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PEPFAR U.S. President's Emergency Plan for AIDS Relief

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Transition Enablers: Informing HIV Workforce Sustainability Planning

A Case Study from Uganda

Contents

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Acronyms

ART	Anti retroviral therapy
CDC	Center for Disease Control and Prevention
GFATM	Gobal Fund to Fight AIDS, Tuberculosis, and Malaria
GOU	Government of Uganda
HCW	Health care worker
HIV/AIDS	Human immunodeficiency virus / acquired immune deficiency syndrome
HRH	Human resources for health
HRH2030	Human Resources for Health in 2030
HW	Health worker
IP	Implementing partners
KII	Key informant interviews
MOU	Memorandum of understanding
PEPFAR	President’s Emergency Plan for AIDS Relief
USAID	United States Agency for International Development

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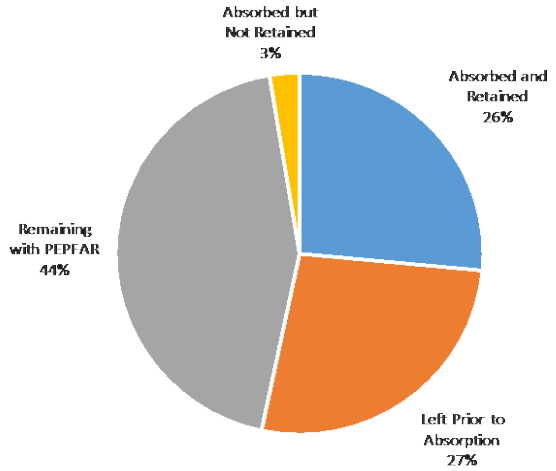
Introduction

Throughout sub-Saharan Africa, human resource challenges have hindered countries' efforts to achieve HIV epidemic control. To accelerate access to the services needed to realize the 95-95-95 goals[1], the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and other donors, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), have invested in tens of thousands of health and social workers, from clinical to lay cadres, across a number of countries. PEPFAR and the GFATM have supplemented the budgets of governments both to hire additional, contracted staff and to amplify the reach and effectiveness of staff through overtime pay, support for outreach activities, motivational benefits, and skills development. Given the important role that these workers have played in HIV control progress and the substantial level of investment made by donors to empower this workforce, it is vital that policymakers understand the factors and motivations that will enable successful transition and retention of donor-supported health workers locally required for sustaining the HIV response.

Uganda offers a rich country experience. In 2012, the Government of Uganda (GOU), hired more than 7,000 health workers mainly at the primary care level in the Health Centers III and IV – known as the "Surge." Despite this investment, the GOU and PEPFAR recognized that severe staffing gaps remained at the hospital level and high-volume Health Centers IIs, undermining Uganda's ability to achieve HIV epidemic control through the global UNAIDS targets of 90-90-90. To supplement this massive recruitment of health workers. Accordingly, the GOU and PEPFAR agreed that PEPFAR would recruit additional health workers eventually totaling 2,213 health workers (1,292 in 2012 and 921 in 2015) health workers across 87 focus districts to address remaining staffing gaps in hospitals and health centers serving a high-volume of people living with HIV. From May 2013 to December 2017, 695 of these PEPFAR-supported health workers applied for and were absorbed into public service, while more than 700 left to find other employment and approximately 1100 remained to be transitioned (See Figure 1).

The USAID Human Resources for Health in 2030 (HRH2030) program conducted a cross-sectional study to better understand the factors and motivations that hindered or enabled the retention of PEPFAR-supported health workers who transitioned to the GOU. The study team used existing government and development partner databases to trace the 695 PEFPAR-supported health workers absorbed into public service and conducted in-depth interviews and focus groups with 75 previously PEPFAR-supported health workers in eight sample districts. For more about the study methodology, see Annex A.[2]

FIGURE 1: ABSORPTION OF PEPFAR-SUPPORTED HCWS



While HRH sustainability planning should include both private sector options and the use of local partners to manage staff, the Ugandan experience focused on the transition of donor-supported staff into the public service. The HRH2030 study revealed that early planning efforts made by development partners and governments in Uganda to transition donor-supported staff into public service was an effective strategy for ensuring that the HIV health workforce continues to be highly engaged in HIV epidemic control, even after donor financing has receded. A major lesson in Uganda was that robust planning and coordination between the GOU and PEPFAR throughout the workforce planning and transition process was critical. Identified best practices to inform broader HIV workforce sustainability planning based on the Uganda experience are outlined below and divided across four key phases (see Figure 2). These best practices should inform planning for governments, donors, and those development partners involved in hiring, managing, and training human resources as well as any development partners providing technical assistance on budgetary and fiscal planning or human resources.

[1] To test 95 percent of all people living with HIV, place 95 percent of those testing positive on continuous anti-retroviral therapy (ART), and have 95 percent of those on ART virally suppressed by 2020

[2] An accompanying case study -- Retention Enablers: Informing HIV Workforce Sustainability Planning -- examines the enabling factors that facilitated: (1) the retention of PEPFAR-supported health workers, and (2) their continued involvement in HIV service delivery, following absorption into public service.

FIGURE 2: PREPARING FOR TRANSITION

Planning

(1) Plan for Health Worker Transition

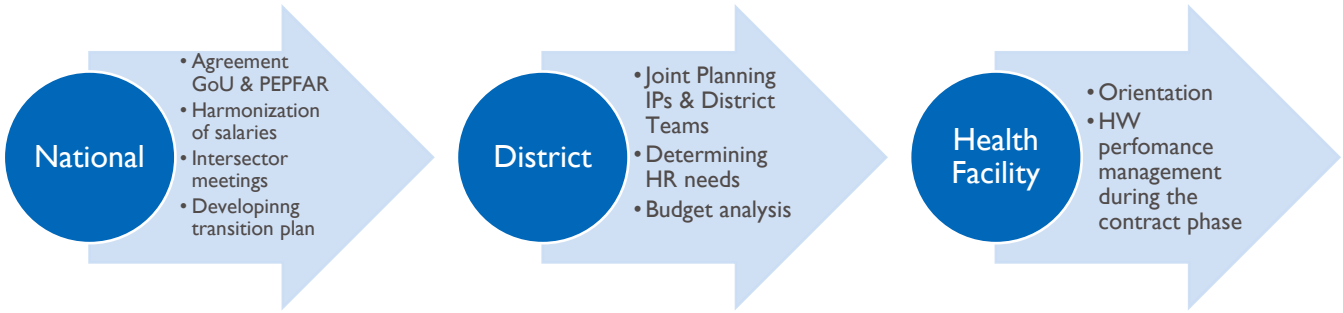
Plan for transition from the beginning, yet be flexible to address evolving needs: Before service delivery partners are authorized to start hiring any health workers, governments, donors, and other stakeholders should discuss the long-term HIV need for the country's health workforce and reach written agreement on how donor priorities and investments in human resource will be supported. Development partners and governments should reach agreement on the broad parameters for: who, how, where and for how long donor-supported workers will be engaged, and, to the greatest extent possible, outline government commitments to transition donor-supported worker functions to government or local supports, including the private sector over time. The agreement should accommodate potential shifts in health workforce investments in response to evolving epidemic control needs and economic conditions in the country, and recognize the value of evaluating and scaling innovative staffing models – from task sharing with facility-based lay cadres, to contracting of the private sector, to social contracting with local organizations to staff community-based ART models. The primary aim is to capture the shared commitment by governments and development partners to jointly plan, manage and appreciate donor investments in the health workforce as a critical and priority investment for achieving HIV epidemic control and other health aims. Furthermore, the agreement should specify which government actors, be they at the central or local level, are responsible for taking action to effectuate transition. Thus, while the agreement should include some flexibility for which functions are transitioned over time, stakeholders should be in general alignment on the process for hiring, which types of cadres are needed, the scope of the hiring, the commitment to prioritize absorption, and whether certain cadres or health workers should be absorbed into the private sector or hiring through contracts outside of the civil service.

In Uganda, in 2012, before PEPFAR and its Implementing Partners contracted any health workers, the GOU and PEPFAR agreed that PEPFAR would amplify the Government's 'Surge' staffing plan by filling critical gaps in facilities that served large numbers of people living with HIV. PEPFAR would support the recruitment process and provide salary support for the initial two (2) years, and the GOU would enroll such health workers on the public payroll as soon as fiscal space allowed. A formal memorandum of understanding (MOU) was not signed, but there was a "gentlemen's agreement" struck between the GOU and PEPFAR and the actions and processes were agreed upon in a series of stakeholder meetings. A few stakeholders felt that the lack of a formal MOU ultimately hindered their ability to hold certain government actors accountable. Yet, the initial consultations and verbal agreement laid the groundwork for a collaborative approach and provided PEPFAR Implementing Partners with the broad contours to proceed with health worker investments in alignment with GOU systems and policies and to accelerate transition, such that some health workers were absorbed within a year of hire. In some instances, districts signed MOUs with PEPFAR Implementing Partners. And while, PEPFAR is still supporting some health workers more than two years from the start of hiring, approximately 40% have been absorbed.

Engage stakeholders at all levels: The level of engagement between national and local governments, donors, service delivery partners, and private sector/non-governmental stakeholders will be country specific and a function of decentralization and devolution policies that dictate where planning, budgeting and hiring authority resides in a country and the role of private entities in the health sector. In addition to engaging line ministries (e.g., health, social services, etc.), early and frequent engagement of governmental ministries and entities in charge of setting recurrent budgets, managing the wage bill and maintaining the establishment list or registry for public service is critical. In countries that have devolved or decentralized decision making for budgeting and human resource, it is critical to engage local authorities early on and continuously throughout the process. Counterparts at the service delivery level also should be consulted on issues such as priority staffing, key challenges and gaps, and factors that affect the process for placing and retaining health workers. Even if the central authorities have ultimate authority, it is often reliant on local influencers to prioritize investments in given localities or facilities. Local champions are critical for ensuring that donor-supported health workers are successfully integrated and eventually transitioned into the public health system; their involvement should be cultivated early and appropriately supported.

In Uganda, prior to PEPFAR Implementing Partners hiring any contracted health workers, the GOU and PEPFAR engaged in extensive multi-stakeholder negotiations involving actors at the national, sub-national and implementation levels. Inter-sectoral meetings included the Ministries of Health, Finance, Public Service, Local Government, PEPFAR, USAID, CDC and their Implementing Partners. At the district level, PEPFAR Implementing Partners engaged Chief Administrative Officers and District Health Officers. See Figure 3.

FIGURE 3: MULTI-STAKEHOLDER ENGAGEMENT IN UGANDA



Government issued directive to guide donor-supported hires and spotlight plans of eventual transition: Once a general agreement has been reached between the government and the development partner, the national authorities should issue a directive or circular to the subnational actors in charge of authorizing and/or hiring health workers. It should define government and development partner roles and responsibilities and provide sufficient guidance to national/subnational actors and development partners on the parameters for engaging donor-supported health workers, while allowing flexibility to customize workforce investments based on the needs of the region or district. For example, in decentralized systems, depending on the local context, development partners might be required to use local government hiring mechanisms to engage health workers, including applying local wage parameters for salary determinations or to solicit letters of appointment from local authorities before hiring and placing. In systems where human resources functions are centralized, development partners might be required to engage in national processes with the Office for Public Service and the Ministries of Health and Social Welfare for the posting, recruitment and hiring of new positions. The directive or circular also should highlight considerations for future transition planning, noting that those positions supported under the development partner program are to be prioritized within public service requests, where the function has been identified as a long term, priority need to support HIV epidemic control by both the government and the development partner.

In Uganda, while there was no formal MOU, the Permanent Secretary for the Ministry of Health wrote to all Chief Administrative Officers informing them of the PEPFAR support and directing them to oversee and support the recruitment process with the understanding that the PEFPAR-supported staff would be prioritized for absorption when there was fiscal space. The circular stated that Chief Administrative Officers were to "integrate the contracted Health Workers into the mainstream Public Service within the available wage bill... [and were] requested to give priority to the regularization of appointment of the [contracted] Health Workers." Chief Administrative Officers were told that staffing gaps that remained after absorption could be filled through open advertisement.[3]

"PEPFAR helped with providing the recruitment funds. It provided sitting allowances to enable District Service Commissions to convene as well as providing allowances to committee members during the interview of candidates." (KII District Official, Sheema).

While more fiscal space is needed to transition the entire PEPFAR-supported cohort, districts recognized that they would have to absorb PEPFAR-supported workers before any new hires, and the successful districts organized, prioritized, and advocated for fiscal space each year.

(2) Recruitment

Utilize government planning and recruitment processes: Development partners should not create parallel processes for hiring donor-supported health workers, especially for positions that are hired with the expectation that they will be transitioned into public service. Rather, donor-supported health workers should be planned for, recruited, hired, deployed and managed using existing government mechanisms. Even if health workers are hired into the private health sector, development partners should

[3] Ministry of Public Service Circular "Recruitment and Regularisation of Contract Health Workers in the Regional Referral Hospitals, Local Governments, and Municipal Councils," dated February 20, 2017.

consider local rules and regulations for hiring, procurement, and government salaries. This ensures that these health workers are hired under similar circumstances as public servants. This does not preclude the development partner from providing additional mentorship, training and supports to their workforce; however, it does facilitate greater ownership and visibility for donor-supported workers within local systems. For most districts in Uganda, PEPFAR-supported health workers were interviewed and vetted by the District Service Commissions along with representatives from the development partners.

When opportunities for transition to public service become available, the donor-supported health worker who was recruited through government mechanisms may be in a better position to be absorbed, as he or she has already been subject to the recruitment process and his or her performance record will be known to local officials. This can lead to a more streamlined and efficient transition process in the future. In Uganda, when it came time to transition donor-supported workers to the public service, in many districts, those who had been offered a position were appointed without having to re-interview and the normal probationary period for public servants was waived. In fact, in a 2017 circular the Ministry of Public Service reiterated the prioritization of those PEFPAR-supported staff who were "recruited directly by the Health Service Commission and District Service Commissions and paid at the same salary as those on Government payroll," noting that they were hired under the understanding that they would be absorbed when a vacancy and wages were made available in the wage bill.[4] Conversely, health workers who were initially recruited directly by development partners or a mission hospital without the involvement of District Service Commissions were considered new applicants. They had to apply, attend District Service Commission interviews, and undergo the six-month probation period. For example, in Mubende and Kamwenge, Bundibugyo and Ntoroko Districts, 66% of PEPFAR-supported staff remain to be absorbed as compared to 45% for the entire country, health workers hired as contractors through the government were required to re-interview and repeat the probationary period, indicating a need for central government to monitor to ensure that the guidelines are implemented uniformly across districts.

Provide targeted assistance to facilitate recruitment: While development partners should strive to leverage existing government systems to recruit donor-supported health workers intended to be absorbed into the public service, providing additionally financial resources and technical assistance can assist in facilitating recruitment processes. It's not unusual for government hiring boards to lack resources to place advertisements, rent space to hold interviews, and transport officials to key meetings and interviews. The cost of initiating recruitment in these areas should not be underestimated. In addition, development partners also can provide technical assistance to support accountable and evidence-driven hiring processes and strengthening of of the District Health Commissions or equivalent. In Uganda, PEPFAR's support to the recruitment process was credited with overcoming challenges common to District Service Commissions, such as delays in convening meetings and failure to advertise openings to the full public. PEPFAR provided the necessary funding to initiate the recruitment processes.

Participate in hiring process: As the service delivery partners and the local district and facility managers will have dual responsibility over the management of health workers, development partners, service delivery partners and/or donors should participate in the contracted health worker interview process. This will ensure that the development partner can advise the hiring commission based on its technical experience and give facilities confidence that the offer of employment goes to the most qualified candidate. In many settings, it is common practice to give government positions in order to curry political favor or due to personal connections. In Uganda, many of those interviewed for the study reported that District Service Commissions had a reputation of questionable objectivity in the selection of personnel. Given this context, the selection of PEPFAR-supported health workers through transparent and merit-based processes lent special legitimacy to this cohort of health workers. District and facility-level managers perceived PEPFAR-supported personnel as having been recruited

"I was looking at it as a good option to recruit staff. At the time of recruitment our district service commissions were given a lot of support by teams from PEPFAR IPs. This issue of our local politics of you are going to recruit this one's daughter (nepotism), you are going to solicit bribes, those ones didn't surface anywhere." (KII District Official, Iganga)

[4] Ministry of Public Service Circular "Recruitment and Regularisation of Bonded and Unbonded Contract Health Workers in the Regional Referral Hospitals, Local Governments, and Municipal Councils," dated March 23, 2015.

through rigorous and objective procedures, which eased their placement into facilities, and district officials felt that the development partners engagement alleviated some of the pressure to engage in "local politics."

Align salaries with government pay scales and cadres: When donor-supported staff are paid more than their government counterparts, including their supervisors, it may impact workplace morale and create divisions between the donor-supported staff and public servants. While health workers may expect higher salaries for short-term contracts—in order to compete with the benefits of long-term employment with the public sector—or to entice them to work in remote or underserved areas, if the stated purpose is to recruit workers that eventually will be absorbed, salaries should be aligned with the official government pay scales and allowances and the short-term contracts should be advertised as probationary periods. Furthermore, given that the contract period can be used as a probationary period, donor-supported health workers also can enable credit to be received for this period of work when hired into the government service. In Uganda, as part of the recruitment and transition plan, stakeholders including Ministries of Health, Finance and Public Service, Local Government, and PEPFAR agreed that the salaries for PEPFAR-supported health workers would be harmonized to GOU pay bands. The effort bore out in the data with almost two-thirds of the 75 previously PEPFAR-supported health workers interviewed as part of this study reporting that they received either the same or more salary post-transition and more than half reporting that they received the same or more benefits (Figures 4 and 5).

Ugandan stakeholders also noted an effort to advertise locally for health workers and while 'The Surge' led to extensive staff mobility, with 61.2% having come from other districts and only 38.8% having stayed in the same district of previous employment,[5] 92% of the absorbed PEPFAR health workers were working in the same district as when they were employed with PEPFAR support.

Design targeted strategy to recruit scarce cadres: Scarce cadres, such as pharmacists, medical officers and laboratory technologists, can be difficult to recruit and retain at government salaries, especially where there is a robust private sector. It may be necessary to develop a targeted recruitment plan for cadres that the government has not traditionally been able to recruit, including reviewing government pay scales for the most difficult to recruit cadres. While it may be difficult to increase salary scales, other options to attract talent could include contracts that allow for part-time work in the private sector, contracting out to the private sector for certain services, or rotations across multiple facility types. In addition, development partners can work with hiring commissions to provide opportunities for research and study; for example, to provide training to existing laboratory technicians with less education with the

FIGURE 4: CHANGE IN SALARY REPORTED AFTER TRANSITION TO PUBLIC SERVICE

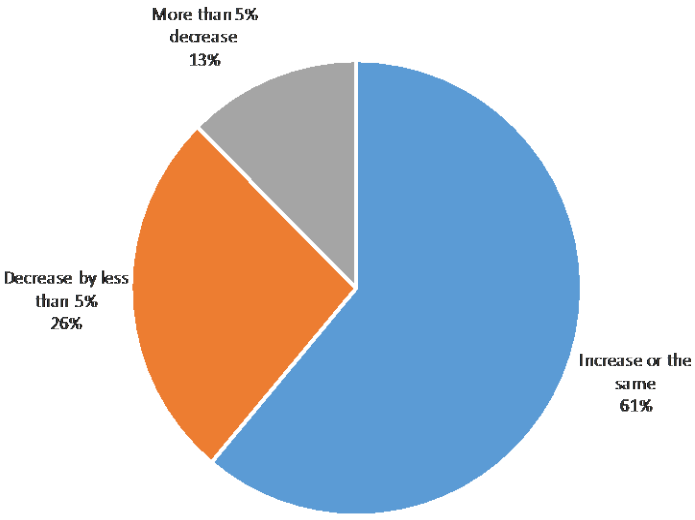
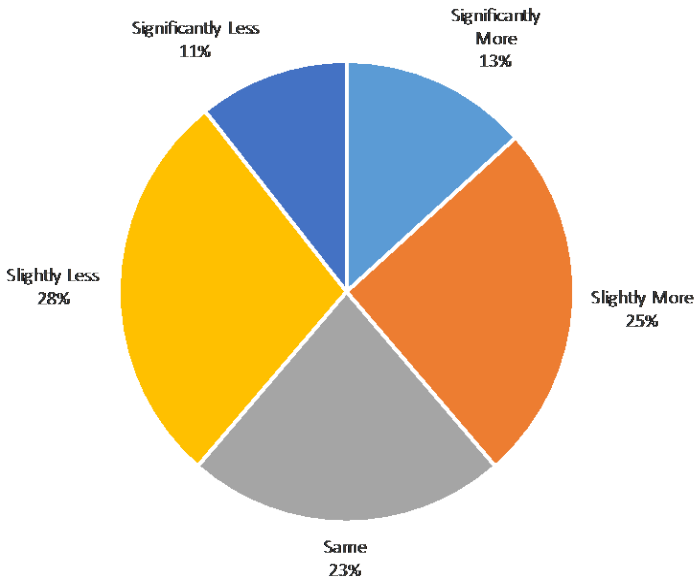


FIGURE 5: CHANGE IN BENEFITS REPORTED AFTER TRANSITION TO PUBLIC SERVICE



[5] Strengthening Human Resources for Health (SHRH), IntraHealth, Impact of the 2012/2013 Massive Health Workforce Recruitment on Staffing and Service Delivery in Districts in Uganda, September 2017.

commitment that they return and will be considered for the higher-level cadres. However, the government will need to ensure that there is space in the establishment list for accommodating laboratory staff with advanced degrees. In Uganda, stakeholders reported that laboratory technologists were especially hard to recruit and retain because the market for their services was "hot." Even when districts were able to recruit laboratory technologists, they hesitated to prioritize them because they feared those cadres would leave soon anyway, and they did not want to waste the effort and resources. In some facilities, they did not have approval to hire the more educated laboratory specialists into the higher lab cadres.

Recruit locally where possible: If possible, health workers should be recruited from their own communities, especially in hard-to-reach areas. This can be facilitated by focusing advertising locally rather than only through a central mechanism. Health workers from the community are more likely to remain in districts where they are familiar and have family ties than seek out employment elsewhere. In addition, local hires are more likely to be satisfied with the pay as they can save on food, transportation, and accommodation. Further, commutes can be long and expensive which can lead health workers to be late and miss work especially when the weather makes roads difficult. In Uganda, stakeholders felt that local hires were more likely to stay for longer than those from other districts, and health workers reported a heightened sense of responsibility for their local communities. One service delivery partner noted that they stopped advertising centrally and focused their efforts locally.

(3) Contract Period

Embed in-charge staff to take ownership of donor-supported health workers: The contract period should be seen as an opportunity to prepare donor-supported staff for government service, familiarizing them with the work environment and vetting them for long term employment. If local recruitment is not feasible, the contract period can orient health workers to the area and local working conditions. In Uganda, once at their facility, facility supervisors, together with development partners, oriented contract staff into public service structures and processes. Ugandan stakeholders felt that this phase provided health workers with an opportunity to be inducted and initiated into government systems and work environments. At absorption, health workers were familiar with the work environment in government, including the constraints that are common in public health facilities like shortage of supplies and heavy workloads, which facility managers felt explained the high levels of retention despite the dissatisfaction with these issues.

Use contract period to identify and reward strong performers: The contract period can be viewed as an opportunity to assess which donor-supported health workers are good performers and committed to the job, enabling better impact and increasing the likelihood that the health worker will be selected for transition, will accept the position, and will remain in their positionAs such, donor-supported health workers should be supervised and appraised by government health workers. Even in those instances where development partners retain contractual authority over the health workers, development partners should clearly communicate to health workers that they are accountable to their government supervisors and regularly consult with the government supervisors on performance and schedule, including if they plan to send a health worker to a training or to approve leave. In Uganda, the dueling authorities did present some challenges, as supervisors felt that they could not discipline workers or hold them to account if, for example, they left for training without warning or prior approval. However, when it came time for transition and positions opened, those health workers who were considered poor performers, who had taken unapproved leave or failed to report to work regularly or on time, were not recommended for absorption. In addition, because the Facility Management Team was also charged with performance management and support supervision for contract staff, they were proponents of transition, including advocating for their inclusion in the yearly budget, encouraging the PEPFAR-supported staff to apply and providing support to them in responding to job adverts.

Ensure government and development partners are well-coordinated: Government and development partners need to create a joint, coordinated plan for hiring health workers, managing payroll systems and providing supervision. While it may be necessary or useful to divide these functions among different partners, a lack of coordination among them can lead to lapses in pay, unexcused absenteeism, and missed opportunities for absorption. The government and development partners should develop a regular or systematized system for tracking health workers, recording their performance, and ensuring their salaries and benefits are transferred when they are moved or absorbed. In Uganda, for example, coordination challenges meant that health workers were sometimes dropped when they should have received a contract extension or conversely had remained on payroll

when they had abandoned their post. In Uganda's Sheema and Iganga Districts, a few health workers noted that they were not paid for months after being absorbed. In most cases, they were paid all or partial arrears, but during this time, they worked for free.

(4) Absorption

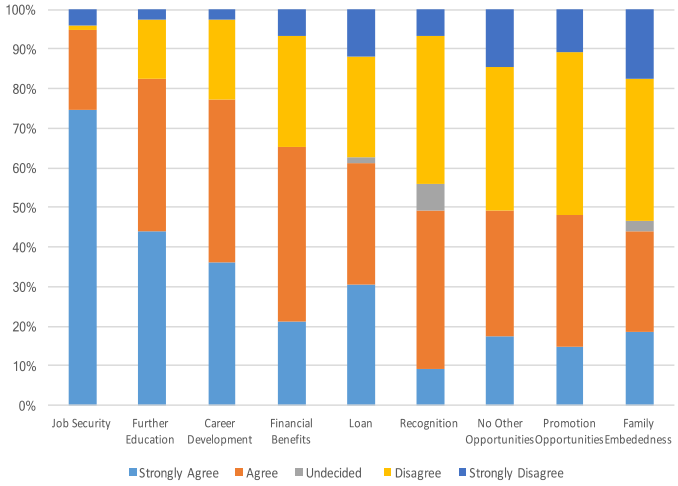
Plan for high levels of absorption, if opportunities are made available: In countries where the discrepancy between the public sector and private sector compensation packages are not significantly divergent, countries should expect that most health workers who remain in good standing throughout their contract period, if offered a comparable position in public service, will accept an offer of government employment due to the benefits of long term job security in the public sector. In Uganda, while 28 percent of PEPFAR-supported staff left before absorption, district and facility managers reported that very few health workers declined to transition when offered a position in civil service. While financial benefits are clearly a major factor in deciding to enter and remain in public service, they are not the only factor. In fact, in Uganda, job security, opportunities for further training, and career development were cited as the strongest reasons for transitioning to and remaining with public service. Among the Sample Cohort, job security was identified as the most important incentive by health workers opting to join and remain in government service (see Figure 6). Seventy-five percent (75%) of those interviewed strongly agreed that job security influenced their decision to stay and continue with public service. Health workers described a government job as a "treasure" and "golden opportunity."

"When they came in, orientation was done so that they know the government working system." (KII District Official, Nwoya).

"It gives time for the district service commission to follow and get good staff because it gives us time to gauge them and monitor them and also have an input in this. You can even say I think this one we cannot manage, this one I think we can take." (KII, Nwoya)

Cultivate local stakeholders to determine transition priorities, advocate for space in the wage bill: Creating space in a wage bill in resource-constrained countries will always be a challenge. For transition to be successful, it is important for the central government, donors, service delivery partners, and local governments to continuously dialogue and revisit the wage bill allocations based on need and available resources. Identifying and advocating for space in the wage bill needs to start early – usually at least a year before absorption occurs depending on how the government budget calendar is set. Even if the government as a whole has committed to absorption, it may be up to the local districts, facilities and communities to advocate for their priority needs and push for the resources to absorb the health worker. Facility managers should work with district heads to create a consolidated request for funding that is ready to submit

FIGURE 6: REASONS FOR ACCEPTING POSITION IN CIVIL SERVICE



before the national budget is determined.

Especially where hiring decisions are decentralized, 'program champions' at district and health-facility levels can be critical for ensuring that transition happened. Local champions emerged organically and included Chief Administrative Officers, District Health Officers and Human Resource Officers who actively pushed space in the wage bill for the recruitment and absorption of health workers and enrollment on the government payroll. Districts which had champions, such as Iganga, Kasese and Sheema, had a higher number of absorbed health workers while those without champions had few or no absorbed health workers. Their absorption rates of 52, 48, and 89 percent respectively exceeded the national average of 27 percent. In Kasese, the development partner followed up regularly with the district to support them in determining who to absorb and how to incorporate the

health worker into their recruitment plan for the year. Even when they were not able to absorb staff, by preparing at the beginning of the year, they were able to recognize early that they would not be able to absorb everyone by the end of the contract period and were able to proactively negotiate an extension with PEPFAR. While in Mubende, the contracts ended, and many health workers were let go.

Phase in absorption over time, with special attention to donor-supported staff at non-governmental facilities: Ideally donor-supported health workers should be transitioned to public service in phases. It can be difficult to get approval for the full budget to absorb all workers in one period and absorbing too many at once can tax human resources systems, resulting in delays and logistical challenges that can frustrate workers and their supervisors. In Uganda, one District Health Officer described it as "bite what you can chew" approach to health worker transition, noting it would not have been possible to absorb all workers at once. Beyond the public sector, development partners also may want to engage private facilities as an additional means of transitioning the donor-supported health workforce.

The government and development partners may wish to make special accommodations for transitioning donor-supported health workers seconded to non-governmental facilities. In many countries, non-for-profit facilities receive a public subsidy from the government that can leveraged to prioritize hiring and or receive seconded public servants to support service delivery. In Uganda, some health workers were seconded to private non-for-profit facilities providing key services, but were often left out of consideration for absorption because the district budgets did not identify or request them. Based on the HRIS data, absorption of PEPFAR-supported workers into public service was considerably lower in the not-for-profit facilities at 30% versus 55% in public facilities. Interviewees suggested that a lack of stakeholders advocating for individual workers at not-for-profit facilities resulted in fewer opportunities for transition. Stakeholders felt that these facilities were not a priority for the government and because their supervisors were not in government service, the health workers seconded to non-governmental facilities did not have anyone pushing for their prioritization in the wage bill.

"Intrahealth helped us analyze the wage bill budget. There was some confusion with the ministry of public service and ministry of health and here at the district so we were in the dark so IntraHealth came and analyzed and found that we had a balance (funds for wages) which we were not using and now we had brought the CAO on board so we even gave those people appointments four months before their contracts ended." (KII District Official, Iganga)

Provide technical assistance in health financing to facilititate transition: Development partners can provide targeted technical assistance to the Ministry of Finance and districts to help in the transition process, especially in identifying fiscal space, and staffing needs. For example, partners can help to assess what resources exist and how to maximize current resources. In Uganda, because hiring is determined at the district level, PEPFAR through the USAID/Uganda Strengthening Human Resources for Health Project supported all 87 focus districts to conduct a human resource needs assessment and wage bill analysis to guide decisions on the number of health workers to be transitioned at a given time. While issues of budgetary space remained a challenge for many districts, the analysis did pave the way in some regions to absorb more workers than expected.

Remember that it is not only the financial package but how benefits are structured and communicated: It is important to clearly communicate with donor-supported health workers when they are considering opportunities for absorption into public service about what they will receive, not only in terms of salary but also benefits, as they transition from being donor-supported staff to government staff. Donor-supported staff often receive different types of benefits post-absorption, which can result in abrupt and unforeseen changes in the health worker experience and foster dissatisfaction. If districts cannot provide the same types of benefits, they should clearly communicate what the package will be and brainstorm strategies with the health worker for how to use their new financial package to get meals and housing. For example, in Uganda, some PEPFAR Implementing Partners had been providing in-kind benefits, such as food allowances and accommodation, which were not provided under public service; rather, public servants tended to receive greater monetary benefits (e.g., pension). Even though more than 50% of the PEPFAR-absorbed health workers reported receiving the same or more benefits (in terms of amount) after transition, the types of benefits and allowances mattered. Health workers, especially those stationed away from home districts, expressed frustration at the lack of accessible food options while working, and accommodation was one factor that health workers repeatedly noted had gotten worse under government service.

Service delivery partners should consider a transitional period where they continue to follow up with absorbed staff during their first year. They can help troubleshoot issues and provide targeted technical assistance to districts if they identify a widespread or fundamental problem after workers have been absorbed.

Health workers in Uganda wished that the PEPFAR partners had remained in communication with them to respond to questions, and facility supervisors appreciated the use of PEPFAR partner monitoring tools, such as timesheets. For more best practices on retention, see accompanying case study -- Retention Enablers: Informing HIV Workforce Sustainability Planning.

Conclusion

The case study of PEPFAR supported HRH in Uganda demonstrates that multi-stakeholder planning from the beginning can facilitate the rapid influx of necessary health workers into the system while easing the process for absorption down the road. Documenting a plan establishes political will and issuing a circular to the relevant local stakeholders provides subnational actors with the backing to take the necessary actions moving forward. The value of aligning cadres and salaries to government's establishment lists at the beginning cannot be overstated. Higher level/scarce cadres and staffing for non-government facilities may require a different, more targeted approach. Local governments and facilities themselves should play key roles in recruitment, supervision, and recommendations on who to ultimately absorb. Nonetheless, planning itself is insufficient and absorption requires the continued commitment and engagement by partners, the government, and facilities to identify priority hires, include them in yearly budgets, and advocate for space in the wage bill over time. Uganda's experience highlights that even with planning, rapid absorption can be challenging and instead should be phased-in over time and incremental absorption should be seen as a success. The contract period should be viewed as an opportunity to test the health workers' skills and work habits and integrate them to the health system. It should be expected that not all health workers are absorbed. Those who remain through their contract and are recommended for absorption generally are eager to accept and gain the benefit of job security and may even be willing to take a small salary cut.

Annex A. Methodology

Approach: This cross-sectional case study used both quantitative and qualitative methods for data collection to complement each other in answering the study questions. The retrospective quantitative component of the study (Component 1) drew on data from the MOH's human resource information system (HRIS), as well as databases at IntraHealth International and other PEPFAR Implementing Partners, and from district level HIV service delivery databases, to identify health workers who were recruited under PEPFAR and later transitioned from PEPFAR to GOU system, and determine whether they remain in service with the GOU. For this component, the study team matched names across the PEPFAR Implementing Partners database to trace them to the MOU HRIS system to identify those health workers who had been absorbed. The study team identified 695 health workers absorbed by the GOU between 2012 and 2017 across the country. Quantitative analyses were conducted on the full 695 absorbed health workers. Then the team determined whether any absorbed health workers had left the MOH and were no longer listed in HRIS as part of the workforce to calculate the percentage of staff retained. While the databases did not include information on whether health workers were offered the opportunity to transition but opted against it, effort was made to identify a few health workers who elected not to transition to understand their motivations.

The mixed-methods component of the study (Component 2) involved collecting primary qualitative and quantitative data among health workers absorbed from PEPFAR to GOU support, policy makers and health service managers involved in the health workers transition in a sample of seven selected districts and Kampala City. Participants included absorbed health workers at health facility level, health workers who elected not to transition, and district and health facility managers. At national level, key informant interviews (KIIs) were conducted with officials from the MOH, PEPFAR, IntraHealth and other PEPFAR Implementing Partners who were involved in planning and implementation of health worker absorption.

Sample selection: The sample districts, Sheema, Iganga, Tororo, Kasese, Mubende, Nwoya, Apac, and Napac, were selected based on the number of health workers absorbed, a mix of urban, rural, and hard to reach and HIV prevalence. They represented 8 of the top 11 districts for number of absorbed health workers. Using data from HRIS, absorbed health workers were identified and a proportionate random sample selected and invited to participate in the study. The eight selected districts (selection criteria for these districts is detailed in Table 1) had a total of 174 transitioned health workers, including those who have since left GOU service. Of these, 75 were purposively selected by cadre of health worker for semi-structured interviews or one of four FGDs of six to eight health workers each. Within the sample districts, only eight had left GOU service and the study team interviewed four of them. In addition, the study team interviewed 16 health facility and District level officials from the department of health and human resource management and 14 national level key informants including officials from the Ministry of Health, Ministry of Finance and Economic Planning (MoFEP), Ministry of Public Service (MoPS), IntraHealth International, Implementing Partners (IPs), PEPFAR, USAID, and CDC.

Limitations: While the case study drew out a rich set of insights and lessons learned especially from the qualitative component, the case study had a few limitations that hindered the quantitative assessment. Because the study required ethics approval, the study design and sample selection had to be determined at the outset which was designed to assess the retention rate for absorbed Ugandan health workers and the factors that enabled or hindered their retention. By selecting those districts with the highest number of absorbed health workers, the study did not include in its sample those districts with few absorbed workers and may have missed additional reasons why some districts were unable to absorb workers. As a next phase, a case study could visit those districts who hired significant numbers of PEPFAR staff but still had many remaining to be absorbed and delve into what factors drove a low absorption rate, building off the insights gathered from this case study.

An HIV counselor tests a client in Lagos, Nigeria. Photo Credit: URC, 2016.

Program Partners

- Chemonics International
- American International Health Alliance (AIHA)
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- Open Development
- Palladium
- ThinkWell
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About HRH2030

HRH2030 strives to build the accessible, available, acceptable, and high-quality health workforce needed to improve health outcomes.

Global Program Objectives

1. **Improve performance and productivity of the health workforce.** Improve service delivery models, strengthen in-service training capacity and continuing professional development programs, and increase the capacity of managers to manage HRH resources more efficiently.
2. **Increase the number, skill mix, and competency of the health workforce.** Ensure that educational institutions meet students' needs and use curriculum relevant to students' future patients. This objective also addresses management capability of pre-service institutions.
3. **Strengthen HRH/HSS leadership and governance capacity.** Promote transparency in HRH decisions, strengthen the regulatory environment, improve management capacity, reduce gender disparities, and improve multi-sectoral collaboration for advancing the HRH agenda.
4. **Increase sustainability of investment in HRH.** Increase the utilization of HRH data for accurate decision-making with the aim of increasing investment in educating, training, and managing a fit-for-purpose and fit-for-practice health workforce.

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