MID-TERM-REVIEW 2007

Human Resource Assistance Programme

Report

NORAD COLLECTED REVIEWS 21/2007

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Human Resource Assistance Programme
BOT 2201

Government of Botswana- Ministry of Health and Government of Norway

REPORT

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We would like to express our warm gratitude to you all.

Joyce Maphorisa and Marilyn Lauglo
Gaborone, May 2007

Table of Contents

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti - Retroviral Therapy
ARV	Anti Retroviral
BOTS	Botswana
DPSM	Directorate of Public Service Management
GOB	Government of Botswana
GP	General Practitioner
HIV	Human Immuno Deficiency Virus
HR	Human Resources
HRH	Human resources for health
HUH	Haukeland University Hospital
ICU	Intensive Care Unit
IDCC	Infectious Disease Care Centre
IHS	Institute of Health Sciences
MLG	Ministry of Local Government
MOH	Ministry of Health
MTR	Mid Term Review
NAC	National AIDS Council
NACA	National Aids Coordinating Agency
PBRS	Performance Based Reward System
PHC	Primary Health Care
PHS	Public Health Specialist
PMTCT	Prevention of Mother to Child Transmission
RNE	Royal Norwegian Embassy
TB	Tuberculosis
TORs	Terms of Reference

Summary, Main Conclusions, and Recommendations

Summary

The Human Resources Assistance Project (BOT 2201) arises out of a request from the President of Botswana to the Norwegian Minister of Development for assistance for the National Anti-Retroviral Treatment (ART) Programme and for the Institutes of Health Sciences (IHS). Based on this request and the long term collaboration between the two countries which dates back to 1973, the governments of Botswana and Norway entered into an agreement for Human Resources Assistance.

Project implementation started immediately after contract signature with a sub-contract between Haukeland University Hospital (HUH) and the MOH. The first Norwegian personnel started work in Botswana on 15 September 2005. Annual meetings were held in May 2005 and June 2006. A no – cost extension was agreed to extend the project to the end of 2008.

We fully recognise that the MOH is badly under – resourced in terms of human resources and over – stretched in terms of responsibilities. It appears that it has limited capacity to manage the health system and the delivery of health services. Problems arising from Project implementation or weaknesses in the Project design have a greater impact on a vulnerable system than they would in a more robust system.

Main Conclusions

i) The Project has made significant positive contributions to the delivery of Botswana's health service. The provision of health personnel is very relevant to the human resource health needs of Botswana. Further, it is in keeping with Botswana and Norway's commitment to universal access to prevention, treatment, care, and support.

ii) The direction of the Project has, in part, moved away from strengthening the system for ART roll – out and more in the direction of meeting Botswana's need for medical expertise.

iii) The project architecture with HUH having a central role as the primary employer of the Norwegian personnel, the mode of funds transfer, and the notion of supervision & monitoring outside Botswana is not in keeping with the Norwegian development principle of 'recipient responsibility'. The involvement of a Norwegian institutional partner is partly because Norway's topping up of the Norwegian personnel's salaries would have been very complicated with another system.

iv) The indicators are inadequate for measuring the Project's goal and achievements.

v) The attempt to treat the Norwegian personnel as other expatriate personnel is a positive attempt to integrate the Project into Botswana's system.

vi) The dual employment contracts held by the Norwegian personnel creates confusion as to the obligations and entitlements of the contract holders, the GOB, and HUH.

vii) We observe that coordination within the MOH and with HUH is weak, characterised by gaps in information and communication.

viii) There is no systematic programme for skills and knowledge transfer aside from the expected duties of the IHS lecturers. A systematic programme of

skills transfer is to be expected given the second Objective of the Project directed towards capacity building.

Recommendations

i) The Project should be continued and the appointment of the remaining health personnel should be concluded

ii) The project goal and objectives should be reviewed so they are more reflective of the current focus of the project and output. Indicators should be developed to measure project success at the end of the project. The indicators ought to be results orientated and aligned to the objectives.

iii) A detailed work plan should be developed to guide the implementation of the project adequately. At the moment the plans are task oriented and focus on recruiting the additional personnel.

iv) The Dual contracts should be examined **to ensure that they do not conflict in terms of obligations and/or entitlements**. It would have been ideal to have one contract to govern the terms and conditions of employment of the Norwegian personnel in Botswana.

v) The recruited personnel should be given substantial preparation for working in Botswana and a satisfactory level of readiness should be established. Expectations should be clarified fully prior to signing of individual contracts. It is important that the Norwegian personnel fully understands the terms and conditions of their employment with Botswana Government and the idiosyncrasies of the Botswana Health system.

vi) Deployment should be made where the personnel can use their best skills in line with the needs and where suitable housing is available. There should be mutual agreement on the standard of suitable accommodation with utmost consideration for security .

vii) Competency and skills transfer should be more systematic and deliberate and be reviewed as one of the key benefits of the project at the annual meetings.

viii) Detailed communication with the managers on site should be made for adequate preparation and proper assignment of the personnel.

ix) Requisite materials and equipment should be availed timely in order to enable personnel to contribute meaningfully to the health system

x) The Ministry should have exit plans and strategies to ensure continuity of services that are being offered by some of the Norwegian specialists.

Introduction

Background

The Human Resources Assistance Project (BOT 2201) arises out of a request from the President of Botswana to the Norwegian Minister of Development for assistance for the National Anti-Retroviral Therapy (ART) Programme and for the Institutes of Health Sciences (IHS). Based on this request and the long term collaboration between the two countries which dates back to 1973, the governments of Botswana and Norway entered into an agreement for Human Resources Assistance to the Ministry of Health (MOH) for the period December 2004 to 2007.

The goal of the project is:

> To improve the delivery of health care services through increased capacity of the National Anti – Retroviral Therapy (ART) and the Institutes of Health Sciences (and Primary Health Care services).

Project objectives are:

1. To recruit fifteen health professionals to support additional ARV Therapy related to workload, and to complement staff of the Institutes of Sciences for a period of 3 years.
2. To build capacity for the training of health personnel with a view to meeting some of the human resource requirements for the health sector.
3. To improve the ARV Therapy programme uptake through enhanced capacity.

Project implementation started immediately after signing of the Agreement with a sub-contract between the implementing partners, Haukeland University Hospital (HUH) and the MOH. The first Norwegian personnel started work in Botswana on 15 September 2005. Subsequent to that, Annual meetings were held in May 2005 and June 2006 to review progress. A no – cost extension was agreed to extend the project to the end of 2008.

Mid – Term Review

This Mid-Term Review (MTR) has been carried out in accordance with the 2006 Annual meeting and the Project Agreement. The Review has been conducted by a Motswana consultant, Joyce Maphorisa, and a Norwegian – based consultant, Marilyn Lauglo, for the Royal Norwegian Embassy (RNE) in Pretoria. The country visit for the Review took place from 21 May to 1 June 2007. TORs for the Review can be found in Annex 1.

Methodology

The Review Team examined documents relevant to the Project (See Annex 2).

Thirty two key informants were interviewed either through face – to – face or telephone interviews. Key informants included staff in the MOH, IHS (Serowe and Gaborone), National AIDS Coordinating Agency (NACA), the Ministry of Finance and Development Planning (MFDP), and the Ministry of Local Government (MLG). Site

visits were made to Mahalapye and Serowe. Selection of people for interview was based on:

- Their position in the Botswana health system
- Direct involvement in the project i.e. the Norwegian personnel when their supervisors were also available for interview
- Geographical spread
- Range of professional positions

Due to the short time – frame for this MTR, it was not possible to interview all the key informants. We regret we were unable to interview the Director, Department of AIDS Prevention and Care although we spoke to the Deputy. Similarly, had the Review started earlier, additional interviews would have been conducted with HUH, the Embassy in Harare which previously administered the Agreement, and with returning Norwegian personnel. Eight of the 11 Norwegian personnel were interviewed. A list of people spoken to is given in Annex 3.

This Report

In line with the TORs for the MTR, this Report focuses its comments on four priority areas:

1. Assessment of the relevance and direction of the project
2. Assessment of project design, and coordination between partners and among stakeholders
3. Assessment of the achievements and possible constraints and failures
4. Sustainability and risks

This Report comments in greater detail than is usually the case with a MTR of a project of this size. These comments are offered in the spirit of 'lessons learnt' which can be used in the implementation of the project in future. It is hoped that they are received in that spirit.

The Report concludes with recommendations.

Relevance and Direction of Project

Relevance to need

The provision of health personnel is very relevant to the human resource in health needs of Botswana.

HIV/AIDS represents the greatest development challenge to Botswana. HIV prevalence is estimated to be 17.1% of the total population [1] while prevalence among pregnant women aged 15 – 49 was found to be 32.4% in 2005. There are considerable differences in prevalence rates among the districts (ranging from 21% to 47% among pregnant women) and a slight reduction was observed among pregnant women in rural areas between 2001 and 2005.

The Government has responded with a number of initiatives such as the national prevention of mother – to – child – transmission (PMTCT) programme which started in 1999. The ART programme was started in selected hospitals in 2002, expanded to 30 clinics in 2007 and is planned to increase to 129 clinics by 2009. The ART roll

[1] 2006 Botswana Second General HIV/AIDS Surveillance Technical Report

– out has significant human resource requirements for midwives, pharmacists, and laboratory technicians. At the time the Project was conceived in 2002, it was anticipated that many doctors would be needed for the ART roll – out.

Adequate numbers of health personnel has long been a serious problem in Botswana. Skilled staff is in short supply, especially medical officers and specialists. Few Batswana doctors work in the public health system, which depends heavily on expatriate doctors. Many hospital posts remain vacant for long periods of time. Only 8 of the 24 health districts had a public health specialist (PHS) at the time of the review.

The AIDS epidemic has exacerbated the problem of shortage of HR by increasing the workload on staff, reducing the numbers of health personnel available to the system, and increasing levels of staff 'burn out.' Along with other African countries, Botswana shares the same underlying factors contributing to the 'push' and 'pull' of migration.

Relevance to Botswana and Norwegian policy frameworks
The Project goal is fully consistent with Botswana's National Strategic Framework for HIV/AIDS 2003 – 2009. Further it is in keeping with Norway's commitment to universal access to prevention, treatment, care, and support which includes the utilisation of Norwegian expertise. The provision of non-specialist medical doctors and IHS lecturers supports the tenet that HIV/AIDS prevention, treatment, care, and support must be seen together.

Direction of the project

The advertisements for the Project sought medical personnel to work in ART and to be lecturers in IHS programmes of midwifery, pharmacy, and laboratory technology. During the recruitment phase Botswana indicated the need for medical doctors who could contribute to the overall work of the hospitals where the ART clinics were located and not limit their work to the provision of ART. This was agreed and it appears that the contributions of the 3 medical officers is increasing the capacity of the Botswana health system to respond to HIV/AIDS as many hospital admissions and out - patients attend for AIDS related conditions. The PHSs are working directly with HIV programmes such as the IDCC and the TB programme.

The lecturers at the IHS are fulfilling the roles intended for them. It was initially anticipated that the greatest IHS need was for midwifery lecturers to increase the intake of midwifery students. The MOH initially requested three lecturers in midwifery. These were selected but two lecturers returned to Norway after a short time. As Botswana gained more experience with the ART roll – out, it became apparent that lecturers with other professional backgrounds were needed. Thus, the current request from Botswana is for 2 pharmacy lecturers, 1 midwifery lecturer, and 1 lecturer in laboratory technology.

There are 3 additional doctors who are specialists in anaesthesiology, general surgery, and internal medicine and infectious diseases. These specialists are not working in HIV/AIDS directly, although they are clearly assisting the Botswana health system which has a great need for experienced medical specialists. As discussed below in the section on 'Achievements', one has initiated a number of capacity building activities in his field of anaesthesiology, intensive care, and trauma. But another, despite her expertise in infectious diseases is disappointed that she has yet to work in the ART clinic, especially since this is what she was recruited for. It

appears that there is a greater need for her internal medicine expertise at the hospital where she is placed.

Thus, the direction of the Project has in part moved away from strengthening the system for ART roll – out and more in the direction of meeting Botswana's need for medical expertise while the support to the IHS continues as it was initially conceived. The participation of 3 Norwegian medical specialists only indirectly supports the Project goal but their inclusion is highly relevant to beneficiaries' requirements, country needs, and Botswana's priorities but they are less relevant to Norway's development priorities.

Project Design

Goals and Objectives

The original emphasis of the project was on support for ART provision in Botswana. This was reflected in the goals and objectives. However there has been a shift in the goals towards a more holistic support to the health system. This shift is not adequately reflected in the goals and objectives.

Indicators in the Project Proposal do not **fully** measure the performance of the project since they were broad and do not measure improved capacity in a meaningful way. Furthermore the indicators do not appear to be fully utilised in the reporting and monitoring process of the project in a systematic manner. The Project Agreement does not list any Project indicators but only Project 'outputs.' These 'outputs are not readily measurable. Baseline values were not given for when the project started. It would not be possible to ascertain whether 'Increased competency among staff' and 'Better access to health services' were due to the contributions of the project.

Contract Design

The MOH – Haukeland contract specifies the roles of HUH and the MOH, though inadequately. But it appears that the role of HUH is 'to assist in providing human resources and manage topping – up of salaries, pension schemes, etc. in Norway.'

The Norwegian health professionals are under an employment contract with HUH and have a 'supplementary sub contract' with the Government of Botswana. Hence HUH is designated as the 'employer' and has overall responsibility. This subcontract is supplementary to the main contract signed with HUH.' The Norwegian health personnel are employed by HUH and have signed a sub – contract with the MOH 'specifying the terms, benefits and duties. At the same time, the MOH has the employer's responsibility for the Norwegian personnel in Botswana.

The arrangement with HUH as the primary employer appears to be inconsistent with a principle of 'recipient responsibility'[2] which has been a central theme in Norwegian development work over the past decade. However, it was decided that HUH would

[2] Norad, 2006, *Norads Strategi mot 2010*: *De fleste mottakerland og givere er na enige om a legge vekt pa nasjonalt eierskap og bistandsharmonisering innenfor rammene av nasjonale fattigdomsstrategier og nasjonal statsbygging. Økt bruk av sektor- og budsjettstøtte vil kreve nye ma ter a dokumentere resultater av norsk innsats. Na r nasjonalt eierskap styrkes, ma givernes støtte tilpasses mottakernes krav og systemer.'* (,Recipient responsibility: Most recipient countries and donors now agree to emphasise national ownership and harmonisation of aid within the framework of national poverty strategies and nation building. Increased use of sector support and budget support will require new ways of documenting the results of Norwegian contributions. When national ownership is strengthened, the support from donors must be adapted to the recipients' requirements and systems.')

be a partner in the Project partly because Norway's topping up of the Norwegian personnel's salaries would be very complicated with another system.

There are inherent conflicts in the terms and conditions of the two contracts for the Norwegian personnel. The dual contract has led to considerable confusion as to the obligations and entitlements of the contract holders, GOB, and HUH. All the Batswana managers spoken to said that they expected that the Norwegians were to be treated as other expatriate staff. Yet, the Norwegian personnel see HUH as their employer with the rights and expectations that accompany this role. There is a lack of clarity on the responsibility for the provision of suitable housing, annual leave arrangements, job grading and placement on the job scale.

Suitable housing is one of the issues highlighted in the Project Appraisal as needing careful attention. While it was one of the factors discussed during the planning and recruitment stages for the Project, difficulty arises when employer and employees' perceptions of 'suitability' do not match.

Financing Design

According to Annex 1 of the Project Agreement, it was anticipated that up to 20% of the budget would be allocated to HUH for the 'supervision; monitoring and recruitment overhead'. This seems to indicate that a role of supervision and monitoring was also expected to be outside Botswana.

The Review Team was informed that funds for the Norwegian topping up are transferred directly from Norwegian sources to HUH.

Planning and Reporting Design

According to the Project Agreement, Botswana is responsible for the planning, administration and implementation of the project. However, the Review Team did not find any comprehensive project planning system or work plans that guide the achievement of the objectives, except for a basic activity sheet, which is not clearly linked to the objectives. The work plan does not reflect the activities for monitoring, other than the joint annual meetings. The work plan is supposed to guide the implementation of the project at the MOH level and it should be the basis for measuring the achievements of the project.

The plans are reviewed at the annual meeting held in May/June every year. It is commendable that the review meetings have been held regularly. The meeting is aimed at reviewing progress of the project; revising work plans and budgets and approving work plans and budget as well as discuss any other issues.[3] However, the review does not seem to be guided by the objectives and the work plan. The Annual Report tends to provide general information and does not necessarily show progress against plan and objectives.

The annual review does not seem to discuss the budget and the expenses fully. According to the summary of expenses, the only identified financial contribution from the Botswana Government are the salaries. This gives an incomplete picture of the expenses on the Botswana side which also includes social costs, travel costs and allowances, follow – up/training, housing and furniture, and Annual meeting costs.

[3] Agreement Between The Government of The Republic of Botswana and The Government of the Kingdom of Norway, Article II:6. Page 2.

Botswana's financial contributions are missing and thus the overall extent of Botswana's contribution is under appreciated.

Roles and Responsibilities

Roles and responsibilities for accountability and follow up are poorly defined, especially in practice. Once the Staff has arrived in Botswana the MOH Coordinating office hands them over to the functional departments like Ministry Management and Clinical services. While this is appropriate, since they have technical expertise, the coordination role should still have an active role to monitor the delivery of the project with proper follow up. .

Implementation

Results

Fifteen health personnel were to be recruited to Botswana and later this was reduced to 14. Much as this represents a significant reduction from the initial request of 55, none of the people interviewed felt that the help was "too small and insignificant". Clearly the country faces major human resources for health (HRH) challenges, where all the PHS are expatriates, and most of the doctors are not Batswana and all the other health professions are in great shortage. Therefore the project provides a sensible response to the HRH challenges of the country and the local respondents would like the support to be continued beyond this agreement. To quote one director: " this is one of the FEW programmes that provide direct human resource support, which is Botswana's greatest challenge."

HUH and MoH Coordination

The dual management structures for this project require even stronger coordination than is usually the case. There are many opportunities to strengthen coordination. Notable examples are, i) improved communication is needed; ii) implementation of planned activities e.g. written job offers are often delayed; and iii) commitment to joint activities such as the June workshop in Victoria Falls.

The focal persons at HUH have remained the same on the Norwegian side while in Botswana the personnel are under the departments within which they are placed in the MOH. Because of this, while the coordination remains the role of the department of Health Sector Relations and Partnerships, HUH does not have a single point of contact in the MOH who is up - to – date with the project details on a day – to – day basis.

MOH Internal Coordination

Most of the managers reported to have been uninformed of the calibre of person being assigned to them. Basically there is little flow of information within the MOH. Had the institutions been well informed, they would have been better prepared to use the Norwegian personnel in a strategic manner where they are able to contribute and use their 'best' skill and expertise. There was no formal process of orientation for the new staff. Routines have not been established for regular reporting on their use.

Recruitment, Selection, and Orientation Processes

There were some delays in getting the first group of Norwegian Health personnel placed in Botswana. According to the activity plan the second group was supposed to be in place in January 2007. Up to the time of this MTR, HUH had not received official notification of their job offers. The employment offers had only been verbal.

The selection process is good in that all the staff are qualified for their jobs, however the selection might not have sufficiently stringent so as to include character reference checks in some cases.

Both MOH and HUH have only partly fulfilled their obligations with respect to the preparation staff for placement in Botswana, where **specific** requirements of each and every position, including but not limited to an up to date job description and reporting structure have to be detailed.

Upon arrival in Botswana, the orientation has not been very deliberate and systematic. The manpower constraints, relatively heavy workloads, cultural differences and the pressure of HIV require even psychological preparation. People seem inadequately prepared for the realities of working in Botswana in terms of the Government accommodation and the working conditions as well as the workload and work environment.

Placement and deployment should not just be need driven, but housing, supervision, and a welcoming team and job and strategic fit are important.

Alignment To Government Procedures

The implementation of the project is only partly aligned to the conditions for governing expatriate staff in Botswana. The Directorate of Public Service Management (DPSM) procedures were not fully complied with. One notable gap is that none of the Norwegian Staff who were interviewed for the MTR had signed their job descriptions. DPSM were not given the job advertisements since they were in the Norwegian language. Some Managers did not have an opportunity to make inputs to the preparation of personnel since it was carried out in India.

Additionally, there are conflicting conditions arising from the dual contracts such as leave days and job grades. For instance in Botswana public servants should deliver to a performance agreement in line with the performance reward system. All public service employees, including expatriate staff, are required to sign performance agreements. However, there have been indications by some managers that some of the Norwegian personnel have not seen the need for such, perhaps because of the issue of dual contracts and the fact that they do not get performance based rewards. However the tool is used for managing performance and not just for rewards. For the Norwegian staff the system is not used for performance feedback and is not linked to any financial rewards, not even inflationary adjustments.

Furthermore, housing regulations and privileges are also a source of mis-alignment. For example, expatriates are entitled to medium to high cost housing. Some of the Norwegians who live in Gaborone have had to top up their housing allowances since they did not find what the Government provided adequate and secure enough.

The formal exit process does not seem to exist in a lot of cases. So far there is no documentation on the interviews for the Staff who resigned.

Achievements

Benefits and multiplier effects

There are 11 co-financed professionals. Six of them are in hospitals working as medical officers and as specialists in the South, Central and Northern parts of the country. Three (3) are in the IHS and two are PHS. Most of the staff have a three year contract.

The programme has made significant positive contributions to the delivery of Botswana's health service. The Norwegian professionals have directly contributed to the care of people with HIV/AIDS in the ARV Therapy programme and indirectly in the specialised medical services. Doctors have been able to work across the system and not only in the distribution of ARV Therapy. The addition of personnel to the hospital rota enables other doctors to give more time to the IDCC.

At the IHS, there has been an increase in student enrolments for midwifery. To quote the deputy principal " the pharmacy programme was so short staffed it could have collapsed if the Norwegian lecturer had not come at that time." This is at a time where Botswana needs a number of pharmacy professionals to provide ARV Therapy in the districts. According to NDP9, a total of 139 pharmacy technicians will be required in the next three years.

The interview with representative of the MLG revealed a high degree of satisfaction with the work of the Norwegian public health specialist. Community gains have been highlighted through the domiciliary programme for the midwifery training. There is also a ripple effect of the Botswana professionals being exposed to international practices or ways of doing things even if the Norwegian personnel are not in leadership or supervisory positions.

The benefit to the programme is mutual. Young doctors from Norway who did not have surgical experience have been trained and are confidently doing operations such as caesarean sections.

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It is not possible to define the outcomes (mid-term) and the impact (long-term) at this stage. It is acknowledged that the Project has delivered in accordance to the formulated expectations and that the Norwegian personnel are generally making a **great impact**.

As the Review Team did not interview all representatives of all the institutions where Norwegian personnel are placed, we do not have a complete list of contributions. However, highlights are summarised below:

Table: A Summary of the Key Benefits and Achievements for Programme Area

Programme Area	Benefits	Comment
IHS Pharmacy	Enrolment and sustainability of the programme	
IHS Laboratory Technology	Links in laboratory technology established with Norwegian institutions Use of computers by Students Improvements in parasitology curriculum	Ideas to be infused if accepted
IHS Midwifery	Increase in enrolment (5) Research based learning involving students and a junior lecturer Links in midwifery established with a Norwegian institution Health promotion included during community domiciliary visits	
Hospital doctors	First time that Nyangabwe hospital has had an ICU specialist; the ICU is transformed and the nurses are trained in ICU	Norwegian doctors have learnt to perform surgical procedures in three to six months
	Participation in the development of trauma care including a workshop for 65 participants from hospitals in the North and South regions w/the Trauma Team from HUH.	
	Two doctors have been included in the hospital rota to cover wards and out-patient clinics	
	Specialist training in anaesthesiology has been instituted for a local counterpart who is attached to a Norwegian specialist and will complete training in South Africa and Norway in collaboration with HUH.	
	Raising awareness of international standards,, practices, and programmes such as IMCI among staff	
Public Health	A district preparedness plan has been developed including first aid training for ambulance drivers	
	Guidelines and preparedness are being developed for the drug resistant TB to position Botswana for its presence.	

The linkages with institutions in Norway will reinforce the sustainability and long – term impact of the Project. A professional exchange has been established between Norway and Botswana for benchmarking in midwifery training, laboratory technology, research, and trauma management. Generally, the Norwegian personnel have brought their experience of practices and standards from a more developed system into their workplaces such as quality standards, efficient systems, computer use, technological advances, and clinical practice.

Possible Constraints and Failures

There are a number of constraints in the Project that arise from the design issues discussed above and to sustainability issues which are discussed below. Here we highlight constraints and failures in relation to project implementation.

Lack of adequate communication between MOH and HUH

Communication between the MOH and HUH is said to be cordial and sometimes, frequent. However, it appears that valuable information which would have assisted in the smooth running of the project e.g. details of the employment contracts with HUH, job descriptions, implications of the job grading and placement for leave days and range of responsibility, details of the expatriate contracts with regard to housing, transport for work – related activities has not been shared.

Optimal use is not being made of the Norwegian personnel's competencies

All managers spoken to said that they were given no information about the person who was assigned to their institution. It appears that because of this, plans were not made as to how to best use the Norwegians' competencies before their arrival. In some cases, because many practitioners in Botswana have not been exposed to practices and standards in a more developed system, some of the Norwegian personnel's competencies have not been recognised, appreciated, and absorbed.

Norwegians lecturers and doctors feel they could also contribute to developing efficient management practices in the institutions where they are placed but there are no deliberate and systematic ways for skills transfer.

Lack of a systematic programme for skills/knowledge transfer

There does not appear to be a systematic planned programme for skills or knowledge transfer aside from the teaching carried on at IHS. Most of the initiatives noted in the 'Achievement' section above resulted from individual initiatives.

The dual contract with the HUH being the primary employer for the Norwegian personnel creates problems.

The dual contracts have led to considerable confusion regarding the obligations and entitlements of the contract holders, the GOB, and HUH. All the Botswana managers spoken to said that they expected that the Norwegians were to be treated as other expatriate staff. But that there is a lack of clarity about who is responsible for the provision of suitable housing, leave entitlements, the extent to which the Botswana general orders pertain to Norwegian personnel, and job grading and placement.

Nearly all the managers mentioned the disruption caused by the activities planned by HUH such as the training course in India and the workshop in Victoria Falls that withdrew Norwegian personnel from the Botswana health system. The course in India was a course in tropical medicine and infectious diseases. Most Norwegian health personnel lack knowledge in these fields and the course was offered to all personnel to prepare them for the job situation in Botswana. A Motswana doctor participated in the course but most managers did not have an opportunity to make inputs to the preparation of personnel since it was carried out in India. A 'Joint

HUH/MOH Workshop with Personnel (held in Vic Falls) is on the Workplan 2006/2007 but does not appear to have been jointly planned.

It may seem that these are small problems, which should be easily resolved. But, in a fragile, overworked system, administrative problems such as unplanned leave by staff have greater impact than in a more robust system. In the future, courses and workshops should be better coordinated among stakeholders.

Job grading and placement

The Ministry interviewing board make decisions on job grade and placements of personnel. The decisions are based on job descriptions and the incumbent's qualifications. Looking at the job descriptions, two of the lecturers appear to have been placed in a job grade that is not commensurate with their qualifications and/or experience.

The significance of proper placement was not communicated adequately to the contract holders. The job grade is important not only for the salary scale but also for the scope of authority and a range of other benefits e.g. annual leave. Failed attempts to remedy the situation are a serious source of frustration for one of the lecturers.

Sustainability and Risks

Policy and Framework Conditions

The policy conditions that support this Project are in place and likely to remain so. An effective response to HIV/AIDS continues to have high political support. The provision of HIV/AIDS care and support is the second goal in the National Strategic Framework for HIV/AIDS 2003 – 2009. The Project is fully consistent with Botswana's and Norwegian HIV/AIDS policies.

The 'Three Ones' have been established: the National AIDS Council; the National Strategic Framework for HIV/AIDS, which is currently being reviewed; and the Botswana HIV Response Information Management System (BHRIMS). Although established, BHRIMS is still a manual system.

A country's HIV/AIDS response should be well integrated into its overall health system development and policies. A human resources plan has been under development for a considerable time and is expected to be available in August 2007. However, this has been delayed in the past and is, in any case, being developed in the absence of a health sector plan. Forecasts of the human resource requirements for Botswana HIV/AIDS response have not been made.

In 2006, Transparency International ranked Botswana as 37th out of 163 countries in terms of perceived lack of corruption. Botswana is the highest ranging African country followed by South Africa in 51st place.

Institutional Aspects and Organisational Aspects

There are institutional and organisational risks to the Project.

Weak capacity at the MOH

The MOH embarked upon a reorganisation in 2005, a process which is still being implemented. Many substantive posts are not filled and it is not apparent that the MOH will be able to attract sufficiently qualified and experienced personnel.

There are considerable capacity constraints in the Department of Health Sector Relations and Partnerships which is the coordinating partner for the MOH. It is currently staffed by a Director, Chief Health Officer, and two Public Relations Officers apart from administration staff. Significant staff positions are vacant. Considerable delays in action have been experienced during the Project (e.g. approval of the midwifery lecturers, agreeing dates for interviews, appointing the remaining personnel) and these have had an impact on Project success.

There is severely limited capacity to manage the health system and management of the health care delivery system is greatly overstretched. There are encouraging signs of improved collaboration between the MOH and MLG for primary health care (PHC). Plans are well advanced for strengthening the management of PHC services provided by the MLG. However, the Department of Clinical Services in the MOH which is responsible for all the hospitals and their support services is greatly over – stretched. This department is larger than most other government ministries. As noted earlier, only 8 of 24 public health specialist posts in the districts are filled. The Health Policy and Planning Division is substantially understaffed with a 42% vacancy rate. Of the four divisions in the department, divisional heads for 2 (monitoring & evaluation, and management information systems) have not been filled. The policy and planning divisional head was filled only 2 months ago.

Inconsistencies Among Project Components.

The Project design has been discussed above. It is suggested that there is a need to amend the project agreement to align the Project Goal and objectives to what was agreed during recruitment and selection, and was tacitly agreed at the Annual Review Meetings.

Indicators to measure achievement of Project objectives in both the Project proposal and the Project Agreement are inadequate for measuring project success. The indicators in the Project Proposal measure some processes but these would give little information as to whether capacity was improved. The ‘outputs’ identified in the Project Agreement are not readily measurable. Baseline values were not given when the Project started. It would not be possible to attribute whether ‘increased competency among staff’ or ‘Better access to health services’ are due to the contributions of this Project.

The purpose of the agreed workplan is unclear. In the 2006 – 2007 workplan, there are no details that show the intended use of the Norwegian personnel currently in Botswana. If skills/knowledge transfer is expected to be part of the Project, this should be reflected in the workplan. Because it is important that the Norwegian personnel are integrated into the Botswana system, we suggest that the Performance Based Reward System (PBRS) be used to identify the competence building activities of the Norwegian personnel.

It is unclear how binding the workplan is. The 'Joint MOH-HUH Workshop with Personnel' in Victoria Falls does not appear to have been jointly planned.

The lack of a detailed Annual workplan presents obstacles to monitoring and evaluating the Project.

Socio – cultural and Gender Aspects

The main cultural risk to the Project is the ability of HUH and health personnel to understand the context in which the Project is placed. This includes understanding the organisation of the MOH, the procedures of the Botswana bureaucracy, and the stakeholders in Botswana's health care delivery system.

Additionally, for the Norwegian personnel, nearly all parties interviewed mentioned the 'culture shock' that expatriates face. For the Norwegian health personnel, Botswana presents two sets of circumstances that are particularly challenging:

1. Working in a resource – poor system. Here resources refers to more than financial resources and extends to human resources and institutional resources such as reliable drug, logistics, and management systems
2. Working in a country with high HIV prevalence with the burdens it places on the health system in terms of volume of workload, types of conditions seen, frequent deaths, and impact on colleagues.

Furthermore, an appreciation and observance of Setswana social conventions eases working relationships.

Economic and Financial aspects

The Econsult report indicates GOB is currently able to meet the financial requirements for universal access to ART although it is clearly aware of and concerned about its long - term sustainability. [4]

Financial reporting to the last 2 Annual meetings did not indicate any problems. Funds appear to be transferred in a timely manner. We did not hear of any instances of lack of payments.

[4] Econsult, October 2006, The Economic Impact of HIV/AIDS in Botswana: Executive Summary

RECOMMENDATIONS

i) The Project should be continued and the appointment of the remaining health personnel should be concluded

ii) The project goal and objectives should be reviewed so they are more reflective of the current focus of the project and output. Indicators should be developed to measure project success at the end of the project. The indicators ought to be results orientated and aligned to the objectives.

iii) Detailed work plan should be developed to guide the implementation of the project adequately. At the moment the plans are task oriented and focus on recruiting the three additional personnel.

iv) The Dual contracts should be examined **to ensure that they do not conflict in terms of obligations and/or entitlements.** It would have been ideal to have one contract to govern the terms and conditions of employment of the Norwegian personnel in Botswana.

v) The recruited personnel should be given substantial preparation for working in Botswana and a satisfactory level of readiness should be established. Expectations should be clarified fully prior to signing of individual contracts. It is important that the Norwegian personnel be made to fully understand the terms and conditions of the their employment with Botswana Government and the idiosyncrasies of the Botswana Health system.

vi) Deployment should be made where the personnel can use their best skills in line with the needs and where suitable housing is available.

vii) Competency and skills transfer should be more systematic and deliberate and be reviewed as one of the key benefits of the project at the annual meetings.

viii) Detailed communication with the managers on site should be made for adequate preparation and proper assignment of the personnel

ix) Requisite materials and equipment should be availed timely in order to enable personnel to contribute meaningfully to the health system

x) The Ministry should have exit plans and strategies to ensure continuity of services that are being offered by some of the Norwegian specialists

Annex 1

Terms of Reference

TERMS OF REFERENCE
Mid Term Review
of BOT 2201:

Human Resources Assistance to the Ministry of Health in Botswana

In accordance with the 2006 Annual Meeting and the Agreement of 8th December 2004 between the governments of the Republic of Botswana and the Kingdom of Norway, a mid-term review of the BOT 2201 project will be carried out during the first half of 2007.

1 Background

Through the financial assistance from Norway under this agreement, the project's goal cited from the Agreement is:

> "To improve the delivery of health care services through increased capacity of the National Antiretroviral (ARV) Therapy and the Institutes of Health Sciences (and Primary Health Care services). The Objectives of the project are:
>
> 1.1 To recruit fifteen Norwegian health professionals to support additional ARV related workload, and to complement staff of the Institutes of Sciences for a period of 3 years.
>
> 1.2 To build capacity for the training of health personnel with a view to meet some of the human resource requirements for the health sector.
>
> 1.3 To improve the ARV Therapy programme uptake through enhanced capacity. "

The project period is three years, but a no cost extension was agreed to following the 2006 Annual Meeting of the project. The project period will thus be from 2005 until end 2008. The grant from Norway for the full project period is NOK 45 mill.

Under the Agreement, 15 Norwegian health professionals are to be recruited to Botswana in support of ART related workload and to complement staff of the Institutes of Sciences for a period of three years. The recruited personnel from Norway will serve under the MOH, and receive their local salaries from the Botswana government. They will receive an additional "topping up" salary from a contracted Norwegian partner institution.

The Botswana Ministry of Health (MOH) has contracted Haukeland University Hospital in Bergen, Norway, as a partner institution to assist in recruitment and administration of Norwegian health professionals to work in Botswana under the agreement.

The set of background documents further explains inputs and implementing arrangements, expected outcomes, as well as risks and possible constraints that the implementation of the project could face. Core documents in this respect are

- Project Proposal for Human Resources Assistance to the Botswana Ministry of Health. Submitted to the Government of the Kingdom of Norway. August 2004.
- Brief report from Pål Jareg, HeSo Norway, June 2nd 2004: Human Resource Assistance to the Ministry of Health in Botswana 2003/2004 – 2006/2007.
- Appraisal report of the project: Human Resource Assistance to the Ministry of Health in Botswana 2003/2004 – 2006/2007. Sissel Hodne Steen and Pål Jareg. Oslo, December 4th 2004.
- Agreement between the Government of the Republic of Botswana and the Government of the Kingdom of Norway regarding Human Resources Assistance to the Ministry of Health in Botswana 2003/2004 – 2006/2007. 8th December 2004.
- Project Contract between Ministry of Health (MOH), Botswana and Haukeland University Hospital (HUH), Norway regarding Human Resources Assistance to Ministry of Health Botswana 2004 –2007. 9th December 2004.
- Two annual meetings between Botswana and Norway have since been held (May 2005, June 2006), and progress has been reported in two annual reports. These, and agreed minutes from the Annual Meetings will be made available for the review team.

2 Purpose of Review

The review will show if project implementation and progress is on track, measured against its goal and objectives, and provide recommendations to its continuation.

3 Priority issues

The project description, the appraisal and subsequent progress reports point to possible success and to risk factors. The Mid-Term Review will explore the following issues:

3.1 *Assessment of the relevance and direction of the project.*
The MOH policies and plans for its HRH component of the health system forms an essential background. Botswana's HRH situation and relevant profile of the national health burdens will provide an overall picture of the project and its environment.

3.2 *Assessment of achievements and possible constraints and failures.*
An overview of what has been delivered, in quantity and quality is expected. The reviewers may undertake field studies and conduct interviews with relevant stakeholders and collect other relevant data for analysis, additional to documents mentioned above, under chapter 1.3. An assessment of policies and plans compared to realities on selected project sites will be relevant. Additional data and review approach will be proposed by the review team if relevant or possible.

3.3 *Assessment of project design, and coordination between partners and among stakeholders.*
To what extent is the project's implementation efficient and useful to HRH in Botswana? Does it give a sensible response to the HRH challenges in the country? Are roles and responsibilities rational and

well functioning, and aligned with Botswana's systems and procedures? Are any positive, or negative, side effects observed?

3.4 Sustainability and risks

Relevant points to the extent these issues are not included above:
- Policy and framework conditions (including corruption)
- Socio-cultural and gender aspects (including HIV/AIDS in the workplace and as professional challenges)
- Economic and financial aspect
- Institutional and organisational aspects
- Technical/technological aspects
- Any other significant risks that seem to prevent achievements of results

4 Implementation of the Review

4A Methodology.

- Desk review of the Core Documents identified in the 'Background' section of these TORs

- Interviews with the key stakeholders involved in the project e.g. the Institute of Health Sciences, HUH, the Ministry of Health, beneficiaries of the capacity building activities, the national agencies for Botswana's AIDS response, and if relevant, key informants at district and institutional levels including direct beneficiaries (or their representatives) of ART services

4B Division of responsibilities

- The Norwegian Embassy in Pretoria shall
  - provide all the relevant project documents and progress reports to the Review Team,
  - circulate the Terms of Reference
  - remunerate one national consultant,
  - circulate the draft and final report,
  - facilitate the communication with the Botswana Ministry of Health and other relevant authorities in Botswana

- Norad's AHHA department shall:
  - Finalise the terms of reference and submit to the Norwegian Embassy
  - Recruit and remunerate an external consultant, including contracting arrangements
  - Administer the contracting of a local consultant

- The Ministry of Health shall:
  - provide the Review Team with documents relevant to Botswana's human resources for health situation
  - provide the Review Team with documents relevant to the current HIV/AIDS situation in Botswana and the national response
  - provide the Review Team with introductions to key stakeholders involved in the Human Resources Assistance to the MOH project
  - provide transport locally for the Review Team on official business

- A Review Team of two consultants who are independent from the project stakeholders will be composed, with one member from Botswana and one from Norway. The consultants are: Joyce Maphorisa Performance Growth Consultants, Gaborone, and Marilyn Lauglo, Centre for Health and Social Development, Oslo. Delineation of tasks, including drafting different portions of the Report shall be agreed upon between the Review Team members.
- Ms. Maphorisa is the Team Leader for the Review and is responsible for:
    - Logistics for the Review Team while carrying out the Review

4C Time Frame for the Review

- The Review will require 6 person weeks and will be carried out in May 2007 In-country work will take place between May 21 – 31, 2007, with possible extension if found suitable.

5 Reporting

A final report in English shall be submitted to the Embassy by 1 June 2007. The final report shall highlight the findings with regard to the priority issues identified in Section 3 above and shall be submitted to the embassy in paper and in electronic form, not exceeding fifteen A4 pages, with an introductory summary with main conclusions and recommendations. An executive written summary shall be submitted in connection with the verbal debriefing given to the Embassy and the Ministry of Health by one member of the Review team on 28 May 2007.

6. Budget

The budget for the Review is found in the separate attachment**.**

Expenses for the team (remuneration and travel costs etc.) and minor expenses incurred in carrying out the Review will be covered by Norad after invoice from the Team. Norad will cover salary expenses for the external consultant, whereas The Norwegian Embassy in Pretoria will remunerate the local consultant (salary expenses). Work is estimated within the framework of six person-weeks in total.

Pretoria, 9 May 2007,

Sten Anders Berge
Charge d' Affaires

Recommended by

Inger K. Stoll
Cousellor

Annex 2

Documents Reviewed

1. Project Proposal For Human Resources Assistance To the Ministry of Health. August 2004
2. Human Resource Assistance to the Ministry of Health In Botswana. 2003/2004-2006/2007. Different Models for Norwegian Support. June 2004. Pal Jareg, HeSo
3. Appraisal report of the project: Human Resource Assistance to the Ministry of Health. In Botswana 2003/2004-2006/2007. Sissel Hodne Steen and Pal Jareg. Oslo December 4th 2004
4. Agreement Between the Government of the Republic of Botswana and the Government of the Kingdom of Norway regarding Human Resource Assistance to the Ministry of Health in Botswana 2003/2004-2006/2007. 8 th December 2004
5. Project Contract between Ministry of Health (MOH), Botswana and Haukeland University Hospital (HUH), Norway Human Resource Assistance to the Ministry of Health. In Botswana 2004-2007. 9th December
6. Minutes of the Annual Meeting For The Project BOT 2201- Human Resource Assistance to the Ministry of Health. In Botswana held on the 10th May 2005.
7. Agreed Minutes of the Annual Meeting on BOT 2201- Human Resource Assistance to the Ministry of Health. In Botswana. 13th June 2006
8. Annual Report BOT 2201- Human Resource Assistance to the Ministry of Health In Botswana. 2004/2005. April 2005
9. Annual Report BOT 2201- Human Resource Assistance to the Ministry of Health In Botswana. 2005/2006. May 2006
10. Ministry of Health Organisation Structure
11. National Development Plan 9. 2003/2004-2008/2009. Ministry of Finance and Development Planning. March, 2003
12. Norad, 2006 *Norads Strategi mot 2010,*
13. Botswana National Strategic Framework for HIV/AIDS. 2003-2009. Republic of Botswana
14. The Economic Impact of HIV/AIDS in Botswana: Executive Summary. Econsult March 2007
15. Norwegian Ministry of Foreign Affairs, November 2006, *Norway's HIV and AIDS Policy: Position Paper in Development Cooperation*

Annex 3

People Interviewed

21 May 2007

Relebeng Otsweleng	PHO, Dept. Health Sector Relations and Partnerships, MOH
Herman Semakula,	Head of Dept., Pharmacy, Institute of Health Sciences, Gaborone
Wendy Roseberry,	Lead Consultant, National AIDS Coordinating Agency
Mompati Mmalane,	Director, Dept. of Clinical services, MOH
Tore Steen,	PHS Dept of Public Health
Trude Arnesen	PHS, Selibe Phikwe

22 May 2007

Grete Marie Eilertsen	Senior Consultant, HUH (by telephone)

23 May 2007

Arnold Madikwe	Director, Development Cooperation, MFDP
Boitumelo Kgaodi	Senior Planning Officer (EU), MFDP
Mrs. Mokopakgosi	Director, Dept. Policy, Planning, Monitoring and Evaluation, MOH
S. Modukanele	Director, Dept. Health Sector Relations and Partnerships, MOH
Mr. Mokgweetsinyana	Acting director, Dept. of Public Health
Ross Kidd	Consultant

24 May 2007

Morten Hovdet	Medical doctor, Mahalapye District Hospital
K. Bose	Chief medical officer, Mahalapye District Hospital
Vibeke Nissen	Specialist in internal medicine & infectious diseases, Sekgoma Memorial Hospital. Serowe
E. E. Kavuru	Chief medical officer, Sekgoma Memorial Hospital
Janny Dvergsdal	Midwifery Lecturer, Institute of Health Sciences, Serowe

25 May 2007

S. G. Rathedi	Principal, Institute of Health Sciences, Serowe
S. Tumelo	Principal, Institute of Health Services, Gaborone
J. Masunge	Medical Superintendent, Nyangabwe Hospital (by telephone)
G. Seetasewa	Dep. director, Dept. of Ministry Management, MOH
S. Kedibonye	Principal Health Manpower Officer – Human Resources, Dept. of Ministry Management, MOH
Mr. Ndibi	Director, Dept. Ministry Management, MOH

27 May 2007

Terje Hanche-Olsen	Specialist in Anasthesia, Nyangabwe Hospital (by telephone)

28 Mar 2007

Pia Pretsch	Pharmacy lecturer, Institute of Health Sciences, Gaborone

29 May 2007

Debriefing

S. Modukanele	Director, Dept. Health Sector Relations and Partnerships, MOH
Relebeng Otsweleng	PHO, Dept. Health Sector Relations and Partnerships, MOH
Hakon Gulbrandsen	First Secretary, Royal Norwegian Embassy
Monica Tselayakgosi	Programme Planning Manager, National AIDS Coordinating Agency
R. Lebelonyane	Director, Dept. of Primary Health Care, MLG
J. Solum	Laboratory Technology lecturer, Institute of Health Sciences, Gaborone
E. Ntema	Dep. director, Institute of Health Sciences, Gaborone

30 May 2007

M. Balosang	Director, Dept.of Public Health, MOH
Ms. Mudanga	Deputy Director, Dept. of AIDS Prevention and Care, MOH

31 May 2007

Debriefing Meeting:

L. Majhane	Deputy Permanent Secretary, MOH
S. Modukanele	Director, Dept. Health Sector Relations and Partnerships, MOH
K. Seipone	Deputy Director, Dept. of AIDS Prevention and Care, MOH
Mompati Mmalane,	Director, Dept. of Clinical services, MOH