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Recruitment Strategy for Human Resources for Health In Timor Leste

Health System Sustainability Activity

Local Health System Sustainability Project
Task Order 1, USAID Integrated Health Systems IDIQ

Local Health System Sustainability Project

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support access to universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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CONTENTS

ACRONYMS

CHC	community health center
ESP	essential services package
HRIS	Human Resources Information System
MoH	Ministry of Health
NDHR	National Directorate of Human Resources
NHSSP II	National Health Sector Strategic Plan II

BACKGROUND

The Government of Timor-Leste, through the Ministry of Health (MoH), and as ratified in its constitution, guarantees free universal health care coverage to all its citizens.[1] A productive, motivated, and well-trained workforce is an essential component of providing high-quality, accessible care necessary to deliver desired health outcomes. The MoH, through its human resources for health strategy, has identified effective planning and management of the health workforce as one of the key areas that need to be addressed to realize the MoH's vision of providing universal health coverage in support of a "healthy East Timorese people in a healthy Timor-Leste."

The recruitment strategy is one element in a suite of strategies[2] that will support the MoH's stewardship and service provision roles as they relate to staff recruitment. This brief strategy section will contextualize recruitment within the broader contexts of human resources for health and the broader health system, with the acknowledgment of the ultimate goal: to provide high-quality, accessible health care services to all Timorese people.

The primary audiences for this strategy are government officials responsible for the recruitment and deployment of health workers. This includes MoH officials at the national and municipal levels involved in human resources administration and the Civil Service Commission. The secondary audiences are other units within the MoH:

- The Cabinet of Quality Assurance for Health team;
- Other government entities, such as the Instituto Nacional de Saúde and Human Capital Development Fund secretariat;
- Pre-service training providers;
- Supportive ministries such as those of finance, education, and labor, who set policies and priorities that affect the training, employment, and retention of health workers;
- Other donor agencies; and
- Civil society partners involved in producing, continually training, and motivating the health workforce in Timor-Leste.

The timespan for the recruitment strategy aligns with the human resources for health strategy and covers 2022–2024. However, it is very likely that full-scale implementation of the recommended initiatives could take until 2026.

This document provides an overview of the current state of the health workforce, the recruitment challenges identified, proposed initiatives to address them, and considerations for how to implement recommended interventions in the near and long term.

NOTE: This document is submitted to USAID meant to ultimately reside as an aspect of the government-owned recruitment strategy and manual.

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[1] Section 57 of the Constitution of the Democratic Republic of Timor-Leste states, "The State shall promote the establishment of a national health service that is universal and general. The national health service shall be free of charge in accordance with the possibilities of the State and in conformity with the law."

[2] See retention strategy and training strategy and implementation plan

OVERVIEW

Successful recruitment and retention help minimize the number and duration of vacancies. Recruiting health care professionals and acclimating them to a community and facility is often an expensive and lengthy endeavor. Therefore, it is important to recruit professionals who are well suited to both the community and the facility in which they will work, especially for positions in rural or remote areas. Recruiting the right candidates also helps with retaining staff in their positions and by extension improves the consistent availability and quality of care.

HEALTH WORKFORCE DEMOGRAPHICS

Based on 2022 Human Resources Information System (HRIS) data, approximately half, or 53 percent, of the current health workforce is aged 30–44 (see Graph 1). Although in aggregate the health workforce is almost equally divided by gender —48 percent female and 52 percent male—there are imbalances when the data is disaggregated by profession (see Graph 2). The exceptions are allied professionals and general doctors, where the variance is negligible. Males are over-represented in the health care administrative, nurse, and assistant nurse categories, and to a lesser extent, in the specialist doctor category as well. Conversely, all midwives are females.

Figure 1. Health workers by age group and professional category

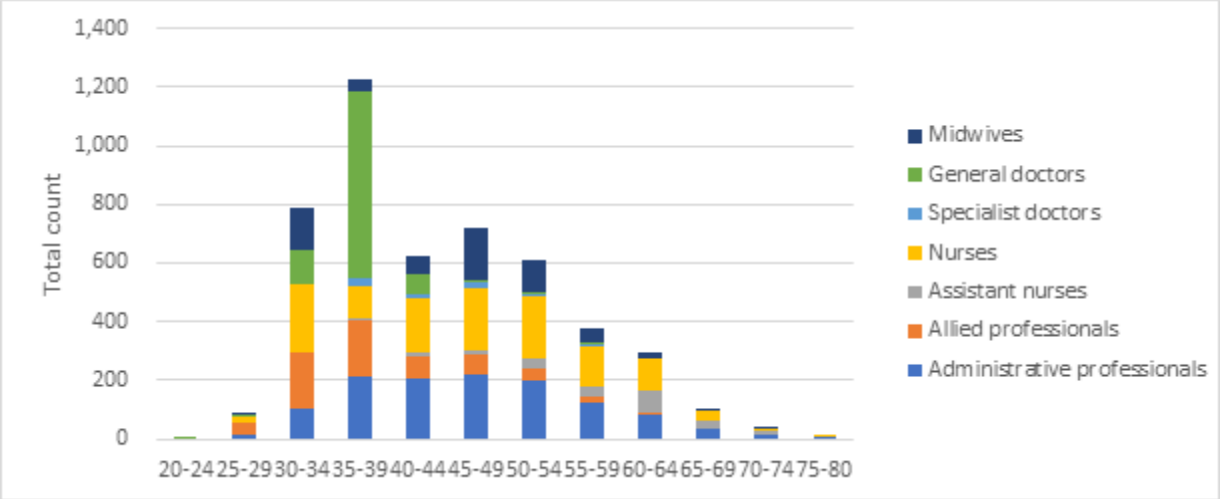
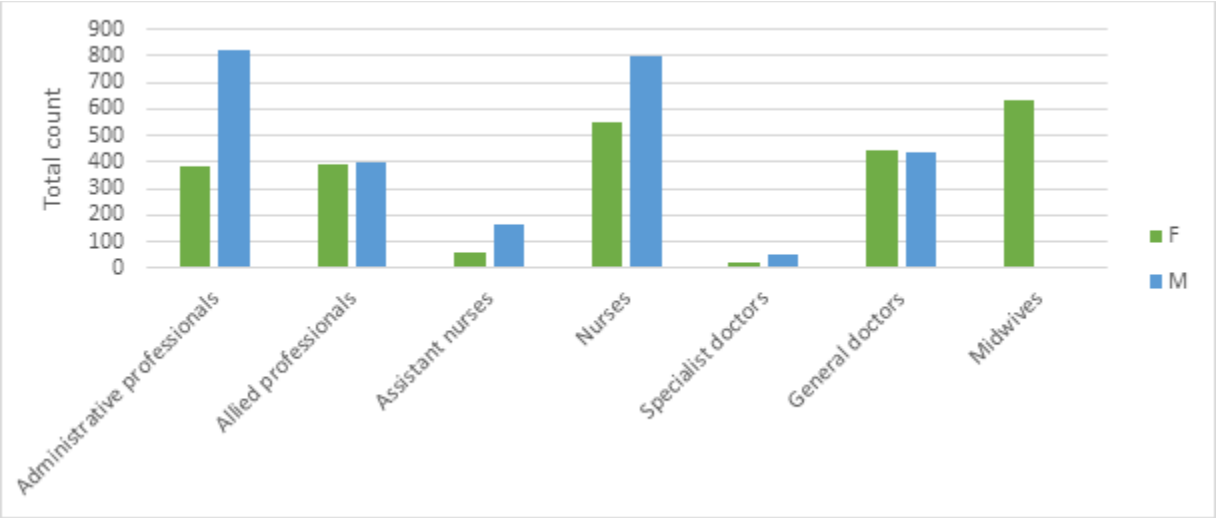


Figure 2. Health workers disaggregated by sex and profession



HEALTH WORKFORCE DISTRIBUTION

The human resources for health strategy and National Health Sector Strategic Plan II (NHSSP II) identify a lack of balance in health workforce distribution between rural and urban settings, and within municipalities, as one of the main challenges. Effective and efficient recruitment and retention of staff, especially in remote settings, are key factors in resolving this challenge.

Recruitment, placement, and retention of health workers in rural areas are pivotal to achieving universal health coverage given that more than 70 percent of Timorese people live in rural areas, including hard-to-access mountainous regions.

Based on HRIS data (2022), there are 288 health workers deployed to 118 health facilities and administrative offices that are in areas classified as remote, very remote, and extremely remote.[3] Out of the 288, 97 are general doctors, 63 are nurses, 44 are midwives, 13 are assistant nurses, 15 are allied professionals, and 56 are administrators (see Table 1).

[3] DL No. 20/2010 of 1 December art 15 defines the criteria for remoteness as follows:
a) Remote location—a location where access is not easy and that has a limited presence of commercial establishments, health care facilities, and other public facilities.
b) Very remote location—a location that can be reached only by using private transport and with little or no access to commercial establishments, health care facilities, and other public facilities.
c) Extremely remote location—a place that can be reached only on foot or by using animal transport for more than an hour of travel, and where it is difficult to access basic food, shelter, and medical care, and public facilities generally.

Table 1: Number of health workers in remote health posts, disaggregated by profession

	Administrative Professionals	Allied Professionals	Assistant Nurses	Nurses	General Doctor	Midwife	Grand Total
Extremely Remote	3	1	2	7	10	4	27
Very Remote	29	7	8	33	56	21	154
Remote	24	7	3	23	31	19	107
Grand Total	56	15	13	63	97	44	288

Out of 118, 29 health facilities in remote settings do not have a doctor, 62 do not have a midwife, and 67 do not have a nurse. The Essential Services Package (ESP) and NHSSP II recommend a minimum of one doctor, one nurse, and one midwife at the health post level, with the numbers increasing for community health centers (CHC) depending on the designated level. See Tables 2 and 3 for the breakdown of such staff at different levels of remoteness.

Table 2: Number of health workers in remote posts , disaggregated by profession

	Extremely Remote	Very Remote	Remote
Doctors	2	20	7
Nurse	7	37	23
Midwife	5	36	21

Note: This table uses the ESP's minimum staffing standards set for health posts. There are a total of 122 health facilities in remote settings, and some have shortages of more than one cadre.

For non-remote locations, there are 4,874 health care workers in 57 administrative units and 413 health centers. The administrative units include MoH departments at the central and regional levels, including cabinets, departments under directorates, etc. Health centers include health posts, community health centers, hospitals, laboratories, and ambulance and emergency service centers. Out of these, 1,149 are administrative professionals, 776 are allied professionals, 212 are assistant nurses, 1,285 are nurses, 74 are specialist doctors, 785 are general doctors, and 592 are midwives (see Table 3).

Table 3: Health workers in non-remote settings, disaggregated by health care worker and work unit designation

Profession	Admin-istrative Profess-ionals	Allied Professionals	Assistant Nurses	General Nurses	Specialist Doctor	General Doctor	Midwife	Grand Total
Administrative unit	411	51	12	25	2	48	3	552
Community health center	293	337	82	432	1	329	272	1.746
Health post	87	22	48	179	1	220	135	692
Municipal health services	182	104	7	94	2	16	40	445
Municipal medical emergency services	7	0	20	30	0	1	1	59
National ambulance services	7	0	0	1	0	4		12
National hospital	68	82	19	292	54	99	72	686
National laboratory	14	43	0	0	0	1		58
Referral hospital	39	92	16	120	7	40	44	358
Regional hospital	41	45	8	111	7	25	25	262
Specialty/ private clinic*	0	0	0	1	0	3	0	4
Grand total	1,149	776	212	1,285	74	786	592	4,874

*Note there is missing data from this category, and doctors who practice in the public and private sectors may be double-counted. The HRIS includes Klinika Parlamento Nasional and Klinika Bairo Pite in this category.

Although the ESP's minimum staffing recommendations categorize CHCs from levels one through three depending on the number of beds available, the official categorization of CHCs into levels has not been completed and is thus unavailable. Therefore, in the short term and for the purposes of this document, the analysis of current staffing standards for CHCs is based on recommendations for level one.

Table 4: Aggregate health worker staffing at health posts and CHCs versus ESP minimum standards

	Health Care Center Type (#)	Allied Professionals Health Post = 1 Public Health CHC = 1 Lab Technician; 1 Pharmacy; Technician; 1 Nutritionist	Nurses Health Post = 1 CHC 1 = 3 3	General Doctors Health Post = 1 CHC 3	Midwives Health Post = 1 CHC 1 = 4	Grand Total
Extremely remote	Health post (8)	-7	-1^	-1	-4	-13
	CHC (2)	-6	-6	-4	-36	-52
Very Remote	Health post (65)	-58	-32*	-14	-44	-148
	CHC (2)	-6	-6	-4	8	-24
Remote	Health post (33)	- 27	-13~	-5	-15	-60
	CHC (5)	-14	-12	-11	-19	-56
Non-remote	Health post (295)	-273	-116*^	-75	-160	-624
	CHC (77)	+106	+201**	+98	-36	+369
Grant Total		-285	15	-16	-322	-608

^There are two assistant nurses in some locations that the table does not include.
*There are eight assistant nurses in some locations that the table does not include.
~There are three assistant nurses in some locations that the table does not include.
** There are 82 assistant nurses in some locations that the table does not include.
*^ There are 48 assistant nurses in some locations that the table does not include.

SYNTHESIS OF STAFFING NEEDS BY FACILITY TYPE AND PROFESSION

Table 4 is based on the MoH's current HRIS data and assumes the numbers of health workers reported are accurate and that they are currently at post. The location categorization (remote, very remote, extremely remote, and non-remote) is also based on the HRIS data, and since the MoH has not completed the official mapping and designation, the data may not be reliable. Additionally, locations that were not labeled as remote, very remote, or extremely remote were automatically categorized as non-remote for the purposes of this data analysis based on the guidance from the MoH.

Remote health centers. The current staffing levels fall short of the minimum staffing recommendations set in the ESP. For remote locations, understaffing is an issue for all health worker types. Thirty-three health centers do not have a doctor, 65 do not have a nurse, and 79 do not have a midwife. However, 15

health centers have assistant nurses even though this is not required in the ESP staffing norms, which in some health centers offsets the lack of a nurse. In accordance with guideline documents, and to facilitate access to health care for Timorese in remote locations, it is imperative for the Directorate of Human Resources to recruit and place doctors, nurses, and midwives to the specified remote health centers with staffing shortages.

Non-remote health centers. Similar to the remote health centers, health posts in non-remote areas also have shortages of all health worker types, whereas for CHCs only midwives are in short supply. There are more allied professionals, nurses, and doctors in CHCs than specified in the ESP.
Referral and regional health centers. There are four referral health centers in different municipalities. For Maliana, Bobonaro, Maubisse, and Covalima , there is an oversupply of health workers of all types except for specialist doctors. For Baucau and Oecusse, it is likely that the HRIS data is not up to date, and thus difficult to assess.

Table 5: Aggregate health worker staffing at referral hospitals versus ESP minimum standards (which are in parentheses)

Referral Hospital	Allied Professionals (14)	Assistant Nurses (4)	Nurses (28*)	Specialist Doctors (10)	General Doctors (6)	Midwives (8)	Total
Baucau	-	-	-	-	1	-	1
Maliana	29	6	42	5	10	16	121
Maubisse	29	7	32		12	12	105
Oecusse	5	-	2	-	-	1	8
Suai	29	3	44	2	17	15	122
Total	92	16	120	7	40	44	358

* 24 general nurses and 4 specialist nurses.

The regional hospital in Baucau has 46 allied health professionals (compared to 26 per the ESP), 8 assistant nurses (compared to 4 per the ESP), 111 nurses (compared to 68 per the ESP), 7 specialist doctors (compared to 18 per the ESP), 25 general doctors (compared to 18 per the ESP), and 25 midwives (compared to 16 per the ESP), for a total of 232 health care workers, excluding 41 administrative professionals.

Summary observations. As outlined in the human resources for health strategic plan and its guiding principles, equitable distribution of the health workforce in urban and remote areas, as well as within municipalities, is a fundamental prerequisite to achieving health goals. Given the need to focus on primary, community-based health care, and the importance of a mixed skills approach, ensuring the recruitment and placement of health staff, or redistribution of the current health workforce, is recommended. It should be noted that this analysis did not include staff at municipal health centers (445), municipal medical emergency services (59), national ambulance and medical emergency services (12), the national laboratory (58), and the national hospital (686), because the ESP did not include staffing standards for aforementioned centers.

RECRUITMENT CHALLENGES AND PROPOSED INITIATIVES TO ACHIEVE HUMAN RESOURCES FOR HEALTH STRATEGIC OBJECTIVES

Recruitment-related challenges are identified in the human resources for health strategy. The human resources for health strategy identifies key challenges related to human resources management in the health sector. The challenges most relevant to recruitment include:

- Inefficient mechanisms to post and transfer staff;
- Maldistribution within municipalities and lack of balance in skill mix;
- Challenges with rural deployments;
- Unclear career pathways; and
- Limited availability and use of data for decision-making.

This section describes each of the challenges and provides recommended initiatives to help alleviate the problem.

Inefficient mechanisms to post and transfer

Although the civil service commission and MoH laws and policies that govern recruitment are in place, implementation is a challenge due to the shortage of staff at the National Directorate of Human Resources (NDHR). Moreover, the NDHR also needs institutional capacity-building in the areas of mapping existing laws, policies, and processes to support staff with operationalizing them through work instructions, standard operating procedures, and hands-on training.

In its current operations, the NDHR has inefficiencies in recruitment: the review, selection, approval, and placement steps all include multiple bottlenecks. The absence of procedures to guide staff transfers and mobility is also a problem. Although the retention strategy and performance management policy documents cover career pathways and competency-based performance, it is important to note the importance of these elements in the recruitment phase to attract the best talent. Moreover, staff movements are not tracked or recorded systematically in the HRIS.

Recommended initiatives to complete by 2024:

- Review the current recruitment manual to minimize redundant or unnecessary steps to expedite the recruitment process.
- Train human resource officers at the central and municipal level on established recruitment laws and practices.
- Define the recruitment process, including identifying the priority cadres that can be recruited at the municipal level and for referral hospitals, and the approvals and checks and balances that need to be instituted.
- Establish targets to monitor efficiencies in the recruitment process—for example, setting average durations to approve/decline new position requests; recommended duration from a job posting to the offer presentation; minimum percentage of vacancies by location, facility type, position type.
- Institute annual or biannual meetings to discuss recruitment issues, best practices, and policy or process implementation challenges that can be refined or updated.
- Institute an annual or biannual training on human resources practices, new laws and regulations, data use, etc.

Recommended initiatives to consider beyond 2024:

- Decentralize the recruitment for priority cadres to the municipal health office level to reduce the length of time for recruitment as well as increase the likelihood of recruiting candidates in their locality.
- Evaluate the decentralized recruitment process, including determining whether recruitment for additional cadres should be decentralized.

Maldistribution of health workers

As shown in the previous section, maldistribution of health workers within municipalities, across facility types, and especially between urban and rural areas, is a persistent challenge. Consequently, some health centers do not have enough workers nor the right skill mix.

Recommended initiatives to complete by 2024:

- Develop a staff transfer/mobility policy that considers the unique needs of women and men health workers, including those that are caregivers.
- Pilot staff transfer/mobility policy for priority remote locations, including reviewing current health care workers' skills mix, allocation, and availability to move to the area (or existing residence in it), and matching current employees to available opportunities.

Recommended initiatives to consider beyond 2024:

- Evaluate the implementation of the pilot staff transfer/mobility policy.
- Scale and implement staff transfer/mobility policy.

Challenges with rural deployments

Health centers in remote settings are short-staffed for all health worker types. Rural deployment is challenging, because workers usually prefer to work in a more urban area that has infrastructure and good access to basic services.

Recommended initiatives to complete by 2024:

- Prioritize recruitment of health workers in remote areas to work in such areas.
- Give remote-posting allowances to all health workers in remote postings, including those who do not move but stay in their own communities.
- Develop a pilot program to test short-term rural rotations for nurses and midwives, and if possible, doctors, to spend one week of every month in remote locations.

Recommended initiatives to consider beyond 2024:

- Fully implement—and, if possible, enhance—rural retention policies such as remote-posting allowances, provision of adequate housing and of transportation, and infrastructure improvements.
- Create career pathways to train family health promoters in rural locations. This provides an opportunity to leverage family health promoters to stay within and serve their communities.
- Redistribute or transfer health workers in non-remote locations to priority remote areas (based on health and population needs), by offering incentives that are currently codified but not fully implemented. If possible, consider transfer or sign-in bonuses with time commitments.
- In collaboration with the Instituto National de Saúde, explore opportunities to make training opportunities accessible to health workers in remote areas through digital platforms and/or cascaded training models through systematic training of trainers model.

Unclear or limited career pathways

Although established career pathways and opportunities for progression are retention strategies, they can also be used as a tool to attract the right candidates to fill difficult positions, for example in health posts and remote locations.

Recommended initiatives to complete by 2024:

- Establish career pathways for each health worker type.
- Establish merit-based career pathways for priority cadres and locations, such as remote health centers.

Recommended initiatives to consider beyond 2024:

- Disseminate career pathways and opportunities during the recruitment process.
- Formalize career progression through additional in-service training, prioritizing health workers in remote locations. Note that doctors, nurses, and midwives have said that training and education opportunities were the most attractive elements associated with motivation.[4]
- Formalize career progression for doctors who serve in remote areas, through fast-track promotion opportunities, and in the long run, through specialization courses funded by scholarships, prioritizing health workers in remote locations.

Data availability and use

Human resources for health planning is an important input for recruitment strategies. Although the ESP and NHSSP II outline the number and type of health workers needed to achieve national health strategic goals, the human resources for health strategy, based on results of functional analysis, recognizes the need to revise the staffing norms to align with current realities, including population needs and budgetary constraints. The availability of high-quality, timely data is an essential prerequisite in the process of reassessing and updating the current staffing norms to align with health and policy goals. The current HRIS data quality and structure need to be improved to better align with normative documents. Although only HRIS data is applicable to recruitment specifically, the availability and use of health service delivery and population demographic data are crucial for effective health workforce planning and are a key input for recruitment. Data availability and use will enable policy makers to better plan for the right balance of skills at health centers as well as devise practical incentive mechanisms for rural deployments.

Recommended initiatives to complete by 2024:

- Conduct a comprehensive HRIS data quality check and update all records.
- Define the scope and cadence of HRIS reporting and the data maintenance process.
- Build the culture of data use by instituting detailed analysis and presentation of up-to-date health workforce data for annual workforce planning and budget meetings.
- Train human resources teams at the central and municipal level on use of HRIS data for recruitment and placement decisions.
- Establish a multi-sectoral working group with key stakeholders (Ministry of Finance, Ministry of Education, Civil Service Commission, etc.) to effectively collaborate and synchronize health workforce needs with education, training, and financing.

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[4] Understanding Health Workers' Job Preferences to Improve Rural Retention in Timor-Leste: Findings from a Discrete Choice Experiment (semanticscholar.org)

Recommended initiatives to consider beyond 2024:

- In line with decentralization initiatives, roll out HRIS to municipal health offices, ensuring interoperability and/or integration with other health information management systems.

Gender considerations. The data shows that all midwives in the health workforce are females, likely due to cultural and professional norms that set the expectation of the midwifery role. The data also shows a shortage of midwives in rural or remote postings. Currently, 93 percent of midwives are in nonremote locations. The availability of adequate equipment and drugs in health facilities is one key intervention area that can make rural postings attractive not only to midwives but to other health workers. Overall, women are less likely to work in remote settings due to a lack of appropriate housing and essential services such as markets and schools for their children. A gender equity and social inclusion analysis conducted by the Local Health System Sustainability Project found that gender-related factors including sexual harassment and lack of safe accommodation affect the retention of female health workers in rural areas. Many midwives and single female doctors are reluctant to live alone in what they feel is inappropriate or unsafe accommodation, particularly in remote areas. The incidence of gender-based violence is also high.

Although limited training and professional development opportunities are available for both men and women, training is often offered in international locations or in Dili, rather than at the municipality level, and requires travel, which is typically harder for women to manage along with their domestic home and caregiving responsibilities. Administrative and management positions are also heavily dominated by men. The goal of gender parity in leadership roles at the central and municipal levels is one of the areas that recruitment can address.

Recommended initiatives to complete by 2024:

- Prioritize amending the current practice that limits remote-posting allowances to health workers being relocated from their resident communities to new communities: pay all workers in remote postings this allowance, regardless of whether they are staying in their home (rural) area. This will help attract and retain female health workers to work and live in the communities where they come from, which could also help with safety concerns.
- In collaboration with Instituto National de Saúde and development partners, provide training at the municipal level to increase the accessibility of in-service training opportunities to women health workers who would otherwise be unable to travel to cities to attend training.
- Identify barriers to hiring and/or promoting women to leadership roles.
- In collaboration with other ministries, through a technical working group, identify "quick wins" that can address some of the challenges not related to infrastructure, including instituting security measures to ensure safety, and requiring mandatory code of conduct training on sexual harassment and gender-based discrimination in the workplace.

Recommended initiatives to consider beyond 2024:

- In collaboration with Instituto National de Saúde and development partners, develop online training modules to increase access to in-service training.
- In collaboration with other ministries, civil society groups, and community members, establish community development initiatives to tackle challenges related to infrastructure and access to basic services such as education.

Intersectoral considerations. Although this document focuses on recruitment strategies, and intervention recommendations that are within the NDHR's purview, it is with the recognition of the pivotal role played by private and public training institutions, professional associations, and other ministries (finance,

education, Civil Service Commission, state administration, public works, etc.). The production of the health workforce, including numbers and type of trainings, availability of scholarships, compensation structure, location of training institutions, and the quality of pre-service education, are just a few examples that determine the recruitment pipeline, although the NDHR does not have the authority to regulate these. Similarly, access to basic public services and utilities, such as adequate infrastructure including roads, electricity, and water, as well as access to education, are key deciding factors for rural deployment and retention. Therefore, effective coordination and planning among all the partners is a crucial success factor.

Recommended initiatives to complete by 2024:

- Establish an intersectoral technical working group at the central and municipal levels to include leadership from the National Directorate of Human Resources, the Civil Service Commission, the Cabinet of Quality Assurance, the Instituto National de Saúde and Human Capital Development Fund secretariat, and the ministries of finance, education, labor, state administration, and public works. The suggested meeting frequency for the technical working group is quarterly for the municipal level and biannually for the central level.

IMPLEMENTATION CONSIDERATIONS FOR SHORT- AND LONG-TERM OPTIONS

The strategy and policy options outlined in section 3 above are targeted and responsive to issues pre-identified in the human resources for health strategy and relevant to recruitment. Although short- and long-term policy options are presented, the focus of this strategy, and recommended next steps, are on the short-term initiatives. The feasibility of implementing the recommended initiatives was also a key factor in selecting the options presented.

Most of the outlined challenges and proposed initiatives, such as inadequate infrastructure and lack of access to basic services, are outside the scope of this document and the purview of the MoH. Therefore, alleviating bottlenecks and creating enabling environments for health workers, and by extension, creating conditions for communities to live in a healthy and thriving society, necessitates intersectoral coordination, and collaboration.

All the initiatives recommended will require staff, accessible data, and financing. Implementation will also require coordination within MoH Directorates, as well as with the Instituto National de Saúde and the Civil Service Commission. Consequently, the immediate next step required to operationalize the recommended initiatives is to validate the information and to develop a detailed implementation plan including required resources, activity leads, and timeline for implementation.

FUTURE CONSIDERATIONS

The recruitment strategy has a short time horizon. However, the implementation of recommended initiatives establishes the grounds for future success. Key areas of consideration, throughout the implementation of this strategy, as well as health governance and financing discussions, should include:

- Availability and accessibility of high-quality data on human resources for health and health service delivery through an HRIS and a Health Management Information System—and preferably through an integrated information management system—is a prerequisite for effective health workforce planning and management. Relatedly, building and institutionalizing a culture of data use for decision-making is essential.

- Multiple policy and strategy documents highlight the need to revise and reevaluate the staffing norms recommended in the ESP and NHSSP II. The revision must take into consideration, as the ESP does, disease burdens, locality, population trends, etc., as well as budget realities.
- Recognizing the cross-cutting and intersectoral nature of health workforce management, the development of a multi-year, national human resources for health master plan is a crucial step to defining the current state (assets and gaps), providing a common vision and commitment mechanism for all stakeholders involved (designating roles and responsibilities), and institutionalizing evidence-based decision-making through a continuous and dynamic monitoring and evaluation approach (governance and accountability mechanism). Through the process of developing a master plan, it is recommended that the MoH conducts activities that will provide key input, implementation of activities such as a health labor market study and workload indicator of staffing (WISN) analysis.
- Lastly, although labor market influencers, such as private health sector providers and their potential consequences, are not issues currently, it would be prudent to start developing guidance documents and regulations to manage the emergence of private providers. That emergence is liable to lead to dual practice, difficult salary expectations, a reduced pool of health care workers for rural placement, and lack of accreditation and licensing requirements.