



**REPORT ON  
ASSESSMENT OF HUMAN RESOURCES MANAGEMENT  
SYSTEMS IN CHAG**

Conducted by

The logo for Health Partners Ghana. It features the words "Health Partners" in a green, sans-serif font, with a blue curved line above the text. Below "Partners", the word "GHANA" is written in a smaller, blue, all-caps, sans-serif font.

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## **LIST OF ABBREVIATIONS**

CHAG	Christian Health Association of Ghana
GCPS	Ghana College of Physicians and Surgeons
GHS	Ghana Health Service
HIV/AIDS	Human Immuno-Deficiency Virus-Acquired Immune Deficiency Syndrome
HRD	Human Resources Division
HRDD	Human Resources Development Division
HSWU	Health Services Workers Union
IMCI	Integrated Management of Childhood Illnesses
IPPD	Integrated Personnel Payroll Data Base
MDAs	Ministries, Departments and Agencies
MLGRD	Ministry of Local Government and Rural Development
MOU	Memorandum of Understanding
MOES	Ministry of education and Sports
MOH	Ministry of Health
NGOs	Non-Governmental Organisations
POW	Programme of Work
TUC	Trade Union Congress

## **EXECUTIVE SUMMARY**

CHAG commissioned an assessment of the current status of human resources capacities, management systems and operations throughout its network, comprising member institutions, the Coordinating Units and the Secretariat.

The objectives of the exercise were:

### ***Policy analysis***

1. To review existing HRD policies, plans and procedures within the health sector and identify the (future) implications thereof for CHAG
2. To assess current HR policies, strategies and plans within CHAG and assess the relevance thereof against the background of ongoing developments within the health sector

### ***Analysis of staffing situation within CHAG***

1. On the basis of staff print-outs from the Executive Secretariat and the MOH assess current staffing levels for all CHAG facilities
2. Working from these staff establishment lists, conduct a comprehensive employee profile analysis to verify employment and identify any inconsistencies
3. Based on this information, provide a detailed and accurate report on current staffing levels, by category of employee per health facility
4. Plot current ratio of clinical to non-clinical staffing at each health facility and provide overall statistics

### ***System Analysis***

1. To describe and analyse HR planning and implementation processes and procedures from identification of staffing needs, definition of job profile, selection, recruitment, appointment to ultimate placement
2. Analyse current strengths and weaknesses in the 'mechanisation chain' from the level of health institution through the Executive Secretariat to MOH/MOF and vice versa
3. Analyse the capacities of CHAG in HR policy and strategy development, planning, management and monitoring
4. Analyse existing administrative systems, processes and procedures at the CHAG Secretariat in relation to the implementation of HR strategies

5. Following this analysis, the consultants were expected to make a series of operational recommendations and concrete proposals to address the challenges identified for each of the above mentioned areas.

#### ***Recommendations at policy level***

1. To draw up an agenda, including priority issues that need discussing between CHAG and the MOH in the short and immediate future
2. Assess projected staffing requirements for the next 5-10 year, including the budgetary implications thereof
3. Make a projection of budget implications for sustainable funding of entire staff establishment of CHAG
4. Provide options for rationalizing human capacity utilization and development in CHAG institutions.

#### ***Recommendations at strategic level***

1. Prepare staffing models based on actual workload variables (not just bed-based staffing norms), patient utilisation rates, appropriate level of care, theatre utilisation rates, epidemiological and health information system data
2. In consultation with key role players develop an optimal staffing model that focuses on health care service delivery (within the limited resources available); the optimal staffing model may vary over time in function of available resources and priorities
3. Design a Retention and Recruitment Strategy that looks at creative yet cost-effective ways of attracting staff with a special emphasis on improved compensation packages and conditions of service to retain them in the public health sector.

#### ***Recommendations at operational level***

1. Develop for implementation a streamlined approach from recruitment to being loaded onto the payroll for all new members of staff (particularly new medical professionals)
2. Define the mandate, role and functions of a HR-desk at the Secretariat, including job description for the HR officer to be appointed
3. Develop the architecture of a computerised Personnel Management Information System at the Secretariat

The approach and methods used in the assessment included collection, collation, review and analysis of relevant policy documents, guidelines, programmes of work (POWs) and reports from CHAG, Ministry of Health (MOH), Church Health Coordinating Units, and the Memorandum of Understanding and Administrative Instructions signed between the MOH and CHAG in 2006 documents.

Findings indicated that the Ministry of Health and CHAG entered into a covenant culminated in the signing of a Memorandum of Understanding (MOU) in 2006.

The document defines the roles and responsibilities of both parties in building HR management and development capacities for improving health service delivery. The MoU requires CHAG to strategically improve on its staff management systems and practices and to operate within the human resources for health principles and policies of the Ministry of Health.

Analysis of payrolls of CHAG hospitals indicated that numbers of health professional staff available and their mix in most places did not befit the status of a hospital. For some facilities designated as hospitals, there were severe shortages of professional staff. It appeared care was mainly provided by semi-skilled or non-skilled personnel. Almost 70.0% of the staff on payroll is non-clinical staff, with 20.7% being health assistants who may be providing clinical services under very little supervision because of the shortage of qualified general nurses.

Institutional personnel data shows that the efforts to put staff on government mechanized payroll has been across board for both health professionals/technicians and non-skilled support staff. However, the current crippling staff cost to the government require that preferences be given to mechanizing of critically needed health professionals. The process for seeking mechanization unto the IPPD system is cumbersome. The role of the Secretariat in the mechanization process has been reduced to a mere formality of providing a covering letter to applications from member institutions without any screening or value addition. The arrangements need to be streamlined.

In all, about 20% of health professional and technical staff in CHAG will be retiring within the next 5 years. Out of this number, about 9% will also retire within the next 2 years.

Whilst some few churches such as the Catholic and to some extent the Presbyterian have developed specific human resources for health policies others use general human resources policies of their church. The Collective Bargaining Agreement signed between the Health Services Workers Union (HSWU) of TUC and the Ghana Health Service, CHAG and the Teaching Hospitals was also cited by some Coordinating Units as a reference document for staff management in their member institutions.

The processes used by the MOH for developing the human resources for health policies for the health sector were not adjudged to be participatory enough. CHAG does not have an overarching strategic human resources plan neither does it have a staffing norm to

guide distribution of staff in its institutions. Each constituent health unit has its own unique staffing norms and plans. This does not augur well for standardization and uniformity as required by MOH. As part of its coordinating responsibilities CHAG should be able to provide a strategic HR framework that will serve as guide for coordinating units and member institutions to develop their detailed human resources plans. This will provide a reasonable and standardized basis and evidence for resource mobilization for CHAG as a corporate body.

Managers in the coordinating units visited emphasized during discussions that the Secretariat needs to focus on its role as a liaison office between CHAG member institutions and the MOH. Streamlining HR management systems and assigning a dedicated staff at the Secretariat to facilitate the processes was emphasized by most informants. It was further suggested that: an incentive package that would motivate staff to remain in their respective institutions and to work diligently should be put together; Coordinators must be encouraged to establish close links among themselves to enable them share professional knowledge, experience, expertise of their staff; and that, a policy permitting transfers of staff among CHAG member institutions would greatly ease the intractable staffing problem.

It is recommended that:

<b>Level of Responsibility</b>	<b>Recommendation</b>
<b><i>Policy (Board)</i></b>	<p>The Board should meet to map out strategies to meet to address the staffing crisis threatening health care delivery in their institutions. Important issues for consideration include:</p> <ul style="list-style-type: none"> <li>• How to maximise the use of available scarce professionals across denominational lines</li> <li>• Procurement of critically needed expatriate health professionals en-bloc where necessary for use by member institutions across denominations</li> <li>• Strengthen CHAG Secretariat and empower the staff to advocate for, and coordinate activities to support member institutions.</li> </ul>
<b><i>CHAG Secretariat</i></b>	<ul style="list-style-type: none"> <li>• CHAG should have a meeting with the MOH to clarify and operationalise the MOU</li> <li>• the regular meetings between the Secretariat and the Coordinating Units that has been instituted should be more focused on priority pertinent issues</li> <li>• the Secretariat should strengthen its linkage with both MOH HRDD and the Coordinating Units through regular briefs</li> </ul>

	<ul style="list-style-type: none"> <li>• an HR Desk should be created and a competent HR Manager be employed</li> <li>• together with the Coordinating Units, the Secretariat should prepare a guideline for submission of inputs to the IPPD;</li> <li>• key staff of the Coordinating Units should be trained in the use of workload indicator tools in determining staffing requirements;</li> <li>• job descriptions should be developed for all staff of the Secretariat and they be re-orientated to focus on performance; and,</li> <li>• form a high powered personnel recruitment committee to work out modalities for mobilizing and sharing health professionals among CHAG institutions.</li> </ul>
<p><b><i>Health Coordinating Unit Level</i></b></p>	<p>Coordinators should:</p> <ul style="list-style-type: none"> <li>• organise regular meetings with Diocesan Coordinators and Institutional Heads to update them on developments in hr management in the health sector</li> <li>• disseminate and review policies</li> <li>• assist Institutions to integrate health sector human resources policies with those of their churches</li> <li>• train and assist Institutions to apply the health sector staffing norms in determining their staffing needs</li> <li>• set up a database of all staff in Institutions under the Coordinating Unit; elicit relevant support for institutions to develop detailed human resources plan</li> <li>• present half yearly reports on human resources issues to the Secretariat; analyse and provide feedback on hr reports to institutions.</li> </ul>
<p><b><i>Institutional level</i></b></p>	<p>Institutions should:</p> <ul style="list-style-type: none"> <li>• integrate health sector human resources policies with those of their churches</li> <li>• apply the health sector staffing norms in determining their staffing needs</li> <li>• set up a database of all staff in the Institution</li> <li>• develop detailed human resources plan for the institution</li> <li>• present quarterly report on human resources to the Coordinating Unit.</li> </ul>

## **1. INTRODUCTION**

### **1.1 The role of CHAG in health care in Ghana**

CHAG member institutions are involved in the provision of curative, preventive and rehabilitative health care at primary and secondary levels especially in rural and deprived communities in all the 10 regions of Ghana. This is in line with the government's policy on public-private partnership which seeks to promote a pluralistic health sector to ensure improved access and quality of care for all people living in the country.

In order to ensure better coverage and quality of care, CHAG has deployed a mix of various categories of health workers to deliver services at different levels. These mixes of health workers include highly trained professionals such as doctors, nurses, midwives, laboratory scientists, pharmacists, health service administrators and others.

In recognition of the efforts of CHAG the government of Ghana provides support in the form of payment of salaries of Ghanaian staff working in the Secretariat and the member institutions.

### **1.2 On-going Human Resources for Health Interventions**

CHAG has been collaborating with the Ministry of Health and its Agencies in the efforts to strengthen capacity for human resources management and development with a focus on developing effective systems and sub-systems for managing the recruitment, training, deployment and performances of staff. In order to arrest the high rate of brain drain, government offered a dramatic increase in remunerations for all categories of health workers both in the public sector and CHAG member institutions.

Though there are indications that the interventions are yielding some positive gains, there are also noted challenges that need to be addressed. In a recent forum of stakeholders on human resources for health held in July 2008, the Honourable Minister of Health whilst acknowledging the slow down of brain drain, also expressed concern about the increasing wage bill for health workers. He stressed that the government will not be in a position to sustain the current remuneration levels for health workers. He also requested that the current inequities in the distribution of some critically needed health professionals should be addressed.

The forum came out with recommendations of some key actions that need to be carried out to address the looming human resources for health crisis in the country including among others, ridding of payrolls of "ghost" names, and improving efficiency in the use of the health workforce.

CHAG intends to improve on the utilisation of its existing health workforce in line with the health sector HR policy directions and recommendations from the HRH forum. To make the interventions relevant to addressing the challenges, CHAG commissioned an assessment of the current status of human resources capacities and management systems and operations within CHAG and the coordinating units of its member institutions.

## **2. OBJECTIVES OF THE ASSESSMENT**

The objectives of the exercise were:

### ***Policy analysis***

3. To review existing HRD policies, plans and procedures within the health sector and identify the (future) implications thereof for CHAG
4. To assess current HR policies, strategies and plans within CHAG and assess the relevance thereof against the background of ongoing developments within the health sector

### ***Analysis of staffing situation within CHAG***

5. On the basis of staff print-outs from the Executive Secretariat and the MOH assess current staffing levels for all CHAG facilities
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### ***System Analysis***

4. To describe and analyse HR planning and implementation processes and procedures from identification of staffing needs, definition of job profile, selection, recruitment, appointment to ultimate placement
5. Analyse current strengths and weaknesses in the 'mechanisation chain' from the level of health institution through the Executive Secretariat to MOH/MOF and vice versa
6. Analyse the capacities of CHAG in HR policy and strategy development, planning, management and monitoring
7. Analyse existing administrative systems, processes and procedures at the CHAG Secretariat in relation to the implementation of HR strategies
8. Following this analysis, the consultants were expected to make a series of operational recommendations and concrete proposals to address the challenges identified for each of the above mentioned areas.

### ***Recommendations at policy level***

9. To draw up an agenda, including priority issues that need discussing between CHAG and the MOH in the short and immediate future
10. Assess projected staffing requirements for the next 5-10 year, including the budgetary implications thereof
11. Make a projection of budget implications for sustainable funding of entire staff establishment of CHAG
12. Provide options for rationalizing human capacity utilization and development in CHAG institutions.

### ***Recommendations at strategic level***

13. Prepare staffing models based on actual workload variables (not just bed-based staffing norms), patient utilisation rates, appropriate level of care, theatre utilisation rates, epidemiological and health information system data
14. In consultation with key role players develop an optimal staffing model that focuses on health care service delivery (within the limited resources available); the optimal staffing model may vary over time in function of available resources and priorities
15. Design a Retention and Recruitment Strategy that looks at creative yet cost-effective ways of attracting staff with a special emphasis on improved compensation packages and conditions of service to retain them in the public health sector.

### ***Recommendations at operational level***

16. Develop for implementation a streamlined approach from recruitment to being loaded onto the payroll for all new members of staff (particularly new medical professionals)
17. Define the mandate, role and functions of a HR-desk at the Secretariat, including job description for the HR officer to be appointed
18. Develop the architecture of a computerised Personnel Management Information System at the Secretariat

### **3. APPROACH AND METHODS**

The approach and methods used in this assessment include collection, collation, review and analysis of relevant policies, plans guidelines, programmes of work (POWs) and reports from CHAG, Ministry of Health (MOH), Church Health Coordinating Units, and the Memorandum of Understanding and Administrative Instructions signed between the MOH and CHAG in 2006 documents.

The essence of the exercise was to establish the linkage between human resources management interventions initiated by CHAG and proposals outlined in documents produced by the MOH to guide human resources for health management and development in the health sector. The approach also aimed at identifying any synchronies or conflicts inherent in these documents.

There was also analysis of data available on staffing distribution and mix among member institutions. Further, there were in-depth discussions with key managers in the CHAG Secretariat, some Heads of the Church Health Coordinating Units, the Director and Deputy of the Human Resources Management and Development Division, and the Head of Integrated Personnel Payroll Database (IPPD) of the Ministry of Health. The purposes of the discussions were to elicit information and evidences on current human resources management systems and procedures in practice in CHAG and its constituent Health Coordinating Units in the light of expectations of the MOH. It was also to determine the perceptions of key individuals on the roles of CHAG now and in the future given the challenges that characterizes human resources management in the health sector in recent times.

#### **3.1 Limitations**

The main constraint was the use of secondary staff data from CHAG member institutions which were proved to be largely inaccurate and unreliable for use in analysis and projections for the short, medium and long term planning. For instance, a random cross-match of the staff data available with data collected from the institution showed that whilst data from the CHAG Secretariat showed Agogo Hospital had only 2 doctors, there were in fact fourteen(14) in the facility. In addition, data on utilization and workloads of facilities were also not readily available for use in categorizing facilities in relation to available norms.

## 4. FINDINGS AND DISCUSSIONS

### 4.1. The Memorandum of Understanding and Administrative Instructions

To affirm their commitment to setting a formal framework for improved and strengthened partnership for the provision of quality health care to the people of Ghana, the Ministry of Health and CHAG entered into a covenant. The covenant culminated in the signing of a Memorandum of Understanding (MOU) in 2006. The document defines the operational and administrative arrangements for the implementation of the MOU which states among others that:

- **CHAG shall agree to support the Human Resource requirements of the Ministry of Health Institutions where the need arises**
- **CHAG agrees to use MOH staffing norms**
- **Human Resources principles and policies of MOH may apply to CHAG**
- **CHAG shall submit its Human Resources needs to MOH for support**
- **CHAG Institutions shall at all levels participate in policy development and implementation**
- **CHAG shall put in place an administrative structure that will ensure prudent utilisation of Human and Financial resources made available to its institutions**
- **CHAG Institutions shall operate efficient Management and administrative structures which shall not compromise the main purpose and objectives of the MOH**

The tenets of the Memorandum of Understanding require that CHAG as an organization and a major health service delivery agency positions itself to strategically improve on its staff management systems and practices, particularly at a time when government is asking for efficient utilisation of the health workforce in order to contain the increasing wage bill. CHAG is expected to operate within the framework of the human resources for health principles and policies of the Ministry of Health.

The Ministry of Health formally published a Human Resources Policies and Plans document for implementation between 2002 and 2006. The policies and plans were reviewed and subsequently re-published for the period 2007 to 2011. Both versions have implications for human resources management for CHAG.

The following are key elements in the human resources principles, policies and plans that have implications for CHAG.

#### **4.2. Human Resources for Health Policies and Plans in the Health Sector and their Implications for the Future of CHAG**

The 2<sup>nd</sup> five year Programme of Work (POW) dubbed “Partnerships for Health, bridging the inequalities gap” recognized that improving the health of the poor is crucial for reducing poverty, given that ill-health is both a consequence and a cause of poverty. The human resource policy response was aimed at increasing production of well equipped staff; and the retention of staff in areas where their services are in most need. Human resources for health have been plagued by numerous challenges that need to be addressed in order to achieve the policy aim.

##### **A) The HR Challenges for the Health Sector and the Strategies 2002-2006**

The main Human Resources challenges identified include:

- Brain drain among health professionals at all levels of service delivery
- Inability to provide affordable package of incentives that encourages staff retention within the health sector
- The mal-distribution of health personnel geographically and by level of service delivery
- The legacy of past failures to take human resource implications into account in hospital- and health facility planning and expansion of services
- The dilemma of a wage bill constraint in the face of expectations for improved financial incentives and remunerations.

In order to confront the challenges above, the following strategic objectives were identified to guide the implementation of the human resources policies:

- Restructuring the number, distribution and skill mix
- Developing and implementing continuing professional programmes for all staff
- Decentralizing all management systems
- Developing performance management systems that recognize hard work and service in deprived areas
- Collaborating with non-governmental providers

The strategic objectives informed the subsequent strategic framework that was developed.

## **B) Human Resources Plan 2002-2006**

The Human Resources Strategic Plan (HRSP) 2002-2006 emphasized on the restructuring of the Health sectors' personnel numbers, distribution, and skills mix through among others:

- Development of programmes for Continuous Professional Development Programmes for all categories of staff
- Linking in-service training and continuing education to staff promotion and career progression to address the issue of retention of staff
- Decentralization of Management systems in order to be able to recognize and reward hard work and services in deprived locations
- Promotion of collaboration between public sector health providers and private practitioners.

The anticipated results for the 2006 POW included but were not limited to:

- Ensure equitable distribution of HR to benefit deprived areas;
- Retain trained staff
- Institute a performance related reward systems
- Foster partnership with non-government providers of health services.

The human resources principles, policies and strategic plans were implemented in the health sector generally in piecemeal and achieved mixed results. For instance, very little was achieved in ensuring equity in staff distribution. Staff performance assessment approaches in the Sector remained rudimentary and do not influence rewards. The documents were revised for the subsequent 5-year period. There was however some significant improvement in public-private partnership as evidenced in the signing of the MOU between CHAG and the MOH, with a focus on improving human resources for health management and development.

## **C) The Revised Human Resources for Health Policies and Strategies 2007-2011**

The revised Policies and strategies for the health sector 2007-2011', were derived from a conceptual framework on global Health workforce issues, National Development Goals, and the 3<sup>rd</sup> MoH five-year programme of work 2007-2011 dubbed "Creating Wealth through Health".

The national health policy dated 2007 shows *a new paradigm* aiming at *health promotion and prevention* of ill-health in order to be able to increase outcomes of the Millennium Development Goals (MDG). The Health policy adopts an approach that addresses the broader determinants of health and focuses on the promotion of healthy lifestyles within the context of a healthy environment; hence increased emphasis on potable water, good sanitation, safe food, improved housing and control of road traffic accidents.

Under this policy, human resources is defined as including all human capacity involved in developing, providing, managing or supporting curative, preventive, promotive and rehabilitative health. It constitutes all 'professionals' and 'non-professionals' (involved in the provision of allopathic, traditional and alternative health), skilled and unskilled whose primary function is to produce health.

Households and communities are being seen as primary producers of health and therefore have to be incorporated in all health programmes and be empowered as producers of health.

Mobilization of 'other' professionals like, for instance, environmental health officers, gym operators, nutritionists, motor traffic units of the Police, school health units, teachers and agricultural extension workers is a priority.

Collaboration with other stakeholders (government, other MDAs, local authorities, private sector, civil society organizations, NGO's, communities and traditional leaders is needed.

The main human resource challenges highlighted included:

- Inequitable distribution of workers at different levels of services delivery.
- Inadequate numbers
- Low morale and motivation of health workforce
- Inadequate supportive/facilitative supervision
- High attrition of health workers
- Weak performance management systems
- Limited training capacity to meet increasing numbers into the training institutions
- Inadequate collaboration between Ministry of Health and Ministry of Education Training Institutions
- Weak Human Resources Information Systems
- Lack of integration and recognition of Traditional, Herbal and alternate medicine within the Public Health system.

Strategic objectives of the Health sector for implementation were:

- Promoting an individual lifestyle and behavioral model for improving health and vitality by addressing risk factors and by strengthening multi-sectoral advocacy and actions
- Rapid scaling up within the existing capacity, high impact interventions and services targeting poor, disadvantaged and vulnerable groups
- Investing in strengthening health system capacity to sustain high coverage and related reward systems
- Foster partnership with non-government providers of health services.

#### **D) Health Sector Annual POW 2007**

The policy thrust for 2007 of the Health sector Annual POW 2007 was to increase the production of middle level cadre, continuously refine strategies for retention, equitable distribution and enhance productivity:

Key activities planned for implementation by the health sector include:

- Increasing home and community based care components of existing programmes such as roll-back malaria, HIV/AIDS, Community IMCI etc.
- Increasing the production and recruitment of health workers focusing on middle level health professionals
- Retaining, distributing equitably and increasing productivity and responsiveness of human resources by: strengthening the systems for supervision, accountability and overall human resource management by piloting decentralization of HR management in 3 regions
- Promoting and enforcing effective legislation and regulation by strengthening support for professional and statutory bodies
- Formation of country HRH consultative group to serve as an advisory body on HR policy direction and other key HR issues
- Collaborating with MLGRD on the effective deployment and functioning of environmental health officers in the promotion of a healthy environment
- In collaboration with GCPS, accrediting regional and district health training sites to rapidly deploy Taking stock of the current staff strength of public health facilities through head count
- Conduct impact assessment of the new salaries and other incentives

#### **E) Health Sector Annual POW 2008**

The policy thrust for 2008 was to ensure an equitable distribution of the right numbers and mix of health staff and introduce staff productivity improvement programmes.

Key Activities earmarked for implementation within the period include:

- Implement the planned Human Resource strategic plan
- Conduct impact assessment to ascertain the impact of the new salary scheme and other incentives to increase staff productivity
- Review the expansion of the middle level training programme
- Deploy resources to the recently established Human Resource Observatory to ensure the governance issues are complied with.
- Collaborate with MLGRD, MOESS and GCPS to effectively train and distribute health personnel.

All the documents cited above highlight some key human resources policies and priority interventions that are relevant for strengthening staff management in CHAG and its institutions. In the spirit of the MOU, CHAG is expected to manage its human resources in line with the policies and priorities.

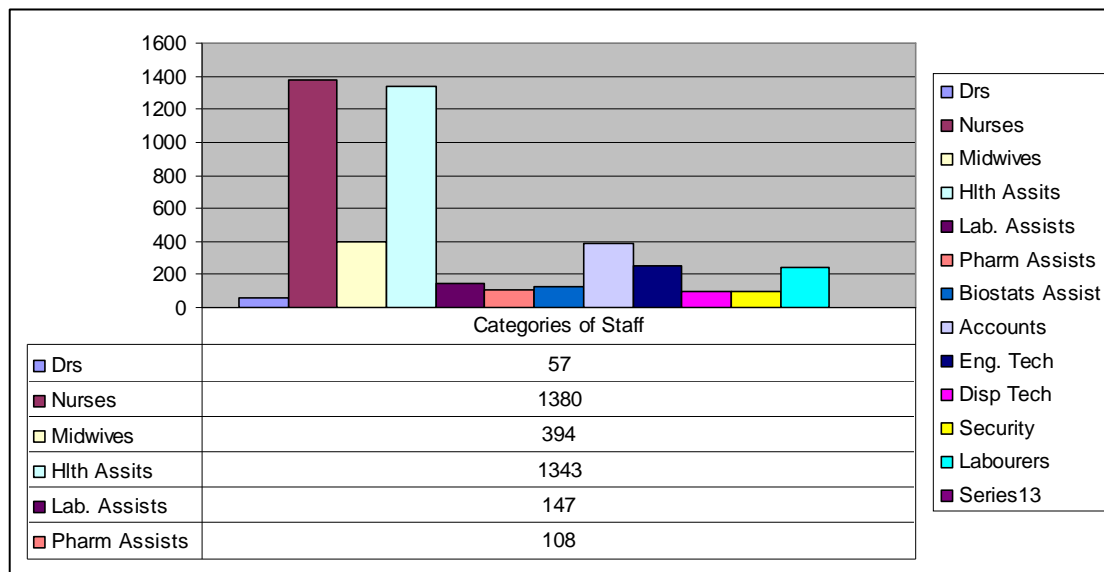
### 4.3. Staffing Situation in CHAG

Staffing in CHAG institutions epitomizes the worst form of inequities in distribution, and the inappropriate mix in the Ghanaian health sector. There are gross shortages of health professionals in all the institutions. Though data on utilization of facilities were not readily available, it was obvious that numbers of health professional staff available and their mix in most places did not befit the status of a hospital. For some facilities designated as hospitals, professional staff shortages was so acute that it appeared care was provided by non-skilled personnel, a situation that is likely to affect quality of care. This calls for standardization or re-designation of facilities within CHAG. In all, there are about 6,488 staff on the mechanized payroll. Out of this number 2,273(35.0%) is clinical staff excluding health assistants numbering 1,343 (20.7%). This connotes that the mechanized payroll is loaded with non-clinical staff. The increasing numbers of health assistants is an indication of the critical shortage of nurses in most institutions, a phenomenon which poses a threat to quality of nursing care in many hospitals. Detailed breakdown of staff per category and by institution are attached in annex 4.

The Catholic Church has the highest number of health facilities and correspondingly, the highest number of health professionals in CHAG. They have a total of 19 medical officers of various grades, and 9 specialists on the government mechanized payroll out of the total of 57 medical officers (including generalist and specialists). The numbers appear relatively large but they are no where near the optimum requirements of the institutions. It should be noted however that, there are likely to be some expatriate health professionals who were captured as part of the cohort. There may also be some staff who are on secondment from GHS and who names therefore are not on the payroll of the institutions.

The chart below depicts the numbers of staff per category in CHAG Institutions.

**Fig. 1: Staff Distribution in CHAG Institutions per Category**



Nurses and Health Assistants constitute the highest category of staff in CHAG institutions. Even though health assistants are expected to be used to assist mainly nurses in providing the non-technical aspects of nursing care, in many facilities they are rather being used as nurse-substitutes.

### Internal Inequities in Staff Distribution

Data from the mechanized payroll suggests that some facilities are relatively better endowed with health professionals than others. However, there are no arrangements in place for facilities sited in close proximity to each other to share the skills of the critically needed staff available. (See annex 1 for distribution of some key staff in CHAG Hospitals).

### Controlling Government Personnel Cost

Institutional personnel data shows that the efforts to put staff on government mechanized payroll has been across board for both health professionals/technicians and non-skilled support staff. The current crippling staff cost to the government and the call by the Hon. Minister for a cut on expenditure on personnel emoluments require that preferences be given to mechanizing of critically needed health professionals. To ensure that institutions conform to this, both Health Coordinating Units and CHAG Secretariat have roles to play. Coordinating Units will have to assist their institutions to assess their critical health professional needs based on the norms from the MOH and prepare realistic HR plans accordingly. CHAG on its part will have to make the norms available to the Health Coordinating Units. Further CHAG should be strengthened to screen all applications for mechanization. Except for exceptional cases, applications that do not meet the eligibility criteria must be rejected.

### Staff Distribution

Ministry of Health has initiated a process of applying a quota arrangement in distributing some critically needed staff such as doctors and nurses to its Agencies. CHAG relatively has a large number of staff other than nurses and doctors compared to staffing in GHS. The figures below depict distribution of nurses and doctors between CHAG and GHS

Fig. 2

HUMAN RESOURCE 2008 (Nurses & Other staff)

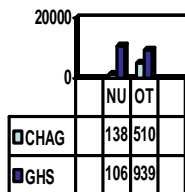
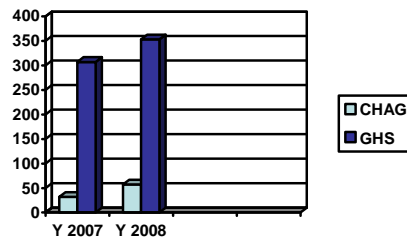


Fig. 3 Drs. in CHAG & in GHS



The looming challenge is for CHAG to make a good case more allocation of the critically need professional staff notably doctors and nurse and to ensure equity in the distribution among CHAG institutions without any suspicions, acrimony, rancour or bitter feeling.

Member institutions are likely to feel cheated if realistic and scientific approaches are not used in the distribution of allocated staff.

#### **Projected Retirements within the Next 5 Years**

Whilst about 21% of the medical officers in hospitals owned by Catholic Church will be reaching their compulsory retirement age within the next 5 years, about 33% of the specialists will also retire within the same period. Similarly, Baptist Church and Church of Pentecost will have about 60% and 50% of their respective midwives retiring within the next 5 years. In all, about 20% of professional staff and technical staff within CHAG will be retiring within the next 5 years. Out of this number, about 9% will also retire within the next 2 years. (see annex 2 for the table of projected retirements).

Any strategic HR plan for the institutions should take into consideration the anticipated retirements within the planned period.

#### **4.4. Human Resources Management Systems, Procedures and Practices in CHAG**

In the discussions with key personalities in the CHAG Secretariat, the Health Coordinating Units, the MOH and GHS, the following were the issues raised and the deductions made:

##### **HRH Policies**

Whilst some churches have developed specific human resources for health policies others use general human resources policies of their church. In all cases however it was explained that they try to also work in conformity with the Human Resources Policies developed for the health Sector by the Ministry of Health and the Collective Bargaining Agreement signed between HSWU of TUC and the GHS, CHAG, and the Teaching Hospitals. . The extent to which the health sector human resources policies are adhered to was not clear.

The processes used by the MOH for developing the human resources for health policies for the health sector were not adjudged to be participatory enough as the involvement of CHAG has been rather peripheral. Health Coordinating Units also did not involve CHAG in the development of their specific HR policies. In effect the extent to which health sector human resources policies reflect staff management guidelines are left purely to each member church to decide

The current arrangement weakens the role of CHAG as a coordinating Secretariat with the responsibility for harmonizing activities of member institutions in line with health sector priorities as required by the MOU.

CHAG, as one of the major employers and developers of health workers should be consulted right from the onset of the human resources for health policy formulation processes. That will deepen their contribution to the processes, provide them deeper insights into the policy priorities and thereby promote their ownership and commitment to implementation.

CHAG has the responsibility to ensure effective and efficient utilisation of its human resources especially in the face of the increasing wage bill to government. To do this, the organisation has to facilitate the process of effectively aligning human resources for health policies of its member institutions to the human resources for health policies and strategic plans of the MOH. In order to smooth the implementation of the HR policies, CHAG is expected to provide a framework, guidelines and protocols to aid member institutions in their planning and budgeting processes. In addition CHAG is expected to provide technical support and guidance to all levels within the organisation. There should be conscious efforts to strengthen collaboration among member institutions through effective communication, knowledge and resource sharing.

### **HRH Strategies and Plans**

CHAG does not have an overarching strategic human resources plan neither does it have a staffing norm to guide distribution of staff in its institutions. Each constituent health unit has its own unique staffing norms and plans. In some health units, each health institution is said to have its own staffing norms and HR plans. Some coordinating units however provide a framework with which its member institutions prepare their plans. Other institutions are also said to use the staffing norms provided by the MOH in assessing their staff requirements.

The MOU enjoins CHAG and its member institutions to use staffing norms provided by the MOH to determine its staffing needs. This implies that CHAG needs to communicate the MOH staffing norms to its member institutions in a way that will ease usage. It will require that institutions are given adequate training and regular updates in the application of the norms in rationalizing staff distribution; and usage among the institutions.

It has become pertinent to use standardized norms that are workload based since MOH plans to henceforth release newly recruited essential staff en bloc based on quota arrangements to agencies for their internal redistribution. Standardized norms based on workloads and services will provide objective basis for staff distribution.

### **Staff on Government Payroll and the Mechanization Process**

Whilst some churches have 70 – 95% of their health workers on the mechanized government payroll, others have about 50% of their staff being paid directly by their hospitals. The mechanized staff is made up of both technical and support staff. Staff of the CHAG Secretariat is all on the government payroll too.

There is a directive that only health professionals will be accepted for mechanization henceforth in view of the increasing wage bill for the government. This implies that all inputs and applications to the MOH and the IPPD Units should be properly scrutinized to ensure that the directives are followed.

The typical mechanization process starts with:

1. Each institution identifying vacancies within its set up
2. The Institution applies to the Head of Civil Service for authorization to recruit and sends same to CHAG for a cover letter
3. Application with the cover letter is taken to the MOH for another cover letter before submission to the Office of the Head of Civil Service
4. After a number of follow ups, when authorization is given, the institution applies for financial clearance
5. Application is submitted for a cover letter from CHAG
6. With the cover letter, application is submitted to the MOH for another cover letter to the Ministry of Finance
7. After a number of follow ups, when financial clearance is obtained: Inputs are prepared and submitted with supporting documents to the MOH IPPD.

Sometimes, both the CHAG Secretariat and the MOH IPPD are bypassed and inputs are submitted directly to the Controller and Accountant-General's Department even though that is against the regulations.

According to the MOH IPPD Office, most often inputs submitted by CHAG member institutions are fraught with inconsistencies, inadequacies and lack supporting documents. Sometimes grades unto which institutions appoint or promote people do not conform to laid down eligibility standards as pertains in the public sector. CHAG payroll is bloated partly because inputs are not submitted for the deletion of names of staff who resign from CHAG member institutions to join GHS .CHAG officials on the other hand complain that it takes several months for inputs submitted to the IPPD to reflect on the payroll.

The IPPD office expects that CHAG will be able to improve on the timeliness and quality of data its member institutions submit for inputting. They indicated that if CHAG should identify dedicated people, they will be prepared to train them in the preparation of inputs for submission.

The role of CHAG Secretariat is limited to only provision of cover letters, with little or no value addition. Staff from member institutions have to spend many months directly doing follow ups to ensure that their inputs have been captured on the payroll. However when problems occur, institutions vent their frustrations on CHAG Secretariat.

The process for seeking mechanization unto the IPPD system is cumbersome. However, the arrangement could be streamlined if CHAG Secretariat could be empowered to, not only provide cover letters but to also submit and follow up on applications to the various Ministries and Departments on behalf of member institutions. Further, CHAG can be charged to scrutinize and ensure that applications conform to laid-down procedures and

regulations before providing cover letters. By such arrangements member institutions will make more efficient use of staff time whilst CHAG's liaison role will be further enhanced. This arrangement will however require that a full time dedicated officer with competences and experience in strategic human resources management is assigned to facilitate human resources issues in CHAG (proposed job description and person specifications attached in annex 3)

It will be to the advantage of CHAG to thoroughly rid payrolls of its institutions of staff who have moved to GHS or migrated to other agencies but continue to retain their names in their former work places thereby inflating the personnel expenditures of the cost centres. A cleaner payroll will enable institutions to provide realist justification when applying for additional staff.

### **Ensuring Efficiency in the Recruitment and Promotion Practices in CHAG Institutions**

In most institutions pains are taken to ensure that only qualified and experienced applicants are selected (via various channels of communication: advertisement in the print media, or even personal contact). The short-listed candidates are then interviewed by properly constituted panels at the facility level (but may include experts from GHS) to choose the most suitable ones. A background check of candidates may be conducted at their previous places of employment. However, recruitments among the member institutions are poorly coordinated. That explains why inputs are submitted haphazardly.

A well-coordinated recruitment process where members agree with the Secretariat on modalities, frequency and streamlined times for submission of inputs will be helpful. For instance, members may agree that each institution should, on the basis of the staffing norms from the MOH, determine its staffing needs, and project requirements for the subsequent four years per each category of staff. Copies of such plans would be submitted to the Secretariat. Members may also agree that the applications for authorization and inputs for mechanization should be submitted twice a year, that is, in April and October each year. The Secretariat will then compile and submit the requests within a given time and follow up regularly till they are all processed.

### **CHAG in the Changing Environment**

In the discussions with the various stakeholders it was emphasized that the CHAG Secretariat needs to focus on its role as a liaison office between CHAG member institutions and the MOH. It should actively coordinate the activities of its members with the MOH, the Ministry of Finance and other departments such as the Comptroller and Accountant-Generals Dept.

CHAG is expected to engage in advocacy, networking and public relations, resource mobilization, provide technical support to member institutions, and conduct monitoring and evaluation.

CHAG is expected to play a lead role in obtaining professional staff e.g. Doctors and Nurses from MOH for its member institutions. CHAG is also expected to mobilize resources for its member institutions and may also help in the training of staff.

It is the responsibility of member institutions and their coordinating units to support the Secretariat to perform their expected functions. If members continue to bypass laid-down procedures in their dealings with the Ministries, departments and Agencies, and turn around to complain when things do not work to their expectations, the Secretariat will remain weak.

### **HRH Management Roles of Coordinating Units**

Informants indicated that the Coordinating Units are expected to develop policies and guidelines to reflect the priorities of the health sector (as set by the MOH) for application in their facilities.

The heads of coordinating units are expected to ensure that their facilities are staffed with qualified personnel through an efficient recruitment process (even if they do not participate directly in the process). The Units also have to ensure that capacities of their staff are enhanced through training e.g. further studies, seminars and workshops.

Through close linkage with the Secretariat the coordinators are expected to obtain and disseminate information, such as policy directives (from MOH) for implementation in their facilities.

Since the Coordinating Units serve as links between the Secretariat and their institutions, it is important that they are strengthened to enable them provide timely support to the institutions.

### **Challenges of CHAG in Human Resources for Health Management**

Informants highlighted the following as the key human resources challenges of CHAG:

- CHAG does not have an HRM system in place at the secretariat and as such nobody appears to be responsible for ensuring that laid-down procedures are followed
- There is no qualified and experienced HR manager, who will handle core HR issues and also share his experience with the coordinators
- No reliable database has been created on institutions and their staff complements. The Coordinators worsen the situation by not providing adequate and accurate data to the CHAG secretariat
- Time spent in supplying information being requested tends to be too long
- Some member-institutions do not adhere to laid down procedures e.g. they may bypass CHAG and submit names of newly recruited staff to the IPPD unit of the MOH or even to the Controller and Accountant-Generals Dept.
- Getting names of newly recruited or promoted staff mechanized has remained an overwhelming difficulty

- Differences in sizes, the varying levels of development and orientation of the Church Health Organizations make it difficult for the Secretariat to effectively coordinate activities of members
- CHAG has never been able to meet the staffing needs of its member institutions.

Streamlining the human resources management systems and assigning a dedicated staff at the Secretariat to facilitate the processes was emphasized by most informants. It should be noted however that for whatever systems to work effectively, there is the need for all stakeholders at all levels to be committed to make it work. Processes and procedures need to be clarified for the different levels.

Communication, both horizontally among institutions, among coordinating units, and vertically between the various levels need to be enhanced to allow timely and free flow of information. Health coordinating units should be encouraged to talk freely and share information across the church divide beyond the scheduled meetings scheduled by the Secretariat. CHAG as a corporate body stands to be more efficient and effective if members commit themselves to supporting each other. Members with well-developed systems and structures for staff management need to share their expertise with the relative smaller ones with weaker structures. Internally, adjoining

Institutions can agree and work out modalities to share expertise (extra-mural practice) and thereby complement each other's efforts.

Delays in submitting information or data to the Secretariat may result in the loss of a golden opportunity or access to a much needed resource. Similarly, uncoordinated submission of inputs from the institutions to the IPPD Units makes it difficult for the Secretariat to track progress of processing. Besides, the IPPD Units also find it cumbersome to deal with the fragmented submissions as some get mixed up with inputs from other sources.

The call by the Honourable Minister of Health that staffing should be rationalized in order to control the increasing government wage bill demands prioritisation of staffing needs and therefore submission of applications for authorization for recruitment, and inputs for mechanization of salaries of new entrants. Emphases should be on priority or critically needed health professionals and technicians such as: doctors, nurses, midwives, pharmacist, pharmacy technicians, medical assistants, laboratory scientists, radiographers, and biostatisticians. Inputs being submitted for these categories of staff must not be interlaced with those of non-skilled support staff. This implies that institutions should explore other sources including Internally Generated Funds (IGF) to take care of remunerations of their non-skilled support staff.

CHAG's inability to meet the staffing needs of its members have been of long-standing concern. At a meeting held in 1975, members then expressed disappointment that CHAG had not been able to use its ecumenical corporate strength to deal with the recruitment of staff to meet the growing needs of its member institutions. It was suggested then that "a much more effective way of dealing with this problem was to have all present and anticipated staffing needs listed with CHAG who could then develop relationship with all

sources for personnel replacement, not only through the Ministry of Health ..., but also through agencies overseas”. The suggestion is relevant today as it was thirty-three years ago. Such a move would require the development of a detailed HR plan indicating areas of shortfall and categories of staff required. The framework for such an initiative should take into consideration ethical codes governing medical practices in member institutions.

### **Support Required to Strengthen CHAG to Overcome Challenges**

Informants were of the opinion that CHAG secretariat should have an HR Desk manned by a professionally trained and experienced HR manager to effectively coordinate human resources management activities of the member units and provide relevant technical support to institutions when needed.

They also suggested that a suitable HRM system should be developed (or some of the software being used in the secretariat or member institutions could be adapted) for application at all levels of the organization.

An informant also felt that Church Health Departments/Coordinators should support CHAG by providing adequate and accurate information needed promptly in order to enable the Secretariat create and regularly update a reliable human resources database.

Informants felt strongly that CHAG should enhance the capacities of its staff; and those of its member institutions through training. It must also build sufficient capacity to implement its side of the MOU. In the words of one informant “CHAG must be proactive and not wait for GHS to dictate the pace. It could initiate policy, develop plans or strategy”.

Some were of the opinion that CHAG should institute an incentive package to motivate staff of the Secretariat as well as those of its member institutions to promote staff retention and to discourage them from leaving to join the GHS or seek greener pastures elsewhere.

It was strongly felt that the coordinators meeting should be institutionalized and held more frequently to serve as a platform for active collaboration and sharing of ideas on pertinent issues.

CHAG, as one of the agencies supported by the MOH necessarily has to position itself to be able to advocate for, compete for resources, and effectively network with other agencies such as the GHS and the Teaching Hospitals. This will require re-defining roles and responsibilities, and re-orientation of staff in the Secretariat and to some extent the Health Coordinating Units. CHAG has to work hard to maintain its lead in promoting best practices in staff management and service delivery.

### **Support Required to facilitate Effective HRH Actions in Coordinating Units.**

Informants re-echoed the need to facilitate prompt action on human resources issues in the Health Coordinating Units, an HR Desk should be created at the CHAG secretariat to liaise with the Units on HR issues. The Desk Officer must be abreast with developments at MOH; and be able to provide needed assistance and accurate information promptly.

In addition Coordinating Units should have professional HR personnel to provide requisite expert backing to the Coordinators.

Some informants were of the view that assistance could be provided to develop a knowledge management base through building the capacity of a core group of people to facilitate acquisition of knowledge and skills in the work environment. Also, Coordinating Units should be supported towards meeting their staffing needs; and enhancing the capacity of their staff through training.

Other suggestions provided include:

- An incentive package to motivate staff to remain in their respective institutions and to work diligently should be put together. Such a package could also attract people from other agencies
- Coordinators must be encouraged to establish close links among themselves to enable them share professional knowledge, experience, expertise of their staff; and the use of special facilities
- A policy permitting transfers of staff among CHAG member institutions would greatly ease the intractable staffing problem.

## **5. CONCLUSIONS**

CHAG member institutions provide curative, preventive and rehabilitative health care to a significant proportion of a cross-section of people living in mostly deprived areas of Ghana. In recognition of the tremendous contribution of CHAG to health care, the government pays salaries of most employees of CHAG institutions. The CHAG-Government relationship in health service delivery is an effective example of public-private partnership.

Health care is labour-intensive, therefore, CHAG has deployed a mix of various categories of health workers to deliver services at both primary and secondary levels.

The assessment of human resources systems has shown that there are a number of documents in the health sector that determine the priority actions CHAG is expected to respond to. The Health Sector Policies and Plans for both 2002-2006 and 2007 – 2011 clearly outline priority HR interventions for the health sector in general. In furtherance of these, CHAG signed a Memorandum of Understanding with the Ministry of Health with which both parties bound themselves to some agreements.

Though implementation of the policies and plans has been generally patchy, MOH has attempted to play its expected roles by making the government of Ghana pay the salaries of CHAG staff. The MOH has also initiated the process of supplying some critically needed staff to CHAG.

Staff management within CHAG is strewn with a number of challenges. Central coordination of human resources management issues has been weak. In the process, there appears to be some disharmony in the way member institutions deal with the MOH and other Departments on staff related issues. The varying sizes and levels of development of coordinating units and institutions also make it difficult for the Secretariat to effectively perform its coordination roles. The weaker institutions are left often without any directions and support. There is inadequate data on personnel and this does not augur well for evidenced-based planning. Since the Secretariat has to present evidence in its quest to mobilize resources it will be useful to have a database that provides a broad view of staff distribution across the country.

CHAG needs to proactively position itself at all levels to effectively dialogue with the MOH and other Agencies in the quest for enhanced resource inflow. In the process however, CHAG has to streamline and strengthen its staff management practices in order to make effective use of available staff and to promote best hr practices.

## **6. RECOMMENDATIONS**

It is recommended that:

### **At the Secretariat:**

- CHAG should have a meeting with the MOH to clarify the MOU. At the meeting CHAG should emphasize its commitment to streamlining its operations for improved human resources management practices. MOH should be reminded in turn to channel all information to the institutions through the Secretariat and to remind institutions who flout the regulations to conform.
- Meetings between the Secretariat and the Coordinating Units should be institutionalized. Meetings should be used to disseminate and review policies and plans, to develop supervisory and monitoring support framework for the institutions, and to share information. The meetings should also be used to develop a minimum set of human resources indicators and to agree on frequency of reporting on human resources issues.
- The set of data required routinely at the Secretariat should include:
  - Categories of Staff,
  - Number Available per Category,
  - Work Location,
  - Number Retired
  - Number Resigned,
  - Number on Approved Study Leave

- The Secretariat should strengthen its linkage with both MOH HRDD and the Coordinating Units through regular briefs. The Secretariat has to create the habit of frequently checking if there are emerging issues or documents available in the MOH that are relevant to the institutions. An approach to such an arrangement will be to:
  - identify possible points in the Ministry from where such relevant issues are likely to emerge; and will be available
  - assign an officer to check at least once every week if any relevant documents have been released at the points
  - Quickly review the documents and disseminate accordingly, iv. Monitor to ensure that documents that are meant for dissemination are not kept for more than 3 days in the Secretariat
  
- Employ a competent HR Manager and create an HR Desk at the Secretariat. The HR Manager should be part of the technical support team. He/she will liaise between CHAG, and its member institutions on one hand, the MOH HRDD/IPPD Ministry of Finance and Controller and Accountant-General's Department, other relevant Ministries, Departments and Agencies on the other. He/she will also provide technical support to the Health Coordinating Units and Institutions. (see annex 3 for detailed job description and person specification).
  
- Together with the Coordinating Units, the Secretariat should prepare a guideline for submission of inputs to the IPPD. (Sample Guidelines are in annex 4).
  
- Train key staff of the Coordinating Units in the use of workload indicator tools in determining staffing requirements.
  
- Develop/or review job descriptions of all staff of the Secretariat and re-orientate them to re-focus on performance. In addition the Secretariat should look for resources to institute a performance-related reward scheme for its staff.
  
- Form a high powered personnel recruitment committee to work out modalities for mobilizing and sharing health professionals among CHAG institutions.

#### **At the Health Coordinating Unit Level**

- Coordinating Units should organise regular meetings with Diocesan Coordinators and Institutional Heads to update them on developments in human resources management in the health sector, disseminate and review policies.
  
- Assist Institutions to integrate health sector human resources policies with those of their churches.
  
- Train and assist Institutions to apply the health sector staffing norms in determining their staffing needs.

- Set up a database of all staff in Institutions under the Coordinating Unit.  
A typical database should contain the following data set:
  - Unique staff ID number
  - Names
  - Grade/post
  - Profession
  - Date of birth
  - Age
  - Level at which employed
  - Date of 1<sup>st</sup> appointment
  - Date of last promotion
  - Health facility
  
- Elicit relevant support for institutions to develop detailed human resources plans.
  
- Present half yearly report on human resources issues to the Secretariat. This will arm the Secretariat with reliable evidence to bargain and mobilize resources for CHAG.
  
- Analyse and provide feedback on HR reports to institutions.

**At the Institutional level:**

- Integrate health sector human resources policies with those of their churches.
- Apply the health sector staffing norms in determining their staffing needs.
- Set up a database of all staff in the Institution. ‘

A typical database should contain the following data set:

- Unique staff ID number
- Names
- Grade/post
- Profession
- Date of birth
- Age
- Level at which employed
- Date of 1<sup>st</sup> appointment
- Date of last promotion
- Health facility

- Develop detailed human resources plan for the institution. The plan should cover: current staffing levels; projected staffing requirements based on current shortfalls and projected attrition; services available and anticipated over the planned period; priority in-service training and other capacity building initiatives; performance management initiatives; planned incentive schemes.
- Present quarterly report to the Coordinating Unit.

**Annex 1**

**KEY STAFF DISTRIBUTION IN CHAG HOSPITALS  
STAFF CATEGORY**

<b>NAME OF HOSPITAL</b>	<b>OWNERSHIP</b>	<b>Drs (Gen)</b>	<b>Drs (Spec)</b>	<b>Nurses</b>	<b>Midwives</b>	<b>MAs</b>	<b>Pharmacists</b>	<b>Pharm Tech</b>	<b>Lab. Tech</b>	<b>Biostats</b>
St. Elizabeth	Catholic	1		15	9			1	1	
St. John of God D'Nkwanta	Catholic	1		24	8	2	1	1	1	
St. Mary's Drobo	Catholic	1		21	9	2		1		
St. Theresah's Nkoranza	Catholic	1		16	7				1	
Wenchi	Methodist			25	4			4	1	
Dormaa Ahenkro	Presby			22	11		1	3	1	
Apam	Catholic	1		21	9				1	
Breman Asikuma	Catholic			28	5			1		
St. Francis Xavier	Catholic	2		29	10			1	2	
Holy Family Nkawkaw	Catholic	1	1	48	6	2		1	3	1
St. Dominic's	Catholic	5	2	63	13	1		6		
St. Martin's Odumase	Catholic			13	4	1	1	4		
St. Joseph's K'dua	Catholic	2	1	38	2		1	2	1	
Manna Mission	Manna	2	1	11		2		1	3	1
Alpha Medical Centre	Pentecost	2	1	10	2	2		2	2	
Baptist Medical	Baptist			26	5	4		2		3
West Gonja	Catholic			20	2	1		2		1
Bawku	Presby			77	20	4	2	7	2	
Jirapa	Catholic			43	28	2	1	2	1	
Nandom	Catholic			31	8	2		1		1
Anfoega	Catholic			11	6					

Battor	Catholic	3	1	31	5	2				
Margaret Marquat	Catholic			30	14	1		2		1
St. Mathias Yeji	Catholic		1	20		1		2	2	1
Janie Speaks	AME Zion					1		1		1
Bryant Mission	Bryant Mission	1	1	3				1		
St. Luke	Catholic	1		2					1	
St. Martin's Agroyesum	Catholic			12	2			1	1	
St. Michael's Pramso	Catholic	2		29	9	1		4	2	
St. Patrick's Offinso	Catholic			35	16			3	1	
Global Evang.	Global Evang.			1						
Ankaase	Methodist	1		6	1					1
Agogo	Presby	2		60	19	2	1	3	1	2
Akomaa Mem.	SDA		2	2				1		
SDA	SDA	4		4		1				
Asamang	SDA			3	6	1		2	1	1
Dominase	SDA			7	3			2		1
Kwadaso	SDA			3						
Holy Family Berekum	Catholic	1	1	52	23	1		1	2	1
Holy Family Techiman	Catholic	3		45	23					
Donkorkrom	Presby			15	1	2	1	1	1	1
Dodi Papase	Catholic	1		8	3			1		
Sacred Heart Abor	Catholic			14	8	1	1	1	1	1
St. Antony Dzodze	Catholic	1		14	15	1		1	1	1

St. Joseph's Nkwan	Catholic			3					1	
Adidome	Presby			9	2			2		
Asankragwa	Catholic			10	1				1	
St. John of God Sefwi Asafo	Catholic			9	4					
St. Martin's Eikwe	Catholic		1	22	13	1			1	

**Annex 2**

**ATTRITION FROM RETIREMENT FOR PROFESSIONAL/TECHNICAL STAFF**

CHURCH	JOB TITLE	NUMBER IN CATEGORY	RETIRING WITHIN 5 YEARS		RETIRING WITHIN 2 YEARS	
				%		%
Catholic	Medical officer	19	4	21	2	11
	Specialist	1	1	100	1	100
Catholic	Specialist	9	3	33	3	33
SDA	Specialist	5	3	60	1	20
Presby	Pharmacist	5	1	20	1	20
Assemblies	Midwife	2	2	100	2	100
Baptist	Midwife	5	3	60	1	20
Catholic	Midwife	290	101	35	31	11
Pentecost	Midwife	6	3	50	1	20
E P	Midwife	3	1	33	0	0
Methodist	Midwife	7	1	14	0	0
Presby	Midwife	61	27	44	12	20
Salvation	Midwife	5	1	20	1	20
SDA	Midwife	12	5	42	3	25
Assemblies	Nurses	5	1	20	1	20
Baptist	Nurses	20	1	5	1	5
Catholic	Nurses	615	72	12	34	6
Church Of God	Nurses	1	1	100	0	0
Pentecost	Nurses	17	3	18	2	22
E P	Nurses	3	1	33	0	0
Methodist	Nurses	17	3	18	3	18
Presby	Nurses	206	21	10	7	3

Salvation	Nurses	15	10	67	4	27
SDA	Nurses	34	4	12	1	3
	Community Health					
Baptist	Nurse	3	1	33	1	33
	Community Health					
Catholic	Nurse	187	38	20	12	6
	Community Health					
Pentecost	Nurse	2	1	50	1	50
	Community Health					
E P	Nurse	6	1	17	1	17
	Community Health					
Methodist	Nurse	4	1	25	0	0
	Community Health					
Presby	Nurse	27	2	7	2	7
	Community Health					
Salvation	Nurse	18	1	6	1	6
	Community Health					
SDA	Nurse	4	1	25	1	25
Anglican	Enrolled Nurses	2	1	50	1	50
Baptist	Enrolled Nurses	7	4	57	4	57
Catholic	Enrolled Nurses	83	22	27	6	7
Pentecost	Enrolled Nurses	2	1	50	1	50
E P	Enrolled Nurses	4	2	50	2	50
Presby	Enrolled Nurses	63	25	40	9	14
Salvation	Enrolled Nurses	2	2	100	0	0
SDA	Enrolled Nurses	11	3	27	1	9
Catholic	Laboratory Assist	88	10	11	5	6
Pentecost	Laboratory Assist	5	1	20	1	20
Presby	Laboratory Assist	16	3	19	1	6
SDA	Laboratory Assist	21	1	5	1	5
Siloam	Laboratory Assist	1	1	100	1	100

Gospel						
Catholic	Laboratory Technical Officer	22	4	18	3	14
Presby	Laboratory Technical Officer	7	2	29	1	14
SDA	Laboratory Technical Officer	2	1	50	1	50
Catholic	Technical Officer	109	13	12	6	6
E P	Technical Officer	3	2	67	2	67
Presby	Technical Officer	17	3	18	2	12
Salvation	Technical Officer	3	1	33	0	0
AME Zion	Medical Assist	1	1	100	1	100
Assemblies	Medical Assist	3	1	33	0	0
Baptist	Medical Assist	6	2	33	1	17
Catholic	Medical Assist	31	6	19	4	13
Pentecost	Medical Assist	3	2	67	2	67
E P	Medical Assist	1	1	100	1	100
Presby	Medical Assist	16	9	56	6	38
SDA	Medical Assist	3	1	33	0	0
Catholic	Anaesthetist	31	9	29	2	6
Catholic	Biomedical Scientist	13	2	15	0	0
Presby	Biomedical Scientist	3	1	33	1	33
Baptist	Biostatistics Officer	4	1	25	0	0
Catholic	Biostatistics Officer	52	4	8	4	8
Presby	Biostatistics Officer	16	1	6	1	6
SDA	Biostatistics Officer	9	2	22	1	11
Siloam						
Gospel	Biostatistics Officer	1	1	100	1	100
Catholic	Blood Donor Organiser	1	1	100	0	0
Catholic	Physiotherapist	7	4	57	0	0
Pentecost	Occupational Therapist	1	1	100	1	100

AME Zion	Pharmacy Technician	1	1	100	1	100
Catholic	Pharmacy Technician	64	2	3	1	2
Pentecost	Pharmacy Technician	2	1	50	0	0
Methodist	Pharmacy Technician	6	1	17	1	17
Presby	Pharmacy Technician	20	7	35	3	15
Catholic	Health Educator	6	1	17	1	17
Catholic	Health Services Admin.	22	4	18	3	14
CHAG	Health Services Admin.	1	1	100	1	100
	<b>Total</b>	<b>2406</b>	<b>489</b>	<b>20</b>	<b>216</b>	<b>8.97</b>

### **Annex 3 JOB-DESCRIPTION FOR HR SPECIALIST**

<b>Job title</b>	<b>Human Resources for Health Specialist/Officer/Consultant</b>
<b>Reporting To</b>	Deputy Director – Technical Support Services
<b>Job Purpose</b>	The post holder will provide strategic advise and technical support for human resources for health planning, management, training and development to Health Coordinating Units and Health Institutions
<b>Roles and responsibilities</b>	<p>Translate health sector HR Policies into strategic plans and guidelines for Coordinating Units and their member institutions</p> <p>Facilitate the adoption of health sector staffing norms by CHAG institutions</p> <p>Assist Coordinating Units and member institutions in incorporating priority health sector policies and plans into theirs</p> <p>Screen all applications for recruitment and promotions from CHAG and all member institutions to ensure conformity to standards required before submission to MOH and other MDAs</p> <p>On behalf of CHAG follow up on all applications and inputs submitted from CHAG institutions to MOH and other MDAs</p> <p>Assist Coordinating Units to strengthen HR Management systems in member institutions</p> <p>Develop and promote a framework for institutionalising assessing best HR practice among Coordinating Units and member institutions</p> <p>Assist in assessing training needs of staff in CHAG</p> <p>Assist in design and provision of In-Service Training for management staff in CHAG</p>

## **PERSON SPECIFICATIONS**

<b>Qualifications</b>	A Postgraduate Qualification in Human Resources Management, Organisational Development, or Psychology.
<b>Experience</b>	A minimum of 3 years experience in managing human resources preferably in the public sector.
<b>Skills Needed</b>	HR Policy Formulation and Analysis Strategic HR Planning Projecting staffing requirements Training Design and Delivery Design of performance management framework Presentation Computer applications in HR Design of HR Information Systems Conducting HR Research Monitoring and Evaluating of HR Interventions
<b>Personal Attributes/Qualities</b>	Trustworthy, Confident, Approachable, Team Player, Self-motivator
<b>Performance Criteria</b>	Percentage of CHAG Institutions that have integrated health sector policies with theirs Percentage of needy Coordinating Units that have been supported to develop their strategic HRH Plans Percentage of health institutions that apply staffing norms correctly in defining their needs. Percentage of applications from CHAG Institutions that are followed up for approval after submission Frequency of monitoring of implementation of HRH

**Annex 4 Guidelines for screening inputs submitted for mechanising new entrants into CHAG Institutions**

Item	Tick as appropriate	
	Yes	No
1. Check if all staff covered are within the priority staff list for CHAG institutions		
2. Check if request fit into agreed HR plans of the institution. (each institution should lodge a copy of its hr plan with the Secretariat		
3. Check if adequate quantities of all relevant documents are attached		
4. Check if the right input forms were used		
5. Check if adequate qualities of inputs have been made		
6. Check if all relevant portions of the input forms were properly filled as required		
7. Check if proposed grades and salary levels conform to standards		
8. Check if there is a cover letter		
9. Check if the cover letter was duly signed and stamped by the authorizing officer of the submitting institution		

- Inputs should be screened as soon as they are submitted to the Secretariat by the designated officer.
- Please insist and assist the submitting officer to make necessary corrections for any item(s) ticked as “No” before acceptance of inputs. If not advice submitting officer to send inputs for rectification before resubmission.

If accepted please let submission officer sign below:

Name of submitting Officer:..... Institution:.....

Signature of Submitting Officer:..... Designation:.....

Date of Submission:.....

Screened by:.....

Designation:..... Date of Screening:.....