Human Resources for Health

Workforce Analytics for Design and Planning Report

BURKINA FASO CASE STUDY

Vital Wave℠   IntraHealth INTERNATIONAL — Because Health Workers Save Lives.   COOPER/SMITH

BURKINA FASO

Health System Overview

Burkina Faso's national health system is centralized, with different administrative levels including the central, province, and district-levels (comprised of 70 health districts). Healthcare is provided by the public and private sectors. Public sector service delivery is organized into primary, secondary, and tertiary care, with 1,959 primary health clinics feeding to eight regional hospitals and a university hospital center.

Current State of Health Workforce Information Ecosystem

Figure 4 – Summary of HRH in Burkina Faso

Knowledge of…

...where health workers are	...how they perform	...if they show up for work	Salary Payment Processes
• Lack of individually identifiable data in any MIS.	• Paper-based system for the entire public service and CHWs. • Process not informed by data.	• Attendance not tracked.	• Functioning payroll system with no salary delays reported. • CHWs paid separately through Orange Money.

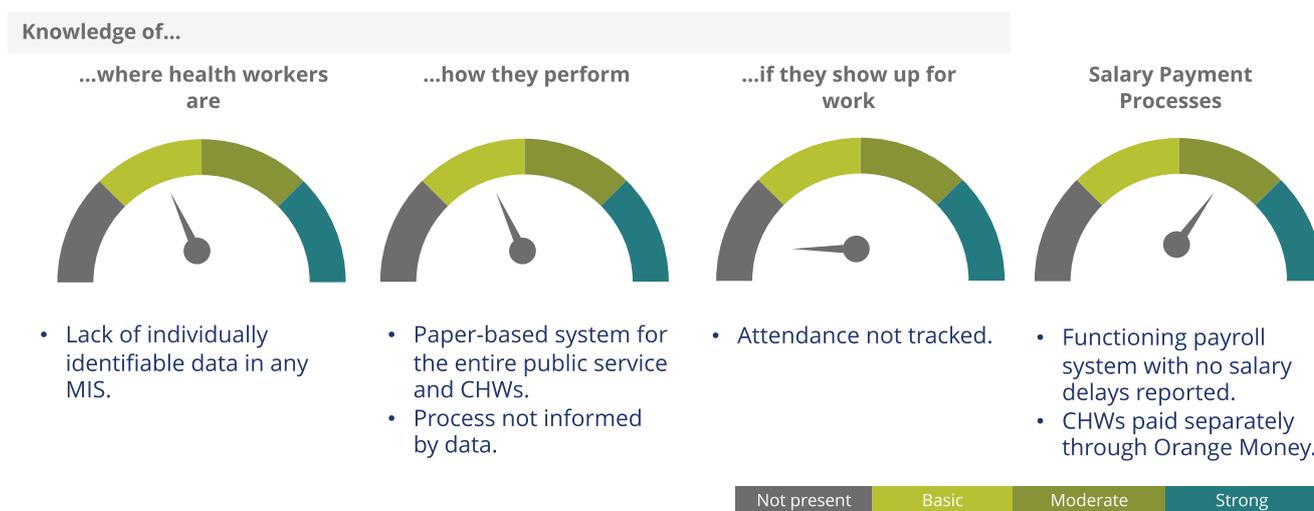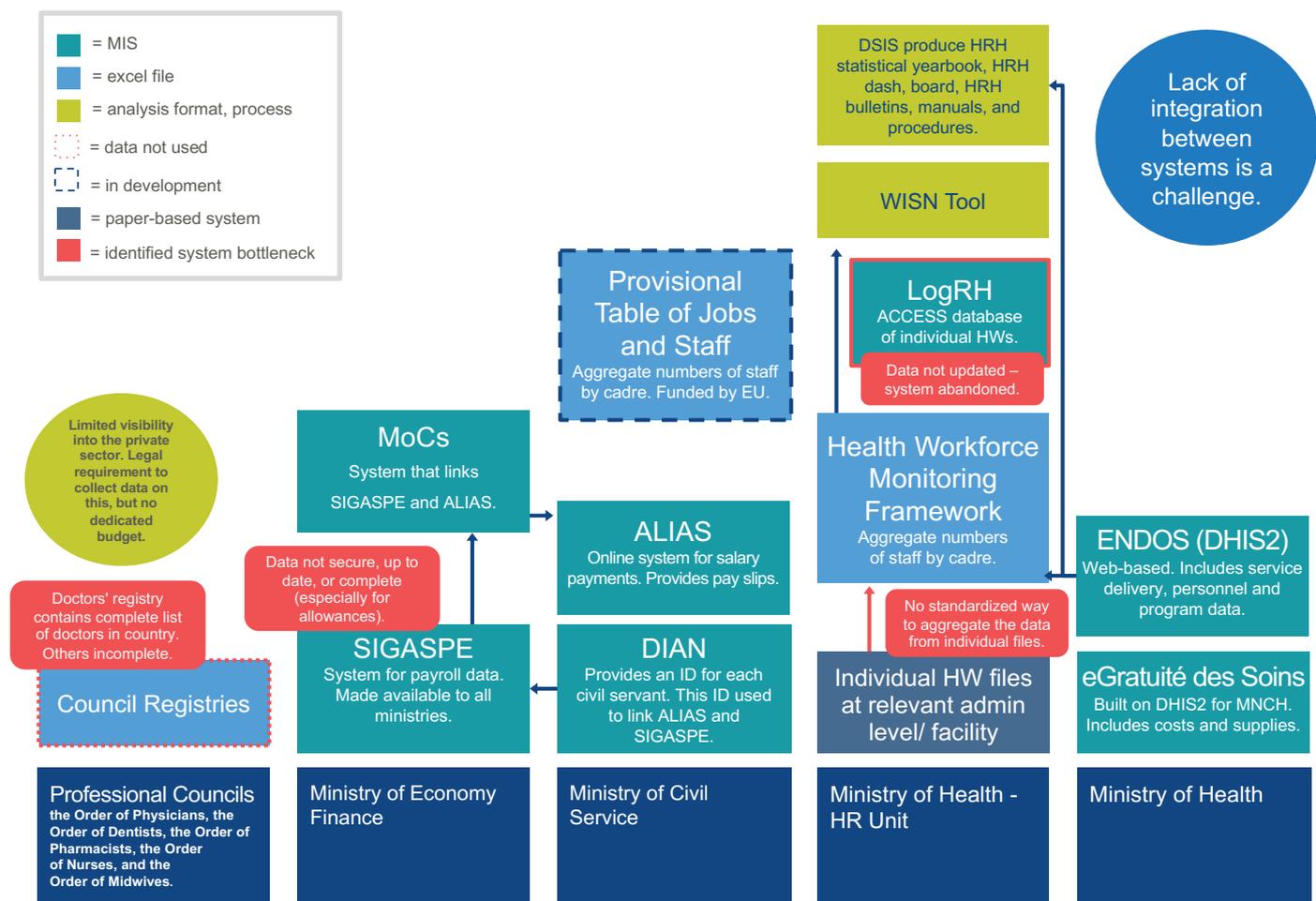| Not present	Basic	Moderate	Strong

Figure 4 above provides an overview of the state of HRIS in Burkina Faso. Burkina Faso maintains several exemplary HRH practices, despite being a fragile state and receiving only modest health investments from donors.[5] The eHealth Strategy (Cyberstratégie Sectorielle eSanté), lays out several major government investments to improve the ability to plan, manage, and track the public-sector health workforce using digital tools and systems. The recent application of WISN in 2018 has rationalized deployment of health workers, often moving them from urban facilities to rural ones based on workload pressure. Additionally, a new, dedicated functional committee (Team 7) oversees donor and partner inputs into HRH to veto projects and ensure alignment with the MoH's goals.

That said, HRIS are at a nascent stage, with most HRH management functions not in place or dependent on highly manual or paper-based systems. Figure 5 shows a mapping of the different information sources and systems across different ministries and departments that create the health workforce information ecosystem.

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[5] *External expenditure on health in Burkina Faso is only 18%, compared to 61% in Mozambique and 43% in Uganda.*

Figure 5 – Burkina Faso Information System Overview

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Legend:
- = MIS
- = excel file
- = analysis format, process
- = data not used
- = in development
- = paper-based system
- = identified system bottleneck

DSIS produce HRH statistical yearbook, HRH dash, board, HRH bulletins, manuals, and procedures.

WISN Tool

Lack of integration between systems is a challenge.

Provisional Table of Jobs and Staff
Aggregate numbers of staff by cadre. Funded by EU.

LogRH
ACCESS database of individual HWs.
Data not updated – system abandoned.

Health Workforce Monitoring Framework
Aggregate numbers of staff by cadre.

ENDOS (DHIS2)
Web-based. Includes service delivery, personnel and program data.

Limited visibility into the private sector. Legal requirement to collect data on this, but no dedicated budget.

MoCs
System that links SIGASPE and ALIAS.

Data not secure, up to date, or complete (especially for allowances).

ALIAS
Online system for salary payments. Provides pay slips.

No standardized way to aggregate the data from individual files.

Doctors' registry contains complete list of doctors in country. Others incomplete.

SIGASPE
System for payroll data. Made available to all ministries.

DIAN
Provides an ID for each civil servant. This ID used to link ALIAS and SIGASPE.

Individual HW files at relevant admin level/ facility

eGratuité des Soins
Built on DHIS2 for MNCH. Includes costs and supplies.

Council Registries

Professional Councils
the Order of Physicians, the Order of Dentists, the Order of Pharmacists, the Order of Nurses, and the Order of Midwives.

Ministry of Economy Finance

Ministry of Civil Service

Ministry of Health - HR Unit

Ministry of Health

As can be seen in the figure above, digital systems exist for payroll management; salary payments; and a vertical, program-specific Maternal, Newborn, and Child Health (MNCH) information system built for the eGratuité des Soins program. Aggregated service delivery data from DHIS2 is also used to calculate workload. Individual HR personnel files are found at the health worker work location, but only aggregate HRH data from these paper files are entered into the Health Workforce Monitoring Framework at the province level, making data difficult to validate and use at the national level. Additionally, each district and region keep individual level lists in various formats including Word and Excel for all health workers in their area, but these files are stand-alone and not linked to the paper-based individual file or the aggregated national HRH database. An HRH Access database (LogRH) was in place and used by the MoH from 2012-2018 but has since been abandoned. When functional, it only covered half the subnational units and was not web-based, located instead on a single computer. This resulted in the database not being regularly updated.

BEST PRACTICE: FUNCTIONAL TEAM 7 FOR HRH STRATEGIES

To ensure that development partners address key issues in the HRH Strategic Plan and other HRH policies, implementing partners need to identify how their proposed intervention supports the direction the MOH. Each intervention must have a sustainability plan and a capacity building strategy to ensure the intervention will continue after completion of the project. Team 7 monitors the partner to ensure compliance with this policy and can ask the partner to end their project if they are not compliant.

Data quality and availability was also reported as a challenge in Burkina. Data in the payroll system (SIGASPE) is not accurate or up to date, especially when it comes to data that impact health worker allowances (e.g., ages of children to determine child allowance eligibility). Meanwhile, Professional Councils are led by volunteers with no full-time staff and have limited scope to ensure quality of workforce or enforce regulations around registration and licensing. Only the medical council has a fairly complete registry for doctors. Registration is closely tied to graduation, meaning that foreign trained doctors are frequently missing. The Nursing Council and other councils do not have a full listing of their cadres at this time.

Visibility Outside Formal Public Sector

Comprehensive data on the private sector is not covered by existing systems even though it is prioritized as a policy requirement. Partial lists are available for CHWs are working in health facilities.

Findings Across Priority Use Cases

Looking across the priority use cases highlights the fact that decision making is supported by aggregate data from standalone systems that cannot be easily verified. Administrative functionaries and decision makers have poor access to data, most of which is in paper files. The processes and systems in place results in a high burden on health workers, data collection clerks, and limit HRH managers' ability to make decisions using data.

> ### BEST PRACTICE: INCLUDING UNIONS
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> In some countries in the multi-country review, unions were a barrier to data use for equitable deployment and have worked to prevent payroll reconciliations removing ghost-workers. However, there are examples of successful union engagement in Burkina Faso. There, labor unions advocated for the special needs of hospital employees, for example, ensuring a higher salary for night shifts. Union representatives also sit on the deployment committee for hospital recruitment.

Recruitment and Deployment

Overall recruitment decisions are made by an assigned committee based on data from Burkina Faso's HIS (ENDOS/DHIS2), WISN, and the Health Workforce Monitoring Framework (the Excel-based aggregated information system of all health workers). A closer look at how recruitment and deployment is conducted in Burkina Faso identifies a fragmented information system that relies on paper files and Excel spreadsheets.

- Changes in deployment status require health workers to travel, in person and with their personnel file, to the Ministry of Health and the Ministry of Finance at the national level to have their official status changed in the SIGASPE payroll system. This can mean absences of several days from their health post.

- Individual health worker files are kept in the province or district offices for primary health care workers and at the hospital for hospital employees.

- Lists of health workers are compiled into Excel spreadsheets and aggregated to create the Health Workforce Management Framework, developed in 2017. Because the data are aggregated, the quality of this data cannot be easily verified. Each local district also keeps a separate list of their employees in Excel or Word which are not standardized or linked to any other data source.

- Service delivery data are collected in facility registers, compiled, and sent to the district level for entry into ENDOS (DHIS2). The overburdened data clerks are responsible for entering data into multiple information systems with limited data quality checks.

- Additionally, while there are policies in place governing HRH practices for recruitment, deployment, and rational distribution of staff, the assessment found that (as in many contexts) these are often not implemented.

Salary Payments and Reconciliation

In Burkina Faso, the SIGASPE information system at the Ministry of Economy and Finance operates the national payroll system. SIGASPE is linked with two other databases at the Ministry of Civil Service. DIAN assigns an identification number for each employee, and ALIAS creates the pay slip with information from SIGASPE. Since 2018, public-sector employees receive salary payments every month through direct deposit into their bank account. The process varies for hospital and non-hospital staff:

- For **non-hospital health workers**, changes in status related to promotion, transfers, or family changes affecting allowances need to be made in person by the employee at national level with the paper-based employment record. Additionally, the information included in SIGASPE is not always updated to reflect allowances or job transfers that may result in a lower salary (e.g., family allowances not being lowered after children age-out of the benefit, or staff transfers not being reflected in a move from an insecure area giving a risk allowance to an area that not eligible for a risk allowance).

- **Hospital-based health workers** salary payment follows a similar process, with the exception that the Ministry of Finance transfers money to hospitals to pay employees. Labor unions advocated for a public hospital law that was established in 2017 to address employment conditions for hospital employees, including registration with the professional orders (councils), conditions for permanent salaried employees, benefits, and special salary for night shift workers. With this new law, employees are paid a salary based on the number of nights in a month they are scheduled to work. One challenge is that no one checks to ensure the person actually showed up and worked those night shifts. In addition, Money generated by patients' fees at hospitals is used to pay contract workers and procure special hospital equipment.

- **CHWs** get paid monthly by the Health Development Support Program and Directorate of Health Education through a mobile payment system called Orange Money. While the process appears straightforward, payment requires monthly activity reports to be compiled and submitted as a requirement for generating payment. However, as CHWs do not perform a consistent package of services, it is challenging to compile their performance reports, making it difficult to review their performance and payments.

Individual Performance Management and Attendance Tracking

Each year, province and district managers are asked to nominate staff from every level of the health systems for service awards based on longevity of service and excellence; however, performance management is not informed by data. The MoH sees that this is an important area for improvement and plans to have performance reviews based on objective criteria and job descriptions in the future.

Specific gaps identified are:

BEST PRACTICE: EGRATUITÉ DES SOINS

The maternal and child health program, eGratuité des Soins, demonstrates a promising opportunity for HRIS integrating human resources, WISN, service statistics, and supply data for decision making and service delivery. The program captures data on costs, drugs, supplies, and human resources in a DHIS2-based platform and has incorporated a financial data entry incentive to encourage timely data entry (payments for medications and supplies are withheld if data are not entered within three months). eGratuité des Soins also includes an HR algorithm using WISN methodology that indicates whether health workers are rationally deployed.

- The 10-point performance assessment is based on the subjective inputs of the supervisor, not on specific roles or job expectations.

- Paper-based performance reports are sent to the Ministry of Civil Service at the national level to be aggregated. If their scores are 6/10 or more, health workers will get moved up into the next salary band. However, these data are not easily accessible or verifiable.

- There are no job descriptions or performance targets for health workers.

- There is no attendance monitoring throughout the health system, and attendance can be irregular with some health workers drawing a salary but also working in the private sector or not showing up at their post.

- Policies are also in place for attendance, management of absences, and private sector reporting, these are not enforced.

Bottleneck Identified

Data Availability	Data Quality and Use	Systems and Tools	Human Capability
• Data are not standardized and found at multiple levels.	• Individual files are paper-based, making them hard to use and verify.	• Health workers required to update deployment status in person.	• Professional councils led by volunteers.
• Public sector health worker data only available in paper forms at health worker location or in aggregate at national level.	• Payroll managers have limited or outdated information.		• Data entry staff tasked with aggregate health worker data are overburdened at subnational levels.
• Only partial data available on private sector workers and CHWs			