries that have already implemented task shifting.

Task shifting has been informally happening in Swaziland. The health system has spontaneously shifted some tasks from one cadre to the other in response to the workload created mainly by the burden of HIV and AIDS including the high co-infection rates of TB and other factors.

To that effect, MOH in collaboration with development partners has developed a task shifting implementation framework. Engaging MOPS at the initial stage of implementation would help to acquire solutions related to regulatory conditions and wage demand that may arise as a result of task shifting.

2.3.7 HRH Research

A number of studies have been conducted on HRH with the support from different development partners in the past five to ten years. The results of these studies have been instrumental in guiding strategies and interventions in HRH planning and development. The Ministry of health has no specific research program on HRH. Areas of research needs and agenda have not been identified and budgeted.

CHAPTER 3: STRATEGIC DIRECTION

1.1 Vision

By the year 2015, the Ministry of Health shall have in place an adequate, well-managed, efficient and motivated human resources for health capable of providing equitable access and distribution of services leading to a healthy and productive Swazi nation.

1.2 Mission

The Ministry is committed to developing a competent, dedicated, productive and client centred workforce through improved planning, management, development and utilization of human resources to deliver quality services to the population.

1.3 Goal

The goal of the strategic plan is to ensure that the right quality, quantity skill mix, and equitable distribution of health personnel are available to meet health care needs in an environment that promotes effective and safe practice.

1.4 Guiding Principles

Implementation of the plan will be governed by the following key principles:

Equity in the Distribution of Health Workforce:	Equity in the distribution of the core health workforce to ensure that imbalances in the rural and urban set up are addressed.
Integrated and Coordinated Approaches:	Implementation of strategies in a manner that ensures one strategy supports another while focusing on coordinating the inputs of various Government Agencies and partners involved in HRH planning, management and development.
Cost-effectiveness:	The HRH Strategic Plan will be implemented using the most efficient and cost-effective systems which will guarantee value for resources used.
Partnerships:	Implementation of HRH strategic interventions will give prominence to taking full advantage of the synergies provided by each stakeholder group from Central Government Agencies, Regional Health Offices, Health Facilities, Development Partners, health sector Non Governmental Organizations, and the communities.

Decentralization:	Devolution of key responsibilities, including HRH planning, development and management from the centre to the Regional Health Offices and facilities.
Evidence and Results based Planning:	Planning for HRH management and development will be based on evidence generated from HRH databases and the HRH information systems to ensure that interventions that address the core issues affecting HRH are implemented
Alignment and Harmonization:	Systems and mechanisms will be developed to ensure that the implementation of the HRH plan is aligned and harmonized with the National Development Plan, National Fiscal Adjustment Road Map, National Health Strategic Plan and Global Aid Harmonization initiatives such as the Paris Declaration on Aid Effectiveness, International Health Partnerships and the Accra Declaration on Aid Effectiveness.
Leadership:	Effective leadership in the implementation of the Strategic Plan, at all stages of the healthcare delivery system with emphasis on strengthening workforce planning, recruitment and deployment of HRH in an equitable manner, creating a conducive workforce environment and applying appropriate performance management systems.

1.5. Key Assumptions/Enabling Factors

The general conditions that should exist at both the organizational level and in the external environment to ensure successful implementation of the HRH Strategic Plan are outlined below:

- Continued commitment to the realization of health sector goals as articulated in the National Health Policy of 2007 by Government and all its Cooperating Partners
- Macroeconomic stability and sustainable economic growth
- Continued political stability and stakeholder goodwill towards the health sector
- Appropriate infrastructure to ensure a conducive work environment and reliable accommodation for health workers
- Health remains a priority sector and there is increased and sustained funding from the Ministry of Finance and Cooperating Partners for all HRH programs
- Availability of skilled and motivated health workers in line with the aspirations of the National Health and Human Resources for Health Strategic Plans

1.6. STRATEGIES

This Strategic Plan is an overarching framework for all Human Resources for Health activities in the health sector, contributing either directly towards specific targets aimed at addressing the HRH crisis facing the health sector, or more broadly, to the Ministry of Health's Strategic Plan objectives under the Human Resources for Health Component. The plan puts a strategic focus on implementing four strategic objectives or components namely:

a) A system for HRH planning established and functional across the sector by 2017

b) Adequate, qualified and competent human resources available in the health sector by 2017

c) An effectively coordinated and resourced HRH management system realized by 2017

d) Adequate financing for HRH mobilized by 2017

Table 13: Strategic Direction

Strategic Area 1: HRH PLANNING		
Strategic Objective 1.1: A system for HRH planning established and functional across the sector by 2017		
Expected Result	**Strategy**	**Activity**
Improved evidence base, strategic intelligence and understanding of labour market dynamics	**Develop Capacity for HRH planning Across the Sector**	Recruit qualified staff trained in Human Resources Management, Administration and Economics and offer short term in service training in HRH Planning at central, regional and facility levels
		Develop training programs required to strengthen HRH planning across the sector to cover key areas including approaches to HRH planning, forecasting health workforce requirements, undertaking skills audits, costing workforce requirements, analysis and interpretation of HRIS data.
		Develop structures, systems, tools and processes for Health Workforce Planning at national, regional and facility levels. Structures will include Workforce Planning Committee at Regional and Facility levels. Tools will include workforce forecasting tools, health workforce gap analysis tools, databases for workforce projections and tools for equitable distribution of health workforce. Introduce a culture of workforce planning using the developed tools through orientation of HRH and planning staff in the tools and processes developed.
		Set up a Task Team for HRH Planning which will be a subcommittee of the bigger HRH Technical Working Group. Its mandate will be to establish joint HRH planning involving all key stakeholders involved in HRH including Ministry of Public Service, Public Service Commission, Ministry of Education, Ministry of Finance, Ministry of Economic Planning and Cooperating Partners. The Task Team will ensure harmony in planning for HRH, analyze and advise on health workforce expenditure and financing on HRH

		professional development, ensure adequate resources for recruitment, retention and production for health workforce
		Mainstream HRH Planning tools at all levels of the health system through identification of staff to undergo training, training of identified staff and support supervision
	Develop Data Bases to Hoard Information for HRH Planning	Develop electronic data bases to generate information for HRH planning including attrition rates, demand for HRH, supply of HRH, needed skills, distribution of staff and staff undergoing training
		In the interim develop a depository in the Strategic Information Department (SID) where all information pertaining to HRH planning will be stored
	Develop a Staff Distribution Plan that will ensure equity in human capital across the health sector	
		Develop a health workforce distribution formula and plan that addresses the inherent rural and urban imbalances. The formula must give more weighting to the rural regions and facilities
	Develop a reliable electronic database on Health Workforce	Develop tools for data collection based on technically proven WHO models for data collection
		Develop appropriate information technology infrastructure and software for health workforce data gathering, planning and management
	Develop systems for data analysis, interpretation and regular reporting	Build capacity at national, regional and facility levels on analysis, interpretation and systematic reporting on observed trends in HRH from various data sources including the HRIS, special surveys etc to multiple stakeholders who require the information for decision making
		Create a platform through the wider Human Resources for Health Technical Working Group for disseminating reports on health workforce issues so that key stakeholders such as the Ministry of Public Service, Civil Service Commission, Ministry of Finance, Ministry of Economic Planning and Cooperating Partners are informed about key HRH issues that require their attention and interventions.
		Periodically gather information on developments in the external environment such as socioeconomic trends, political trends, and social cultural trends, technological trends including political pronouncements that may impact on HRH planning, management and development and develop interventions to address such developments.
	Provide Information that will be used to ascertain health workforce needs	Identify critical numbers of posts that should be in place so as to ensure a critical mass of competent health workers at all levels of the health care delivery system
		Identify public sector posts that should be available in order to absorb graduates, develop career paths and improve access to quality health care
	Forge International and local Strategic Alliances and Partnerships	Swaziland should become part of the international global initiatives to address the HRH crisis. This will include the WHO Global Health Workforce Alliance, the WHO African Health Workforce Observatory. These alliances provide a common platform for exchanging ideas on country innovations to address the HRH crisis and new developments on addressing various health workforce challenges
		Forge links with renowned international hospitals and health

		workers training schools to improve health workers practical skills through exchange and attachment of staff and scaling up training of core health workers
		As a way of harnessing Public Private Partnerships, assess capacities of the private sector and provide information on private sector providers who can complement the public sector in providing health services on contractual arrangements
	Revive and Upgrade the Human Resources Information System	Develop a system for classifying health workers onto the HRIS based on the WHO coding system which will disaggregate health professions into their various health specialties and sub categories
		Through consultation with all key stakeholders develop a core set of HRH indicators which will monitor progress on HRH. Indicators must include basic indicators of HRH stock and distribution, indicators of HRH labour activity, indicators of HRH productivity and indicators of HRH renewal and loss. The definition of core indicators will be bottom up with appropriate consultations with key stakeholders who will use the indicators tracked for decision making to inform the process so that the desired indicators are tracked
		Develop capacity through training of central, regional and facility level staff on collection, analysis, interpretation and presentation of HRIS data and reports to key stakeholders
		Procure hardware and software for HRIS for all levels of the health system
		Allocate 10% of program budget to M&E in general and HRIS in particular
		Develop a HRIS that is compatible and can interface with other Human Resources Information Systems at Ministry of Public Service (MoPS), Civil Service Commission (CSO), Ministry of Finance, Ministry of Labour and Social Security, Training Institutions, Professional Bodies, Regional Offices and harmonize all HRIS systems within key institutions involved in HRH
		Create a common platform where key technical staff from MoPS, CSC and MoH and the regions will meet to discuss and address operational challenges regarding the operations of the HRIS
Strategic Area 2: HRH DEVELOPMENT		
Strategic Objective 2.1: Adequate, qualified and competent human resources available in the health sector by 2017		
Expected Result	**Strategy**	**Activity**
Improved pre-service	Strengthen the coordination	Develop a comprehensive health sector pre-service training

training to meet the evidence based demand of the health sector	and strategy formulation of pre-service training	strategy
		Conduct health workforce training needs assessment (skills audit), including projections and develop a master plan on pre-service training for the health sector
		Assess alternatives and develop sustainable funding mechanisms for pre-service training institutes
		Establish a Higher Education Forum to strengthen the link between MOE, MOH, MOLSS and other key stakeholders for pre-service education
		Bring all relevant agencies for pre-service training under the coordination of SWAP
		Conduct feasibility assessment to establish training programs for cadres whose employment depend on international recruitment, in close consultation and collaboration with in-country training institutes
		Support the initiative of establishing medical education program in the country, especially in curriculum development and staffing
	Improve physical and organizational/operational capacity of training institutes	Undertake capacity assessment of training institutes, including physical and organizational/operational capacity (infrastructure, teaching learning materials, human resource, curriculum review), including capacity of health facilities where practical attachments are conducted
		Develop capacity enhancement implementation plan based on the capacity assessment result
		For a short or medium term solution use the capacity enhancement plans/proposals of the institutes to build or maintain infrastructures, equip facilities and employ human resources
		Assess the situations to retain and attract teachers in the training schools and develop retention strategy and action plans
		Conduct needs assessment and develop a continued education plan for lecturers and support staff in the training institutes
	Establish preceptorship program	Assess and identify health facilities than have the capacity to carry out the clinical practical attachment program for nurses
		Provide training and post training follow up and support for preceptors
		Support the monitoring and quality improvement of the preceptorship program

	Strengthen the regulation and quality assurance system for pre-service trainings	Advocate for the establishment of a Training Authority to govern all qualifications and trainings
		Expedite the finalization of the National Qualification Framework.
		Develop a pre-service training quality assurance system
		Build the capacity of SMDC to fully represent the other professional cadres in registration, continuing medical education programs: The capacity building activities should include proper staffing, training, computerized database establishment for registration and documenting the health cadre's profile, furnishing with computers, printers, copiers and other necessary office supplies.
Improved in-service and continuous education program linked to staff and heath sector need	Strengthen coordination of in-service trainings	Review the coordination mechanisms and composition of responsible agencies for in-service training
		Develop a guideline for coordination of in-service education
		Develop in-service training strategy for the health sector
		Develop a training coordination guideline for short term trainings provided by development partners and government agencies, which also guides standardization of trainings
		Develop a resource mobilization strategy for in-service trainings.
	Develop evidence informed and need based training plan	Develop a skills audit guideline and tools
		Conduct a regular skills audit for MOH staff on a yearly basis
		Develop a comprehensive training plan and calendar based on needs identified and established staffing norms
		Asses the capacity of professional councils to lead continued education program and provide the necessary capacity support
		Support the development of continuing medical education program for doctors and other cadres under the leadership of SMDC: needs assessment, framework development, web based training program development
		Support the Swaziland Nursing Council continuing professional development (CPD) framework implementation: establishing a web based continuing nursing education program
		Develop in-service training database
	Ensure quality of in-service trainings	Develop an in-service training quality assurance system
		Develop guideline that set minimum standards for short term

		trainings provided in the country, including accreditation mechanisms for training agencies
		Establish educational resource centers to support and encourage distance learning
		Train officers in MOH involved in training planning and management in HRH development
Strategic Area 3: HRH MANAGEMENT		
Strategic Objective3.1: An effectively coordinated and resourced HRH management system realized by 2017		
Expected Result	**Strategic interventions**	**Activity**
Effective recruitment and deployment system that ensure equitable and need based distribution of health work force in place	Strengthen recruitment and deployment procedures	Engage MOPS and CSC to review and revise recruitment and deployment procedures to reduce cumbersome process, delays and improve effectiveness in recruitment, deployment, transfers, grading of posts, etc. Define process, responsibilities and timelines
		Lobby CSC to advertise vacant posts widely on government websites
		Involve CSC and MOPS in the recruitment of donor supported posts and contracts and define process and timelines to create posts for absorption into government system
		Produce a monthly report of all staff on contract which shows their contract start date and end date so that they are monitored on a monthly basis to allow for preparation of their absorption at the end of their contract
		Undertake analysis of rural/urban staff imbalances and deploy staff in a manner that will address the intrinsic imbalances
		Review the current MOH structure to incorporate career progression and succession planning, especially within the health facility
		Engage in policy dialogue and lobby with Ministry of Public Service, Civil Service Commission, Ministry of Finance and Ministry of Economic Planning through presentation of the staffing norms and staff requirements to implement the Essential Package of Care so that they continue prioritizing the health.
		Lobby for increased Personnel Emoluments budget allocation to the health sector for new recruitment, deployment and retention of core health workers. .
		Develop a contingency plan that will address the challenges associated with over dependence on expatriate health workers

		in the long term
		Develop a program for private sector health specialists to work in public facilities on contract. Also allow them to treat their patients at well equipped public facilities at a fee
	Implement the Task Shifting framework	Assess the regulatory framework for the different cadres who are involved in task shifting
		Work with the regulatory bodies to revise regulations favorable for task shifting
		Provide training for existing and new cadres within task shifting
		Mainstream supportive supervision and mentoring systems in support of task shifting
		Monitor, evaluate and document best practices for task shifting
		Create awareness on task shifting among health care workers, managers and officials through sensitization workshops, developing and distributing brochures
Improved work environment and retention of health personnel	Reduce staff migration and turn over	Assess the existing retention schemes and the situation of internal and external migration, particularly targeting medical officers
		Develop retention strategy addressing the needs of all health personnel: Establish task force to lead the process, particularly involve professional associations and councils
		Assess areas with scarce skill and define and grade posts
		Enforce bonding arrangement with medical students and other cadres pre-service training program to ensure their commitment for service in government after graduation
		Establish a follow –up mechanisms for medical doctors training program, through mentorship, supportive supervision
		Find out the country's Diaspora and from those who come back, especially from the medical officers, what conditions might bring them back to the country
		Work with SA Medical Council and other relevant bodies to control the registration of Swazi Medical Officers graduating from SA Universities: Establish a bilateral agreement to ensure that registrations will only take place if only official support letter is provided by Swaziland MOH.
		Advocate and lobby relevant department in the MOH and Government to equip and furnish health facilities according to the EHCP
		Balance the benefit packages of local medical officers with

		expat staff, including accommodation
		Recruit students for pre-service medical education who likely to serve
	Work with Universities in SA to expand the medical officers internship programs in Swaziland	Under the director of health services establish medical officers internship program that oversees the establishment and implementation
		Work with SA Universities on drafting guideline for the program, including selection of internship sites, selection and assignment of tutors/preceptors, working modalities, rotations
		Prepare the necessary logistic, including housing, transport, allowances for the interns and preceptors
	Improve job satisfaction, working and living conditions.	Review and incorporate the occupational safety and health structure in the wellness program: Create post and assign occupational safety and health officer at MOH and each region.
		Provide training to Bio-Medical Staff on maintenance and replacement of new machines and equipment
		Lobby the relevant department to develop maintenance and replacement plan
		Work with relevant department in MOH to train store managers on procurement, maintenance and replacement
		Advocate for the development of policy to regulate donated equipment
		Hire private security firms to provide security services in clinics
		Review the current on-call circular and standardize the on call allowances for doctors
		Work with relevant Government body to identify suitable accommodation, or other solutions, including building staff accommodations where required. Before transfers are carried out the Ministry of Health, especially in rural areas, should first explore availability of renting facilities in the areas.
		Legalize health workers to work at private practices during their own spare time.
		Establish a forum for regular consultations with key stakeholders (unions, etc.) on the issue of improving job satisfaction, working and living conditions.
Improved HRH performance	Work hand in hand with MOPS to implement the new PMS	Review and develop clear job descriptions tailored to each cadre performance plan and MOH strategic plan

management system	under development	Assess and develop clear reporting structures within departments
		Assess and define a continuous monitoring for PMS
	Implement the supportive supervision and mentoring framework	Build the capacity of supervisors through 1) integration of supportive supervision in induction curriculum; 2) training using standardized curriculum
		Develop tools and guidelines for supportive supervision
Enhanced leadership and coordination capacity of HR department at MOH	Improve HR management capacity of HR department	Assess need and provide training of existing HR department staff at MOH in HRH planning, development and management
		Short term secondment of HR specialist to provide technical guidance and advise in HR planning, management and development
	Strengthen the structure and functions of HR management at MOH	Review procedures of assignment of MOPS staff in MOH HR department to reduce inter- ministerial staff turn over
		Work with MOPS to revisit procedures in assigning HR staff for the department with proper qualification and experience
		Redefine the HR department functions at MOH to lead and coordinate HR planning, development and management responsibilities: create post and assign staff for HR planning
	Decentralize HR functions to Regions	Establish HR manager position for each region and deploy personnel
		Train HR managers at regions in HR planning, development and management
		Train supervisors at health facilities in HRH planning, management and development
		Orient managers at regions and facilities on the HRH tools, including performance appraisal, supervision and mentoring tools.
Strategic Objective 4: Adequate financing for HRH mobilized by 2017		
Sustainable financing for HRH	Mobilize additional resources for implementation of HRH activities	Develop an HRH resource mobilization strategy
	Forge International and local Strategic Alliances and Partnerships	Participate in international global initiatives to address the HRH crisis including WHO Global Health Workforce Alliance, the WHO African Health Workforce Observatory. These alliances provide a common platform for exchanging ideas on country innovations to address the HRH crisis and new developments on addressing various health workforce challenges

		Forge links with renowned international hospitals and health workers training schools to improve health workers practical skills through exchange and attachment of staff and scaling up training of core health workers
		As a way of harnessing Public Private Partnerships, assess capacities of the private sector and provide information on private sector providers who can complement the public sector in providing health services on contractual arrangements

CHAPTER 4: INSITUTIONAL ARRANGMENTS AND COORDINATION MECHANISMS

4.1 Approach

It is crucial that all relevant stakeholders are actively involved in the implementation of the strategic plan. Stakeholders include government, cooperating partners, private sector and civil society. Each player has specific roles and responsibilities in ensuring that each of the components of the strategic plan is fully implemented.

The Ministry of Health will assume a lead role in the implementation of the plan. In particular, the MOH will coordinate and facilitate the implementation of all the components of the plan through the human resources department. All activities will be initiated by the MOH with support from the other key players. The HRH Technical Working Group chaired by the MOH Under Secretary (Administration) is expected to play a pivotal role in advising and providing technical expertise. The MOH will also collaborate with the MOE to establish a Higher Education Forum for Health geared towards development of health workers. The forum will also involve all pre-service training institutions in the country.

Monitoring and evaluation of the plan including reporting on progress will also be a responsibility of the MOH through the Strategic Information Department (SID). This will be done in line with the M&E framework developed for the plan.

The Central Agencies (MOPS, MOF and MOEPD) will support the MOH in fully implementing the plan. Their roles are not expected to deviate from what they normally do. However, it would be crucial that they provide the necessary advice to ensure that implementation of the plan remains consistent with government's vision and overall development strategy (e.g budget outlook, Economic Recovery Strategy, Fiscal adjustment roadmap, MTEF and National Development Strategy). The Central Agencies will be expected to assist the MOH to generate the adequate numbers and skills for the sector within the available resource envelope. All the sectoral officers from these agencies will actively participate in the HRH TWG.

The MOE and MOLS are line ministries relevant to the implementation of the plan. Links with the MOE and MOLS will be strengthened, in particular, with the Under Secretary (Administration) at MOH. The MOE will be represented in the HRH TWG and will also co-chair the Higher Education Forum for Health. The MOH is expected to forge stronger relationship with MOLS especially with regard to prioritizing scholarships for health related training.

Cooperating partners including UN agencies and USAID funded agencies will continue providing technical expertise and funding. The MOH will make a deliberate effort to prioritize HRH in most of their partnerships over the next five years.

NGOs and FBOs are expected to implement some of the activities captured in the plan. To some extent, this includes capacity building, recruitment and retention.

The key stakeholders involved in the implementation of the strategic plan and their roles are outlined in the table below;

Table 14: Institutional Arrangements

Organization	Roles in HRH	HRH-related initiatives
Ministry of Health	HRH policy and strategy development, HRH planning, maintaining training database, day-to-day human resources management, short listing candidates and submitting requests to CSC for recruitment, promotion and transfer	Coordinating the national structures/forums related to HRH e.g HRH TWG, Creating enabling policy and legal environment (facilitating approval of bills) Facilitating monitoring and evaluation of the plan
Ministry of Public Service	Setting and regulating recruitment, selection, promotion and terms and conditions for public servants, as shown in the general orders and regulations; setting the government establishment register	Approval of additional posts in MOHSW establishment Salary increments and improvements in benefits
Ministry of Labor and Social Security	Facilitating the award of scholarships for pre-service training	Implementation of a Scholarship Policy that will favor the development of health related cadres
Ministry of Finance	Mobilizing and providing public finance Setting the budget and economic outlook for the country	Prioritizing the financing of health and meeting the Abuja Declaration
Ministry of Economic Planning and Development	Mobilizing and providing capital funding Setting the National Development Agenda for the country	Prioritizing the implementation of the Human capital development component as reflected in the Economic Recovery Strategy
Ministry of Education	The highest responsible body for pre-service education Recruitment, placement and follow-up of students for pre-service training. Funding or facilitating funding for scholarships	Setting standards for higher education in health Coordination of higher education forum in collaboration with MOH
Civil Service Commission	Carrying out recruitment, promotion, discipline, leave, retirement, according to the public service general orders and	Fast tracking recruitment of staff to meet staffing norms

	regulations	

Organization	**Roles in HRH**	**HRH-related initiatives**
HRH Technical Working Group	Providing technical advice on HRH related issues to the MoH and relevant stakeholders	Coordinating input, resources and effort of different stakeholders involved in HRH activities in the health sector.
Medical and Dental Council and Nursing Council	Registration, licensure, drafting scope of practice, and standards of care	Revising professional acts Development of scope of practice
Training Institutions UNISWA, SANU, Good Shepherd, SIMPA, IDM)	Pre-service and in-service training	Increased numbers of health workers Improved skills and knowledge amongst health workers
HRAA project	HRH capacity-building	Providing Technical and financial assistance for implementation of specific activities in the HRH annual operational plan.
WHO	HRH technical capacity-building and standardization	Providing Technical and financial assistance for implementation of specific activities in the HRH annual operational plan.
Other donors (PEPFAR, Global Fund, UN agencies)	HRH capacity-building	Providing Technical and financial assistance for implementation of specific activities in the HRH annual operational plan

CHAPTER 5: FINANCING PLAN

5.1 Costing of the Strategic Plan

Background

With funding from the PEPFAR office in Swaziland, technical assistance was obtained from the USAID global project 'Health Systems 20/20' (HS 20/20) to perform the costing of the strategic plan. Accordingly, HS 20/20 led the process of designing a costing framework, developing an Excel-based computerized costing tool, and accomplishing the cost estimates for the strategic plan. As part of the technical assistance, also was conducted a 3-day capacity strengthening training workshop for a group of local specialists, to impart to them the knowledge and skills of costing HRH plans using the tool. Representatives from a number of relevant ministries and technical organizations attended the training. It is expected that these local specialists would spearhead the future work on adapting the costing tool and the cost estimates, as warranted by the strategic plan implementation process.

The costing tool follows the activity-based costing approach, and is organized around the following key activity areas:

- Workforce mobilization needs
  - Salary and allowance costs
  - New hiring costs, including induction training
- Pre-service training needs (Student scholarships costs; PST institution strengthening costs, including both capital/development and recurrent/operational support)
- In-service training needs (IS training costs; IST institution strengthening costs, including both capital/development and recurrent/operational support)
- Retention and productivity improvement needs (Financial incentive costs; infrastructure improvement costs, including both capital/development and recurrent/operational support)
- Strengthening of HRH systems and functions needs (MOH HR functions and other HRH systems strengthening costs)

Collection of all related input-data for the cost estimates was coordinated by the Health Resource Alliance in Africa office in Swaziland under the overall leadership of the HRH Strategic Plan Technical Working Group, with support from the East Central and Southern African Health

Community (ECSA-HC). Data was obtained from the MOH, MOPS, MOLSS and other national sources. The cost estimates were made using the costing tool.

Underlying Assumptions

1. Seven HRH cadres were considered as the focus for the current strategic plan: Medical officers (including Specialists, Medical & Dental), Nurses (Assistant, General & Staff Nurse), Dentists (Hygienists/Assistants), Pharmacy technicians & Pharmacists, Laboratory technicians, Environmental Health staff (Officers/Assistants), and Medical imaging technicians (Radiographers).
2. Year-wise targets (projections) for mobilizing the priority cadres were based on attaining complete fill-up of the establishment-approved staffing positions for the MOH systems as well as for Nazarene and Good Shepherd health facilities during the strategic plan period (2012-2017). The target numbers were worked out separately for the four regions, and were adjusted for the corresponding population growth rates. Population figures and growth rates were taken from the UNFPA document on "Swaziland Population Projections: 2007-2030".
3. Year-wise targets (projections) for hiring new positions during the strategic plan period were adjusted for the national staff attrition rate for the health sector (7.9% per annum).
4. The costing tool was made flexible to recalculate the target projections for workforce mobilization and new hires for the HRH cadres as prioritized by the strategic plan, based on the upcoming recommendations of the ongoing staffing norm study in Swaziland.
5. Salary and allowance costs were calculated on the basis of: (a) Average base salary (average of the highest and lowest grade/notch) per employee for the priority HRH cadres considered as the focus for the strategic plan; (b) Average of housing, transport and other standard benefits/allowances per employee; (c) Presumed percentage of employees receiving these benefits; and (d) Average rate of base salary increment per year.
6. For estimating the new hire costs, detailed costing of recruitment expenses such as advertisement, interview, post-selection, induction training for the newly-hired employees was considered.
7. In estimating the Pre-service training (PST) costs, scholarship support (student stipend costs) to be offered by the government in the production of priority HRH cadres, as well as institutional support (capital and recurrent/operational costs) planned for strengthening the local PST institutes (Nazarene, Good Shepherd, University of Swaziland, Sithobela) were considered.
8. In-service training (IST) costs were estimated on the basis of 2 types of training for the priority HRH cadres: Continuing medical education (CME)-type of short-term training each year for a presumed percentage of employees, and Long-term course to train a planned number of employees in various specialty areas. Although the costing tool possesses the provision to incorporate the institutional support costs (capital and recurrent/operational) intended for strengthening the local IST institutes, the current cost estimates presumed no such costs. The TWG maintained that no additional infrastructural development needs were required in the current strategic plan period since the relevant IST institutions are housed in relatively newly built structures with no imminent requirements for any major construction or refurbishment.
9. To estimate the retention and productivity improvement costs, direct financial benefits planned for the priority HRH cadres as well as planned infrastructural support (capital and

recurrent/operational costs) to boost up retention and productivity improvement was considered.

10. Costs for strengthening the HRH systems and MOH HR functions were ascertained on the basis of data provided in 2 capacity-strengthening areas: (a) Training needs for MOH staff on various topics germane to HR planning and management; and (c) Certain infrastructure development needs.
11. The costing exercise was concluded with the development of 2 scenarios:

    Scenario #1 (or the base model) that assumed a 100% attainment of the strategic plan yearly target numbers for mobilizing the priority cadres in all 4 regions of the country, right from the 1st year of implementation;

    Scenario #2 presumed a phased implementation that gradually reaches to 100% over years as proposed below. This implementation option could be considered as Plan–B, which is suggested in the case that financing arrangements (government and donor together) are not adequate to implement Scenario 1.

Table 15: Scenarios: Phasing of Implementation

Regions	Year 1	Year 2	Year 3	Year 4	Year 5
Manzini	80%	85%	90%	95%	100%
Hhohho	75%	80%	85%	90%	100%
Lubombo	90%	95%	100%	100%	100%
Sheselweni	95%	100%	100%	100%	100%

The above phasing presumptions were made so as to attain a somewhat balanced staffing norm across the regions. However, these assumptions might always be changed in the costing tool, as the strategic plan implementation process may deem it required, and the corresponding new cost estimates be derived.

Summary of the Cost Estimates for the Strategic Plan

Detailed information on the staffing numbers for Scenario #1 and Scenario #2 could be found in the tables and charts appended in Annex 2 and Annex 3, respectively, at the end of the strategic plan document. The numbers for currently approved and currently filled staffing positions, gaps in the current staffing deployment, and year-wise strategic plan targets (projections) for mobilizing priority cadres together with the new hiring targets have been is exhibited in these tables and charts.

A summary of the key staffing numbers for Scenario #1 and Scenario #2, respectively, has been presented below in Tables 5.1 and 5.2.

Table 16: Scenario #1 Staffing Numbers for Currently Approved, Currently Filled, and Year-wise Strategic Plan Targets for Mobilizing HRH Priority Cadres
(Adjusted for Population Growth and Staff Attrition Rates)

Priority HRH cadres	Currently approved positions	Currently filled positions	Strategic plan targets for mobilizing					Strategic plan targets for new hiring				
			Year 1	Year 2	Year 3	Year 4	Year 5	Year 1	Year 2	Year 3	Year 4	Y
Medical Officers (Includes Specialists, Medical & Dental)	163	143	163	165	167	169	172	31	15	15	15	
Nursing (Assistant, General & Staff Nurse)	1,689	1,508	1,689	1,711	1,732	1,755	1,778	300	156	157	160	
Dental (Hygienists/Assistants)	36	15	36	36	37	37	37	22	2	3	2	
Pharmaceutical (Pharmacy technicians/ Pharmacists)	40	21	40	40	41	41	42	21	3	4	3	
Laboratory (Lab Technicians)	47	18	47	47	47	48	49	29	4	4	5	
Environmental health (Officers/Assistants)	84	73	84	84	86	87	88	16	6	8	7	
Medical imaging (Radiographers)	38	18	38	38	38	40	40	20	3	3	5	
Total	2,097	1,796	2,097	2,121	2,148	2,177	2,206	439	189	194	197	

Table 17: Scenario #2 Staffing Numbers for Currently Approved, Currently Filled, and Year-wise Strategic Plan Targets for Mobilizing HRH Priority Cadres
(Adjusted for Population Growth and Staff Attrition Rates)

Priority HRH cadres	Currently approved positions	Currently filled positions	Strategic plan targets for mobilizing					Strategic plan targets for new hiring				
			Year 1	Year 2	Year 3	Year 4	Year 5	Year 1	Year 2	Year 3	Year 4	Y
Medical Officers (Includes Specialists, Medical & Dental)	163	143	146	150	153	158	172	14	15	15	17	
Nursing (Assistant, General & Staff Nurse)	1,689	1,508	1,542	1,569	1,584	1,663	1,778	153	149	139	204	
Dental (Hygienists/Assistants)	36	15	30	31	33	35	37	16	2	3	4	
Pharmaceutical (Pharmacy technicians/ Pharmacists)	40	21	34	36	38	39	42	15	5	5	4	
Laboratory (Lab Technicians)	47	18	39	42	44	46	49	21	7	6	6	
Environmental health (Officers/Assistants)	84	73	75	78	81	83	88	7	8	8	8	
Medical imaging (Radiographers)	38	18	32	33	35	38	40	14	4	5	6	
Total	2,097	1,796	1,898	1,939	1,968	2,062	2,206	240	190	181	249	

Scenario #1 Cost Estimates

As explained above, Scenario #1 aims at urgent fill-up of the existing gaps in the approved staffing establishment. This is the desired model recommended for implementation in the first order. However, as the findings of the pending staffing norm study become available, the strategic plan targets for HRH mobilization and hiring would require undergoing re-adjustments, leading in turn to changes in the cost estimates.

Year-wise cost estimates for implementing Scenario #1, broken down by the key activity/cost areas for the strategic plan as well as by capital and recurrent costs, is provided in Table 5.3.

Table 18: Summary of Cost Estimates for Scenario #1, by Key Activity/Cost Areas of the HRH Strategic Plan, and by Capital and Recurrent Costs (In Million Emalangeni)

Activity/ Cost Areas	Year 1			Year 2			Year 3			Year 4			Year 5	
	Rec	Cap	Tot	Rec	Cap	Tot	Rec	Cap	Tot	Rec	Cap	Tot	Rec	Cap
Salary & allowance costs	483.2		483.2	502.8		502.8	523.9		523.9	546.3		546.3	570.6	
Hiring costs	4.2		4.2	1.8		1.8	1.9		1.9	1.9		1.9	1.9	
Pre-service training costs	54.5	17.5	72.0	59.3	40.2	99.5	64.5	47.1	111.6	70.3	37.4	107.7	76.6	15.0
In-service training costs	9.2	0	9.2	1.8	0	1.8	1.8	0	1.8	1.8	0	1.8	1.9	0
Retention & productivity improvement costs	5.6	4.8	10.4	5.9	14.8	20.7	6.2	11.0	17.2	6.6	8.5	15.1	7.0	5.0
HRH systems & MOH HR functions strengthening costs	0.3	0.7	1.0	1.1	0.4	1.5	0	0	0	0	0	0	0	0
TOTAL	**557.0**	**23.0**	**580.0**	**572.7**	**55.4**	**628.1**	**598.3**	**58.1**	**656.4**	**626.9**	**45.9**	**672.8**	**658.0**	**20.0**
Percentage shares	**96%**	**4%**	**100%**	**91%**	**9%**	**100%**	**91%**	**4%**	**100%**	**93%**	**7%**	**100%**	**97%**	**3%**

As seen from above, Scenario #1 implementation of the HRH strategic plan would require E580 million in Year 1, E628 million in Year 2, E656 million in Year 3, E673 million in Year 4, and E678 million in Year 5. More than 90% of these costs account for recurrent costs (also refer to Figure 5.1 below).

HRH strategic plan activity/cost area-wise, salary and allowance is the single biggest item, followed by pre-service training and retention & productivity improvement costs. Percentage shares of the individual activity/cost areas in the yearly totals for implementing the HRH strategic plan are displayed in Figure 5.2. Salary and allowance occupies 80% to 84%, pre-service training 12% to 17%, and retention & productivity improvement 2% to 3% of the yearly implementation costs. Relative shares of hiring, in-service training, and HRH systems & MOH HR functions strengthening are fairly low.

Figure 1: Scenario-1 Percentage Shares of Capital and Recurrent Costs in the Yearly Totals for Strategic Plan Implementation (Total Costs in Million Emalangeni)

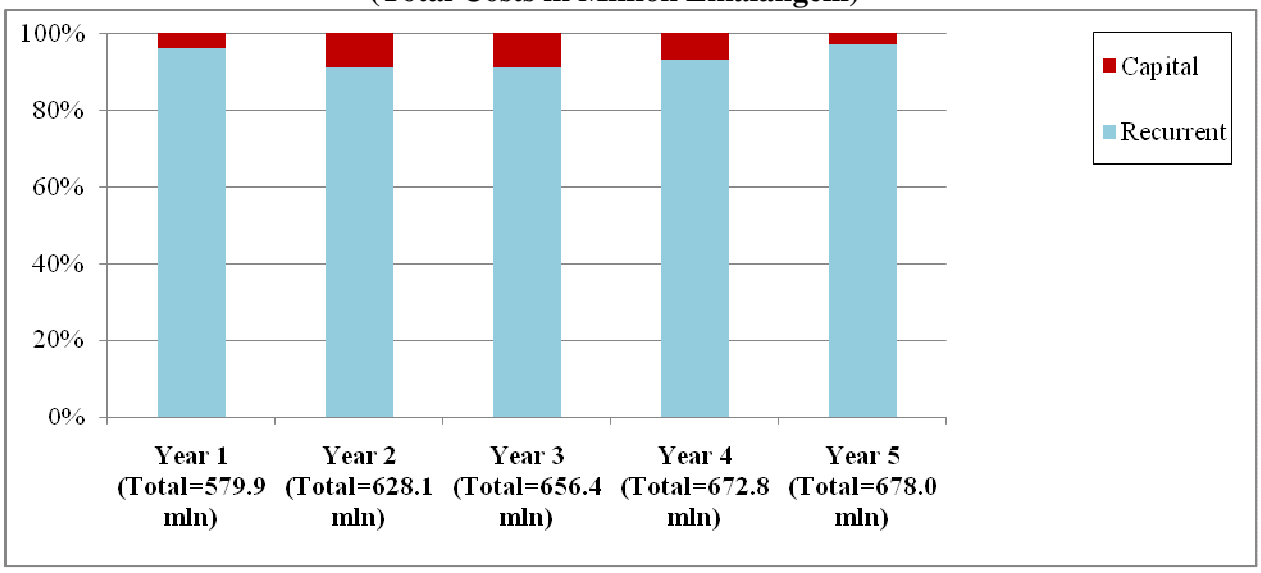
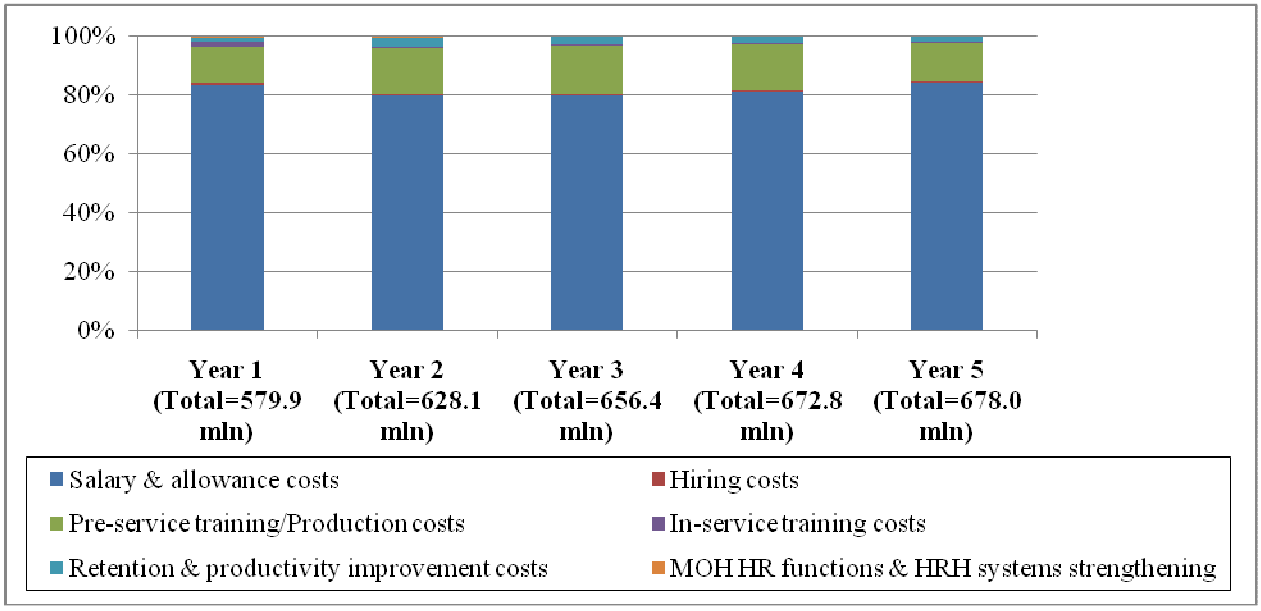


Figure 2: Scenario-1 Percentage Shares of the Strategic Plan Components in the Yearly Totals for Strategic Plan Implementation (Total Costs in Million Emalangeni)



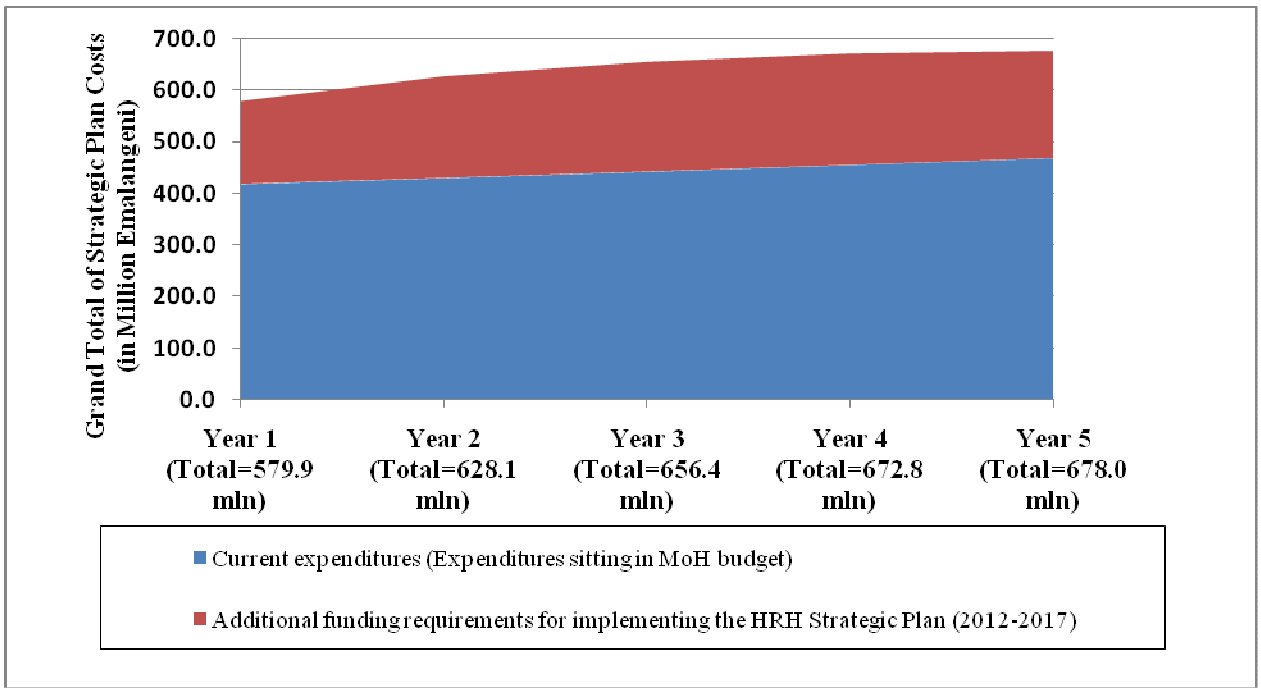
The HRH strategic plan implementation costs estimated above includes certain items part of which are borne by the government through the current MOH budget expenditures. For example, the strategic plan costs include salary and allowance costs for the target number of priority cadres to be mobilized within the plan. But the target numbers for the priority cadres are comprised of staff numbers currently available under the budget-supported establishment as well as the incremental needs (positions to be newly hired). Therefore, to derive the net additional cost implications of the strategic plan, the total implementation costs might require some adjustment for such pertinent government (budgetary) contributions.

Accordingly, additional funding needs for implementing Scenario #1 of the HRH strategic plan have been summarized in Table 5.4 and Figure 5.3. Thus, the net incremental costs for Scenario #1 implementation of the HRH strategic plan would amount to E162 million in Year 1, E198 million in Year 2, E214 million in Year 3, E217 million in Year 4, and E209 million in Year 5.

Table 19: Summary of Additional Funding Needs for Implementing Scenario #1 of the HRH Strategic Plan (In Million Emalangeni)

Required and Current costs	Year 1	Year 2	Year 3	Year 4	Year 5
Grand total of the estimated costs for the new Strategic Plan	580.0	628.1	656.4	672.8	678.0
Minus:					
Current MOH budget expenditure on salary & allowance costs for existing staff	418.4	430.2	442.5	455.4	468.9
TOTAL	**161.6**	**197.9**	**213.9**	**217.4**	**209.1**

Figure 3: Scenario-1 Year-wise Total of the Strategic Plan Costs, Current Government Expenditures, and Additional Funding Needs for Implementing the HRH Strategic Plan (Total Costs in Million Emalangeni)



Scenario #2 Cost Estimates

As described earlier, Scenario #2 is an alternative option suggested in the case that likely mobilization of actual funding for implementing Scenario #1 is anticipated inadequate, and a phased attainment of the target HRH numbers, with lower implementation costs, would have to be explored.

Year-wise cost estimates for implementing Scenario #2, broken down by the key activity/cost areas for the strategic plan as well as by capital and recurrent costs, is provided in Table 5.5.

Table 20: Summary of Cost Estimates for Scenario #2, by Key Activity/Cost Areas of the HRH Strategic Plan, and by Capital and Recurrent Costs (In Million Emalangeni)

Activity/ Cost Areas	Year 1			Year 2			Year 3			Year 4			Year 5		
	Rec	Cap	Tot	Rec	Cap	Tot	Rec	Cap	Tot	Rec	Cap	Tot	Rec	Cap	Tot
Salary & allowance costs	436.8		436.8	459.4		459.4	480.0		480.0	516.0		570.6	570.6		570.6
Hiring costs	2.3		2.3	1.8		1.8	1.7		1.7	2.4		2.9	2.9		2.9

Pre-service training costs	54.6	17.5	72.1	59.3	40.2	99.5	64.5	47.1	111.6	70.3	37.4	76.6	76.6	15.0	91.6
In-service training costs	9.0	0	9.0	1.7	0	1.7	1.7	0	1.7	1.7	0	1.9	1.9	0	1.9
Retention & productivity improvement costs	5.0	4.8	9.8	5.4	14.8	20.2	5.7	11.0	16.7	6.2	8.5	7.0	7.0	5.0	12.0
HRH systems & MOH HR functions strengthening costs	0.3	0.7	1.0	1.1	0.4	1.5	0	0	0	0	0	0	0	0	0
TOTAL	**508.0**	**23.0**	**531.0**	**528.6**	**55.4**	**584.0**	**553.6**	**58.1**	**611.7**	**596.6**	**45.9**	**642.5**	**659.0**	**20.0**	**679.0**
Percentage shares	**96%**	**4%**	**100%**	**91%**	**9%**	**100%**	**91%**	**4%**	**100%**	**93%**	**7%**	**100%**	**97%**	**3%**	**100%**

As seen from above, Scenario #2 implementation of the HRH strategic plan would require E531 million or around E50 million less than Strategy #1 in Year 1, E584 million or E44 million less than Strategy #1 in Year 2, E612 million or also E44 million less than Strategy #1 in Year 3, E643 million or E30 million less than Strategy #1 in Year 4, and E679 million or nearly E1 million more than Strategy #1 in Year 5. Similar to Strategy #1, also for Strategy #2, more than 90% of these costs account for recurrent costs (refer to Figure 5.4 below as well).

In Scenario #2 too, HRH strategic plan activity/cost area-wise, salary and allowance is the single biggest item, followed by pre-service training and retention & productivity improvement costs. Percentage shares of the individual activity/cost areas in the yearly totals for implementing the HRH strategic plan are displayed in Figure 5.5. Salary and allowance occupy 79% to 84%, pre-service training 14% to 18%, and retention & productivity improvement 2% to 3% of the yearly implementation costs. Relative shares of hiring, in-service training, and HRH systems & MOH HR functions strengthening are fairly low.

Figure 4: Scenario-2 Percentage Shares of Capital and Recurrent Costs in the Yearly Totals for Strategic Plan Implementation (Total Costs in Million Emalangeni)

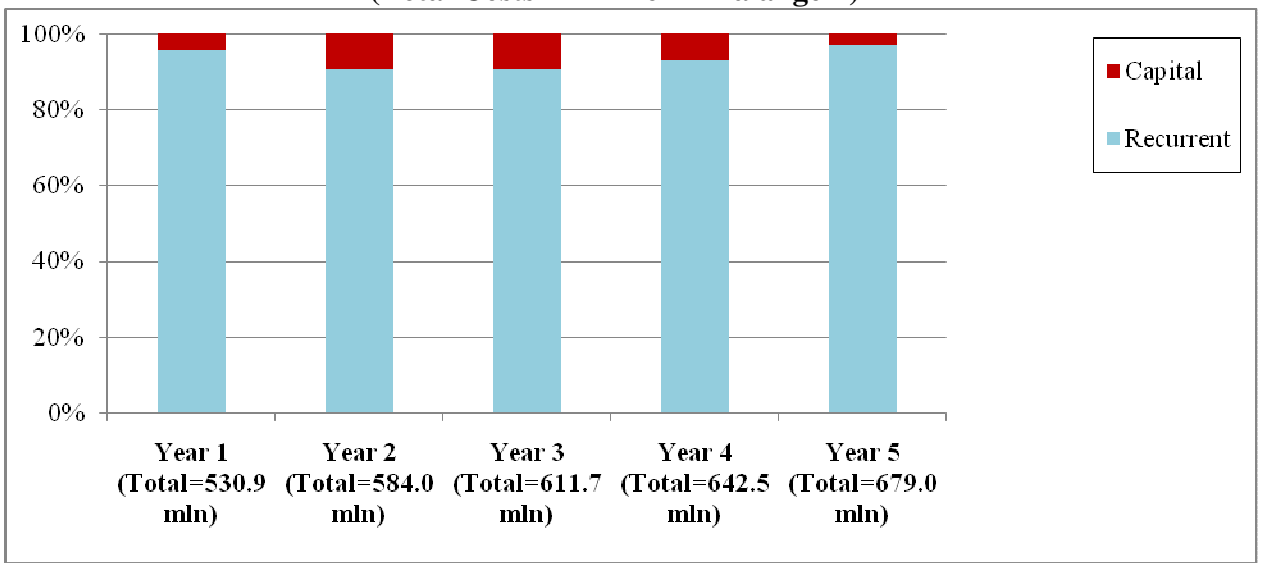
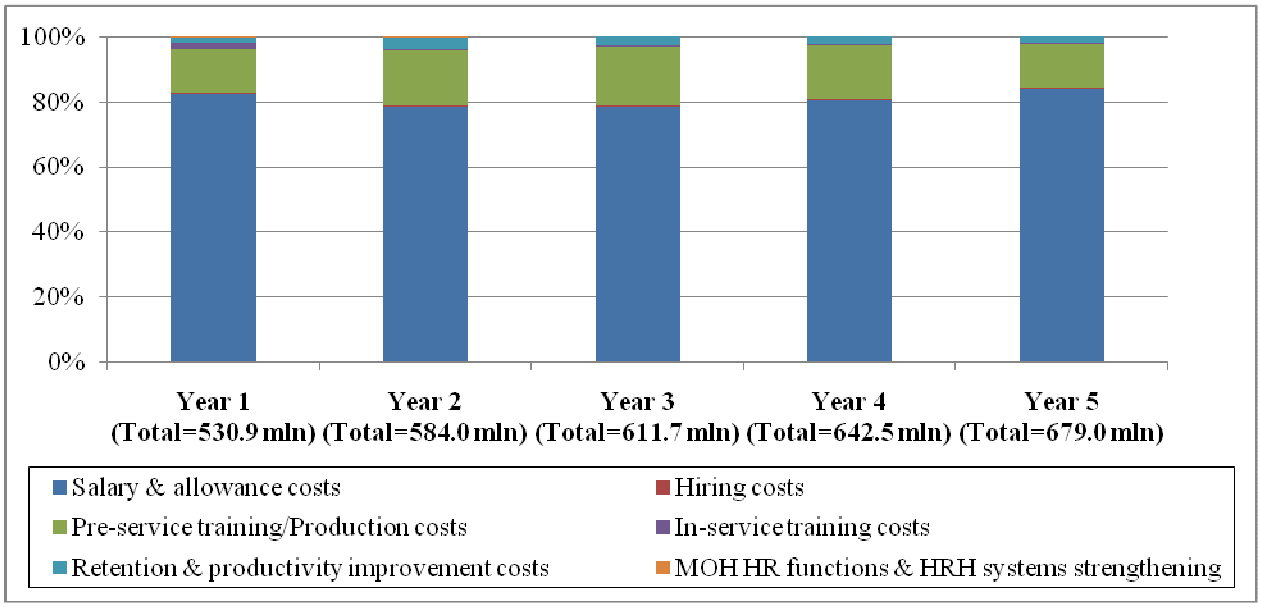


Figure 5: Scenario-2 Percentage Shares of the Strategic Plan Components in the Yearly Totals for Strategic Plan Implementation (Total Costs in Million Emalangeni)



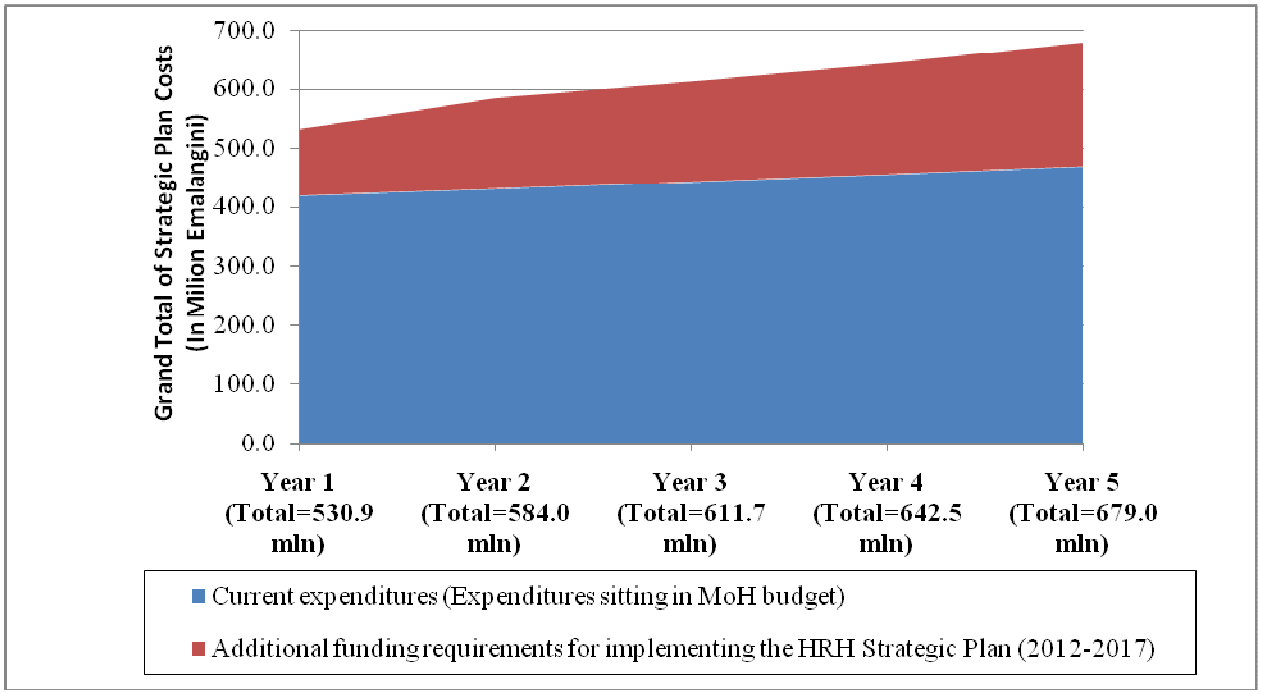
Additional funding needs for implementing Scenario #2 of the HRH strategic plan have been summarized in Table 5.6 and Figure 5.6 below. Net incremental costs for Scenario #2 implementation of the HRH strategic plan would amount to:

E113 million in Year 1 (as against E162 million for Strategy #1)
E154 million in Year 2 (as against E198 million for Strategy #1)
E169 million in Year 3 (as against E214 million for Strategy #1)
E187 million in Year 4 (as against E217 million for Strategy #1)
E210 million in Year 5 (as against E209 million for Strategy #1).

Table 21: Summary of Additional Funding Needs for Implementing Scenario #2 of the HRH Strategic Plan (In Million Emalangeni)

Required and Current costs	Year 1	Year 2	Year 3	Year 4	Year 5
Grand total of the estimated costs for the new Strategic Plan	530.9	584.0	611.7	642.5	679.0
Minus:					
Current MOH budget expenditure on salary & allowance costs for existing staff	418.4	430.2	442.5	455.4	468.9
TOTAL	**112.5**	**153.8**	**169.2**	**187.1**	**210.1**

Figure 6: Scenario-2 Year-wise Total of the Strategic Plan Costs, Current Government Expenditures, and Additional Funding Needs for Implementing the HRH Strategic Plan (Total Costs in Million Emalangeni)



5.2 Financing the Plan

Despite the prevailing economical and financial challenges faced by the country, government has officially stated that the Ministry of Health remains a priority sector (Budget Outlook Paper 2011/12). The MOH has been given the leeway to continue hiring and filling of critical posts including funding of selected operational costs such as maintenance of medical equipment, procurement of drugs and medical supplies and support supervision to the regions and facilities. The Economic Recovery Strategy (ERS) also prioritizes human capital development, placing emphasis on development of the health workforce. Specifically, one of the strategies in the ERS is to "Prioritize funding of education & health and streamline spending to achieve efficiency and effectiveness of such spending".

On the other hand, the continued support from development partners has cushioned the health sector from the negative effects of the fiscal constraints. Partners have continued funding service delivery through employing and training (pre-service and in-service) of health workers. It is anticipated that most partners will be supporting the MOH over the duration of the strategic plan.

Financing of the plan will be based on the commitments made by both the Government of Swaziland and its and Cooperating Partners supporting the health sector. Projected inflows from donor sources including the Global Fund, PEPFAR, World Bank, World Health Organisation, UNICEF will complement Government efforts to support the implementation of the plan. A Memorandum of Understanding between the MOH and the Cooperating Partners to provide a financing and coordinating framework for the National Health Strategic Plan and the HRH Strategic Plan will be developed. Initiatives will be made to reengineer available financing such as the Phalala Fund and the Medical Referrals Scheme for Civil Servants to expand coverage of patients that require specialized treatment abroad. This will involve, amongst others, drawing resources from the two schemes to finance bringing into the country specialist medical doctors on contract to undertake locums in Swaziland for periods ranging from one week to one month during which they will treat all patients requiring specialized treatment abroad.

CHAPTER 6: MONITORING AND EVALUATION

Monitoring and Evaluation of the strategic plan will be based on a specific minimum set of indicators as reflected in Table 15 below. The indicators relate to the three pillars of HRH (Planning, Development and Management) as well as to the institutional and financing aspects of the plan. Changes in the policy and legislation front will also be monitored as a way of assessing factors enabling the implementation of the plan. Information collected from the M&E activities will be used to track changes in strengthening HRH capacity throughout the five years and advocating for increased financial commitment to HRH interventions.

The HMIS is expected to generate routine information to track the implementation of the plan and the HRIS will specifically generate HRH routine data such as vacancies by months, vacancies by recruitment progress, vacancies by cadre, nationality by cadre, staff within 5 years of statutory retirement age, personnel by expiry date and personnel by facility. The HRIS will thus enable the tracking of indicators such as attrition rates, stock of health personnel, staff-population ratio, skill mix and distribution of health personnel.

The effects of strengthened national capacity of HRH on the disease burden will be determined through regular population based surveys normally conducted in the country such as the Maternal Audit and Demographic and Health Surveys. Regular Job satisfaction surveys and Assessments of health-worker skills and knowledge will be used to determine the effects of improved HRH management and development on the health workforce. Improvements in staffing and availability of services will be tracked through Service Availability Mapping.

Tools will also be developed to monitor the implementation of the activities at the different levels. Efforts will be made to use or adapt existing Monitoring tools in order to reduce duplication. In order to improve quality assurance, it may be necessary to re-visit some of the data sources such as health service records and administrative records.

Monitoring reports shall be produced quarterly and mid-term evaluation will be carried out. The reporting will capture amongst other factors progress related to the following;

- Ratios of staff to patients and population
- Availability of appropriate skills
- Distribution of staff in public and private sector as well as in preventive and curative care
- Numbers of staff trained and types of training
- Extent to which the workforce is appropriately managed
- Working conditions at the different levels of the health system
- Matching of skills with tasks and staff with workload
- Changes in retention measures
- Preventable mortality in the population
- Changes in morbidity rates

The table below reflects the minimum set of indicators to be used for tracking implementation of the strategic plan. The indicators have been adapted from the WHO Handbook for Monitoring and Evaluation of Human Resources for Health (HRH) and the Human Resources for Health Indicator Compendium (2011).

Table 15: Minimum set of HRH indicators

Component	Indicator
Institutional Capacity and Leadership	1. Existence of mechanism to collaborate with government entities, donors, technical agencies and NGOs 2. Existence of national advisory body on HRH issues 3. Existence of national forum to coordinate higher education 4. Appropriate policies and legislation in place
HRH Financing	5. Budget for HRH and the total annual investment in human resources as a percentage of total health expenditure
HRH Planning	6. Number of staff working in health care facilities by professional category. 7. Numbers and ratios of public/private health workers working in urban and rural areas 8. Number of staff relative to population ratio 9. Staff attrition rates 10. Annual total outflow of health workers 11. Stock (and density) of HRH by category 12. Skills mix - Distribution of HRH by occupation, specialization, or other skill-related characteristic
HRH Development	13. Existence of national education plans for health professionals responsive to health workforce needs 14. Ratios of full-time academic staff to students by health worker category 15. Existence of institutional academic quality improvement and/ or accreditation programs 16. Existence of national training/continuing education policy and plan. 17. Existence of provision for in-

	service/continuing education training 18. Percentage of facility staff receiving in-service training/continuing education annually 19. No. of students graduating each year, per cadre and health education institution 20. No. of education and training places per cadre and health education institution 21. Establishment of global code of practice and international recruitment ethical norms (country level)
HRH Management	22. No. of promotions No. of positions (promotion rate) 23. Existence of staff satisfaction survey data. 24. Existence of processes for credentialing or certifying practitioners with achieved competencies 25. No. of staff leaving each month/ annual Total staff each month / annual *(Turnover rate)* 26. Existence of national occupational health and safety plans or programs. . 27. Existence of institutional models for projecting, monitoring, and evaluating staffing requirements 28. National HRH information and monitoring system populated with data at the sub national and national levels on a regular basis (e.g., quarterly/annually

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Annex 1: Implementation Framework

STRATEGY	ACTIVITIES	IMPLEMENTING PARTNER/S	IMPLEMENTATION PERIOD			
HRH PLANNING			**Year 1**	**Year2**	**Year3**	**Year4-5**
Develop Capacity for HRH planning Across the Sector	Recruit qualified staff trained in Human Resources Management, Administration and Economics and offer short term in service training in HRH Planning	MOH, MOPS				
	Develop training programs required to strengthen HRH planning across the sector	MOH, MOPS, SIMPA, IDM,WHO				
	Develop structures, systems, tools and processes for Health Workforce Planning at national, regional and facility levels.	MOH, WHO, HRAA, MOPS				
	Set up a Task Team for HRH Planning which will be a subcommittee of the bigger HRH Technical Working Group.	MOH				
	Mainstream HRH Planning tools at all levels of the health system through identification of staff to undergo training and training of identified staff and provide support supervision	MOH				
Develop Data Bases to Hoard Information for HRH Planning	Develop electronic data bases to generate information for HRH planning including attrition rates, demand for HRH, supply of HRH, needed skills, distribution of staff and staff undergoing training	MOH, WHO, HRAA				
	In the interim develop a depository in the office of the Strategic Information Department (SID) where all information pertaining to HRH planning will be stored	MoH, HRAA				
Develop a staff recruitment program that will ensure a staff complement across the sector that will meet the WHO Benchmarks for staff to	Engage in policy dialogue and lobby with Ministry of Public Service, Civil Service Commission, Ministry of Finance and Ministry of Economic Planning through presentation of the staffing norms and staff requirements to implement the Essential Package of Care so that they continue prioritizing the health.	MoH, WHO				

STRATEGY	ACTIVITIES	IMPLEMENTING PARTNER/S	IMPLEMENTATION PERIOD			
population ratios						
	Lobby for increased Personnel Emoluments budget allocation to the health sector for new recruitment, deployment and retention of core health workers. .	MoH, MOPS, MOF				
	Develop a contingency plan that will address the challenges associated with over dependence on expatriate health workers in the long term	MoH, HRAA				
	Create incentives to attract Swaziland nationals working as health workers in the Diaspora to return home and be integrated into the Swaziland health care system	MoH, HRAA				
	Develop a program for private sector health specialists to work in public facilities on contract. Also allow them to treat their patients at well equipped public facilities at a fee	MoH, HRAA				
Develop a Staff Distribution Plan that will ensure equity in human capital across the health sector	Undertake analysis of rural/urban staff imbalances and deploy staff in a manner that will address the intrinsic imbalances	MoH, HRAA, WHO				
	Address the challenges in rural facilities that make such facilities unattractive to health workers. This will include dealing with poor staff accommodation, water and sanitation and ensuring that there is a professional staff support and supervision program so that staff do not feel intellectually and socially isolated	MoH, WB, PEPFAR, MoF				
	Develop a health workforce distribution formula and plan that addresses the inherent rural and urban imbalances. The formula must give more weighting to the rural regions and facilities	MoH, MoF, HRAA, WHO				
Develop a reliable electronic database on Health Workforce	Develop tools for data collection based on technically proven WHO models for data collection	WHO, HRAA				
	Develop appropriate information technology infrastructure and software for health workforce data gathering, planning and management	HRAA				
Develop systems for data analysis, interpretation and regular reporting	Build capacity at national, regional and facility levels on analysis, interpretation and systematic reporting on observed trends in HRH from various data sources including the HRIS, special surveys etc to multiple stakeholders who require the information for decision making	HRAA, WHO				

STRATEGY	ACTIVITIES	IMPLEMENTING PARTNER/S	IMPLEMENTATION PERIOD			
	Create a platform through the wider Human Resources for Health Technical Working Group for disseminating reports on health workforce issues so that key stakeholders such as the Ministry of Public Service, Civil Service Commission, Ministry of Finance, Ministry of Economic Planning and Cooperating Partners are informed about key HRH issues that require their attention and interventions.	MoH, WHO, HRAA, MOPS				
	Periodically gather information on developments in the external environment such as socioeconomic trends, political trends, and social cultural trends, technological trends including political pronouncements that may impact on HRH planning, management and development and develop interventions to address such developments.					
Provide Information that will be used to ascertain health workforce needs	Identify critical numbers of posts that should be in place so as to ensure a critical mass of competent health workers at all levels of the health care delivery system					
	Identify public sector posts that should be available in order to absorb graduates, develop career paths and improve access to quality health care					
Forge International and local Strategic Alliances and Partnerships	Swaziland should become part of the international global initiatives to address the HRH crisis. This will include the WHO Global Health Workforce Alliance, the WHO African Health Workforce Observatory. These alliances provide a common platform for exchanging ideas on country innovations to address the HRH crisis and new developments on addressing various health workforce challenges					
	Forge links with renowned international hospitals and health workers training schools to improve health workers practical skills through exchange and attachment of staff and scaling up training of core health workers					
	As a way of harnessing Public Private Partnerships, assess capacities of the private sector and provide information on private sector providers who can complement the public sector in providing health services on contractual arrangements					
Revive and Upgrade the Human Resources Information System	Develop a system for classifying health workers onto the HRIS based on the WHO coding system which will disaggregate health professions into their various health specialties and sub categories					
	Through consultation with all key stakeholders develop a core set of HRH indicators which will monitor progress on HRH.					

STRATEGY	ACTIVITIES	IMPLEMENTING PARTNER/S	IMPLEMENTATION PERIOD			
	Indicators must include basic indicators of HRH stock and distribution, indicators of HRH labour activity, indicators of HRH productivity and indicators of HRH renewal and loss. The definition of core indicators will be bottom up with appropriate consultations with key stakeholders who will use the indicators tracked for decision making to inform the process so that the desired indicators are tracked					
	Develop capacity through training of central, regional and facility level staff on collection, analysis, interpretation and presentation of HRIS data and reports to key stakeholders					
	Procure hardware and software for HRIS for all levels of the health system					
	Allocate 10% of program budget to M&E in general and HRIS in particular					
	Develop a HRIS that is compatible and can interface with other Human Resources Information Systems at Ministry of Public Service (MoPS), Civil Service Commission (CSO), MoF, MoE, Training Institutions, Regional Health Offices and harmonize all HRIS systems within key institutions involved in HRH					
	Create a common platform where key technical staff from MoPS, CSC and MoH and the regions will meet to discuss and address operational challenges regarding the operations of the HRIS					
HRH DEVELOPMENT: Pre-service training						
Strengthen the coordination and strategy formulation of pre-service training	Develop a comprehensive health sector pre-service training strategy	MOH				
	Conduct health workforce training needs assessment (skills audit), including projections and develop a master plan on pre-service training for the health sector	MOH				
	Assess alternatives and develop sustainable funding mechanisms for pre-service training institutes	MOE, MOLSC, training institutes				
	Establish a Higher Education Forum to strengthen the link between MOE, MOH, MOLSC and other key stakeholders for pre-service education	MOE, MOLSC, MOH				
	Bring all relevant agencies for pre-service training under the coordination of SWAP	MOE, MOLSC, MOH, MOPS				
	Conduct feasibility assessment to establish t raining programs for cadres whose employment depend on international recruitment, in close consultation and collaboration with in-country training institutes	MOE, MOH				

STRATEGY	ACTIVITIES	IMPLEMENTING PARTNER/S	IMPLEMENTATION PERIOD			
	Support the initiative of establishing medical education program in the country, especially in curriculum development and staffing	MOH, MOE				
Improve physical and organizational/operational capacity of training institutes	Undertake capacity assessment of training institutes, including physical and organizational/operational capacity (infrastructure, teaching learning materials, human resource, curriculum review), including capacity of health facilities where practical attachments are conducted	MOE, MOH, Training institutes				
	Develop capacity enhancement implementation plan based on the capacity assessment result	MOE, MOH, Training institutes				
	For a short or medium term solution use the capacity enhancement plans/proposals of the institutes to build or maintain infrastructures, equip facilities and employ human resources	MOE, MOH, Training institutes				
	Assess the situations to retain and attract teachers in the training schools and develop retention strategy and action plans	MOE, MOH, Training institutes				
	Conduct needs assessment and develop a continued education plan for lecturers and support staff in the training institutes	MOE, MOH, Training institutes				
Establish preceptorship program	Assess and identify health facilities than have the capacity to carry out the clinical practical attachment program for nurses	MOE, MOH, Training institutes				
	Provide training and post training follow up and support for preceptors	MOE, MOH, Training institutes				
	Support the monitoring and quality improvement of the preceptorship program	MOE, MOH, Training institutes				
Strengthen the regulation and quality assurance system for pre-service trainings	Advocate for the establishment of a Training Authority to govern all qualifications and trainings	MOE, MOH, Training institutes				
	Expedite the finalization of the National Qualification Framework.	MOE				
	Develop a pre-service training quality assurance system	MOE, MOH, Training institutes				
	Build the capacity of SMDC to fully represent the other professional cadres in registration, continuing medical education programs: The capacity building activities should include proper staffing, training, computerized database establishment for registration and documenting the health cadres profile, furnishing with computers, printers, copiers and other necessary office supplies.	MOH				
HRH DEVELOPMENT: In-service training						
Strengthen coordination of in-service trainings	Review the coordination mechanisms and composition of responsible agencies for in-service training	MOH, MOLSC, MOPS				
	Develop a guideline for coordination of in-service education	MOH				

STRATEGY	ACTIVITIES	IMPLEMENTING PARTNER/S	IMPLEMENTATION PERIOD			
	Develop in-service training strategy for the health sector	MOH				
	Develop a training coordination guideline for short term trainings provided by development partners and government agencies, which also guides standardization of trainings	MOH, development partners				
	Develop a resource mobilization strategy for in-service trainings.	MOH, MOLSC				
Develop evidence informed and need based training plan	Develop a skills audit guideline and tools	MOH				
	Conduct a regular skills audit for MOH staff on a yearly basis	MOH				
	Develop a comprehensive training plan and calendar based on needs identified and established staffing norms	MOH				
	Asses the capacity of professional councils to lead continued education program and provide the necessary capacity support	MOH				
	Support the development of continuing medical education program for doctors and other cadres under the leadership of SMDC: needs assessment, framework development, web based training program development	MOH, SMDC, development partners				
	Support the Swaziland Nursing Council continuing professional development (CPD) framework implementation: establishing a web based continuing nursing education program	MOH, SNC, development partners				
	Develop in-service training database	MOH, development partners				
Ensure quality of in-service trainings	Develop an in-service training quality assurance system	MOH, development partners				
	Develop guideline that set minimum standards for short term trainings provided in the country, including accreditation mechanisms for training agencies	MOH, development partners				
	Establish educational resource centers to support and encourage distance learning	MOH, development partners				
	Train officers in MOH involved in training planning and management in HRH development	MOH, development partners				
HRH MANAGEMENT						
Strengthen recruitment and deployment procedures	Engage MOPS and CSC to review and revise recruitment and deployment procedures to reduce cumbersome process, delays and improve effectiveness in recruitment, deployment, transfers, grading of posts, etc. Define process, responsibilities and timelines	MOH, MOPS, CSC				

STRATEGY	ACTIVITIES	IMPLEMENTING PARTNER/S	IMPLEMENTATION PERIOD			
	Lobby CSC to advertise vacant posts widely on government websites	MOH, CSC				
	Involve CSC and MOPS in the recruitment of donor supported posts and contracts and define process and timelines to create posts for absorption into government system	MOH, MOPS, CSC				
	Produce a monthly report of all staff on contract which shows their contract start date and end date so that they are monitored on a monthly basis to allow for preparation of their absorption at the end of their contract	MOH				
	Review the current MOH structure to incorporate career progression and succession planning , especially within the health facility	MOH, MOPS, CSC				
	Conduct orientation/induction for new employees and those making significant change in role on Civil Service regulations, including health sector strategy, goals, values, plans and performance standards expected	MOH, MOPS, CSC				
Implement the Task Shifting framework	Assess the regulatory framework for the different cadres who are involved in task shifting	MOH, MOPS, CSC				
	Work with the regulatory bodies to revise regulations favorable for task shifting	MOH, MOPS, CSC				
	Provide training for existing and new cadres within task shifting	MOH, development partners				
	Mainstream supportive supervision and mentoring systems in support of task shifting	MOH, development partners				
	Monitor, evaluate and document best practices for task shifting	MOH, development partners				
	Create awareness on task shifting among health care workers, managers and officials through sensitization workshops, developing and distributing brochures	MOH, development partners				
Reduce staff migration and turn over	Assess the existing retention schemes and the situation of internal and external migration, particularly targeting medical officers	MOH, MOE, MOLSC, SMDC, SNC				
	Develop retention strategy addressing the needs of all health personnel: Establish task force to lead the process, particularly involve professional associations and councils	MOH, MOE, MOLSC, SMDC, SNC				
	Assess areas with scarce skill and define and grade posts	MOH, MOPS				
	Enforce bonding arrangement with medical students and other cadres pre-service training program to ensure their commitment for service in government after graduation	MOH, MOPS, CSC, MOLSC				

STRATEGY	ACTIVITIES	IMPLEMENTING PARTNER/S	IMPLEMENTATION PERIOD			
	Establish a follow –up mechanisms for medical doctors training program, through mentorship, supportive supervision	MOH, MOE				
	Find out the country's Diaspora and from those who come back, especially from the medical officers, what conditions might bring them back to the country	MOH				
	Work with SA Medical Council and other relevant bodies to control the registration of Swazi Medical Officers graduating from SA Universities: Establish a bilateral agreement to ensure that registrations will only take place if only official support letter is provided by Swaziland MOH.	MOH, MOLSC				
	Advocate and lobby relevant department in the MOH and Government to equip and furnish health facilities according to the EHCP	MOH, development partners				
	Balance the benefit packages of local medical officers with expat staff, including accommodation	MOH				
	Recruit students for pre-service medical education who likely to serve	MOH, MOLSC, MOE				
Work with Universities in SA to expand the medical officers internship programs in Swaziland	Under the director of health services establish medical officers internship program that oversees the establishment and implementation	MOH				
	Work with SA Universities on drafting guideline for the program, including selection of internship sites, selection and assignment of tutors/preceptors, working modalities, rotations	MOH				
	Prepare the necessary logistic, including housing, transport, allowances for the interns and preceptors	MOH, development partners				
Improve job satisfaction, working and living conditions.	Review and incorporate the occupational safety and health structure in the wellness program: Create post and assign occupational safety and health officer at MOH and each region.	MOH, MOPS				
	Provide training to Bio-Medical Staff on maintenance and replacement of new machines and equipment	MOH, development partners				
	Lobby the relevant department to develop maintenance and replacement plan	MOH				
	Work with relevant department in MOH to train store managers on procurement, maintenance and replacement	MOH				
	Advocate for the development of policy to regulate donated equipment	MOH				
	Hire private security firms to provide security services in clinics	MOH, development partners				
	Review the current on-call circular and standardize the on call allowances for doctors	MOH, MOPS				

STRATEGY	ACTIVITIES	IMPLEMENTING PARTNER/S	IMPLEMENTATION PERIOD			
	Work with relevant Government body to identify suitable accommodation, or other solutions, including building staff accommodations where required. Before transfers are carried out the Ministry of Health, especially in rural areas, should first explore availability of renting facilities in the areas.	MOH				
	Legalize health workers to work at private practices during their own spare time.	MOH, MOPS				
	Establish a forum for regular consultations with key stakeholders (unions, etc.) on the issue of improving job satisfaction, working and living conditions.	MOH, Unions, professional councils				
Work hand in hand with MOPS to implement the new PMS under development	Review and develop clear job descriptions tailored to each cadre performance plan and MOH strategic plan	MOH, MOPS				
	Assess and develop clear reporting structures within departments	MOH, MOPS				
	Assess and define a continuous monitoring for PMS	MOH, MOPS				
Implement the supportive supervision and mentoring framework	Build the capacity of supervisors through 1) integration of supportive supervision in induction curriculum; 2) training using standardized curriculum	MOH, development partners				
	Develop tools and guidelines for supportive supervision	MOH, development partners				
Improve HR management capacity of HR department	Assess need and provide training of existing HR department staff at MOH in HRH planning, development and management	MOH, development partners				
	Short term secondment of HR specialist to provide technical guidance and advise in HR planning, management and development	MOH, development partners				
Strengthen the structure and functions of HR management at MOH	Review procedures of assignment of MOPS staff in MOH HR department to reduce inter- ministerial staff turn over	MOH, MOPS				
	Work with MOPS to revisit procedures in assigning HR staff for the department with proper qualification and experience	MOH, MOPS				
	Redefine the HR department functions at MOH to lead and coordinate HR planning, development and management responsibilities: create post and assign staff for HR planning	MOH, MOPS				
Decentralize HR functions to Regions	Establish HR manager position for each region and deploy personnel	MOH, MOPS				
	Train HR managers at regions in HR planning, development and management	MOH, MOPS, development partners				
	Train supervisors at health facilities in HRH planning, management and development	MOH, development partners				
	Orient managers at regions and facilities on the HRH tools, including performance appraisal, supervision and mentoring tools.	MOH				