IMA WORLD HEALTH

UKaid
from the British people

iHRIS
in the Democratic Republic of Congo
ASSP and ASSR - 2013 to 2022

CRITICAL TOOL FOR IMPROVED HEALTH WORKFORCE MANAGEMENT

BACKGROUND

Good management of human resources (HR) is the linchpin for quality outcomes and sustainability of health systems. In the DRC prior to 2010 the human resource management was paper based, making the efficient management of human resources complex and near impossible. IMA began investment in the DRC health workforce in 2005 and soon gained traction with the Ministry of Health and the World Bank. At that time, focus was primarily on staff identification and payments with no account for initial qualifications, licensing, continuing education or professional development of health workers.

EARLY EXPERIENCE WITH IHRIS IN DRC

In response to this challenge, ASSP introduced the iHRIS Manage 4.2 software as the health workforce database of choice because of its capacity to address not only payroll, but also licensing and professional development. It was also the only tool available at that time which could navigate the complexity of the Health Workforce recruitment, funding and remuneration system in the DRC. In DRC, four government ministries are intricately involved in maintaining the Health Workforce, including the Ministry of Health, Ministry of Budget, Ministry of Public Services and Ministry of Finance, each with different lists and different payment mechanisms. iHRIS had been developed with the support of USAID and IntraHealth and was already used in several African countries. As part of the iHRIS selection process, IMA travelled to Kenya with key representatives from central government to observe how this tool was used in that country and compare with other options.

A TOTAL OF 3,051 PHANTOM EMPLOYEES WERE ELIMINATED FROM THE SYSTEM DURING THE FIRST YEAR, SAVING $1.1 MILLION PER YEAR.

Intense education and lobbying on the part of IMA and supportive donors finally resulted in a pilot roll-out of iHRIS in 2016 in the four ASSR provinces (Kasai, Kasai

Central, Maniema and Nord Ubangi). This successful pilot demonstrated enormous potential for cost savings to the health system simply by reallocating "ghost worker" salaries to on-site employees:

Health worker identification - 66,343 employees were registered in the iHRIS database

Bonuses "Primes de risque" - There were 5,062 employees on the national budget payroll listing who received special bonuses for work in remote areas, costing CDF 300,843,629, or $180,000 per month. Using the data captured by iHRIS, 2,124, or 42 percent, of these employees were not found in the iHRIS database, e.g. ghost workers. These ghost workers were costing about $44,000 per month. These funds were subsequently reallocated to the staff of health workers.

Salary - Of 3,380 employees reported in the salary payroll listing, 927, or 27 percent, were phantom workers not found in the iHRIS database. These phantom workers were costing CDF 77,412,292, or $48,000 per month to the system. About $40,000 per month of these funds were reallocated to support salary payments of over 780 health workers in pilot provinces.

iHRIS pilot data was also shared with the Ministry of Public Service (MPS) for retirement planning when it was found that 356 health workers in these provinces were eligible for retirement in 2017. The MPS committed to use iHRIS, with financing from the World Bank, as part of their programme to support transition to retirement of eligible workers and open the market to a younger workforce (i.e. Rajeunissement des Agents de l'Administration de la Fonction Publique). Finally, iHRIS was used to develop Workforce Registries (Annuaires) for tracking and personnel development.

As such, iHRIS roll-out through the early pilot phases demonstrated the following:

iHRIS was possible.

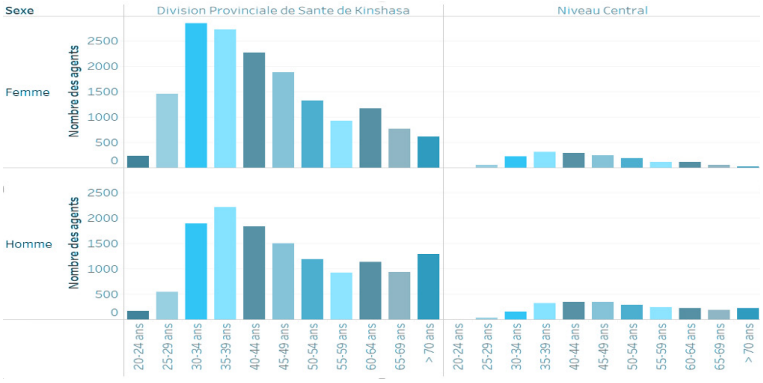
Abuses such as ghost workers and gaps in the payment of workers are rampant.

Correcting these gaps can lead to significant government savings.

However, following publication of these findings the initiative began to suffer resistance to changing the opacity of the status quo.

ENHANCED QUALITY AND COMPLETENESS OF IHRIS DATA ENTRY

After initial interest in iHRIS, toward the end of ASSP (2017-18) routine data reporting began to lag, resulting in a resurgence of « declarative lists » from the health zones. To support the government's strategic intention to achieve routine use of the iHRIS database as the sole source of human resources for health (HRH) data, IMA World Health put in place a two-part system of routine HRH data collection and reporting. Supported by all relevant stakeholders, the first part collects data on benefits and compensation and provides information on the actual presence at work and the payments received by health workers. Payments might include salary, risk



premium paid by the state, or local premiums paid by local communities, patient fees, or other income provided by international donor projects. The second part collects data related to worker qualifications and experience. The goal is to enhance transparency in recruitment and hiring, and to support transition to compensation based on performance or merit.

In 2019, the DRC Ministry of Public Health (MSPHP) and the Bill and Melinda Gates Foundation tapped IMA to conduct a health worker census covering over 40,000 workers in the City Province of Kinshasa and the Central Health Administration. Similarly, IMA was contacted by the World Bank via the Ministry of the Civil Service to recover and integrate into iHRIS data of the HRH censuses of the eight additional provinces.

Overall, the 36 months of ASSR (2019-2022) focused on supporting provinces enter and use HRH data (iHRIS Reporting). Despite the dramatic decrease in funding mid-way through ASSR and COVID, which prevented planned refresher trainings and support visits, iHRIS data entry continued with appreciable results in terms of data completeness in the project zones. Today, DRC counts 15 provinces where iHRIS is being implemented. Of these, ASSR provided direct support in four provinces and offered technical support in three others.

REPUBLIQUE DEMOCRATIQUE DU CONGO
MINISTERE DE LA SANTE PUBLIQUE
SECRETARIAT GENERAL

Direction des Services Généraux et Ressources Humaines

Complétude des prestations

National

(May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21,)

18-05-2022 21:06:44

No	Province	Effectif Général	Effectif Actif	Effectif Actif (%)	Effectif Inactif	Effectif Inactif (%)	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Rapportage moyen	Taux de rapportage (Effectif général)	Taux de rapportage (Effectif actif)
1	PROVINCE DE MANIEMA	6 454	6 454	88,47%	744,00	11,53%	1567	1475	1438	1425	1475	1438	1507	1510	1 479,38	22,92% %	25,91% %
2	PROVINCE DU KASAI	5 578	5 578	93,51%	362,00	6,49%	3232	3298	4345	4344	4339	4387	3995	3794	3 966,75	71,11% %	76,05% %
3	PROVINCE DU KASAI CENTRAL	7 304	7 304	35,83%	4 687,00	64,17%	2029	2068	2061	2104	1972	2119	1894	1800	2 005,88	27,46% %	76,65% %
4	PROVINCE DU KONGO CENTRAL	7 873	7 873	1,35%	7 767,00	98,65%	3	2	5	12	31	38	41	62	24,25	0,31% %	22,88% %
5	PROVINCE DU NORD KIVU	13 812	13 812	9,36%	12 519,00	90,64%	0	0	0	0	0	4	62	53	14,88	0,11% %	1,15% %
6	PROVINCE DU NORD UBANGI	3 779	3 779	88,65%	429,00	11,35%	3195	3184	3166	3165	3163	3157	3161	3164	3 169,38	83,87% %	94,61% %
7	VILLE PROVINCE DE KINSHASA	39 785	39 785	0,04%	39 770,00	99,96%	2	2	2	2	2	7	5	4	3,25	0,01% %	21,67% %
Total		84 585	18 307	21,64%	66 278	78,36%	10028	10029	11017	11052	10982	11150	10665	10387	10 663,75	12,61	58,25

FACTORS OF SUCCESS AND LESSONS LEARNED

Despite fluctuating political interest, iHRIS has become important for health workers. Now able to communicate through iHRIS their real situation, health workers are beginning to hope for improvements in work conditions, compensation and benefits. At the provincial level, ASSR-supported human resources working groups are examining iHRIS data to find solutions to workforce challenges. In North Ubangi, iHRIS data was used by various parties to demonstrate some of the gaps in workforce remuneration.

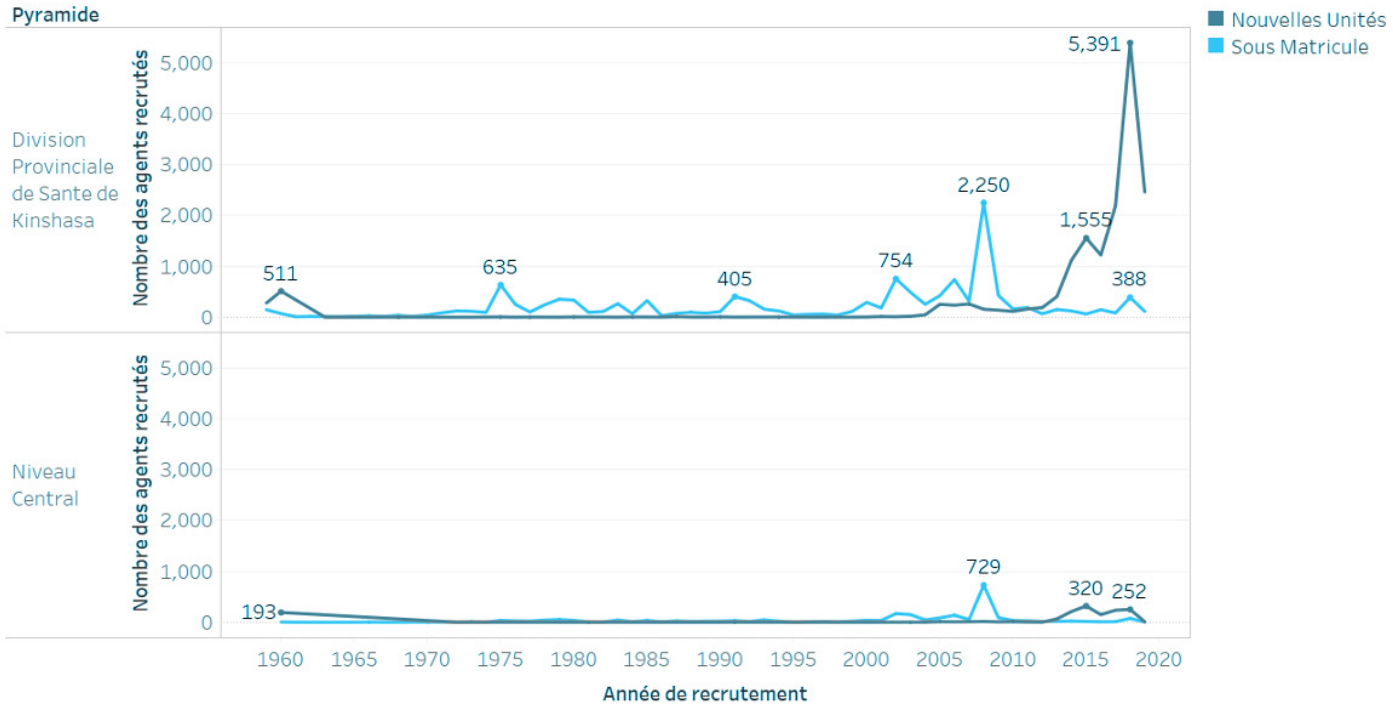
Performance-based incentive payments of the data managers was important to ensure continuous data entry, even when supervisory visits and training were suspended due to COVID. These front-line data entry persons are critical to ensuring reliability of the data.

Within a given province, partial or limited support for human resource management limits the system as a whole. This is the case in the province of Kasai-Central where the ASSR project supported 11 out of 26 health zones. The other 15 SLAs are supported by the USAID-PROSANI project. In this province, only the DPS, the IPS and the 11 health zones receiving ASSR support were able to produce useful data. The other 15 health zones remained silent due to lack of support. Provincial health authorities were therefore limited in their ability to make decisions for the province, given partial data. The same situation was also observed in the province of Kongo-Central where the very limited funding from JICA and weak strategic support did not allow results to be obtained despite the support of the IMA technical team.

The role of leadership and technical support is as important as financial support. In North Ubangi and Kasai, for example, health authorities have restricted the use of “declarative lists”, promoting instead exclusive use if iHRIS for HRH data capture. In these provinces, iHRIS is used for routine administrative matters such as personnel management, payroll, and retirement. And while iHRIS has taken hold in provinces directly supported by ASSR, provinces such as Tshuapa and Haut-Katanga, without government or other technical support, have had very limited success. The drafting and regular publication of the directories has improved the capacity to analyse and monitor key indicators on human resources management in health, such as the number of staff receiving hazard pay or salaries, and to advocate with the relevant authorities to improve the situation of staff who are actually working.

NEXT STEPS: ADOPTION AND SCALE UP

iHRIS provides a tool for good health workforce



management. While promoted at the highest levels of government, it still has not rolled out to all 26 DRC provinces. Where it is rolled out, some health managers see it as another "report generator". Others see it as parallel and more cumbersome than "listes declaratives". Only a few actively use the data to make decisions about recruiting, hiring and compensating workers. To reach this tipping point, the following steps need to be taken:

1. Institutional donors need to pool efforts to ensure financial and technical support is adequate and evenly to support scale up. The initiative of the Global Fund to support revitalisation of iHRIS in Maniema is to be commended, but better results cannot be achieved without good technical assistance to ensure necessary adaptations of the system based on feedback from users.
2. iHRIS needs to become the sole HRH database for health structures with large numbers of employees. This allows for strengthening career development within that system and at the local level.
3. iHRIS promotion and use need to be part of a continuous training and monitoring system. This system should include annual appraisal for state employees, which is a statutory activity not yet implemented. The iHRIS platform can integrate the data from the annual appraisal of health workers and capitalise on it to prepare an integrated training plan for all health workers.
4. The iHRIS database needs to include the health workforce in private for-profit, not-for-profit and faith-based institutions to get a complete picture of the DRC health workforce.
5. Beyond training level and remuneration, iHRIS should be leveraged to information to support professional development, fill training gaps and prevent redundancy.
6. iHRIS in DRC needs to be upgraded from the iHRIS Manage 4.3 to the iHRIS Manage 5.0 platform. This will offer inter-operability with other Ministry open source platforms such as DHIS2.

VALUE-FOR-MONEY

The add value of iHRIS is not evident at all levels. It is costly to roll out and tedious to maintain in the early stages. Indeed, to inform future scale-up plans, stakeholders will want guaranteed return on the investment. The IMA team is pleased that FCDO and our TPM HERA have commissioned a cost-benefit analysis to quantify savings to the health system with scale up.

ADVOCACY

iHRIS will force an opaque human resource management system to become transparent. This transition has met, and will continue to meet, resistance. It is imperative that institutional donors collectively support iHRIS as the sole source for HRH data management. Armed with impact data from the 2021 health worker strike and iHRIS tracking, IMA supports FCDO's lead in rallying donors around the problem of DRC health workforce management. With pressure from major donors on all four Ministries, there may be some impetus for reform. Finally, a concerted focus on the health workforce in DRC, where compensation is reliable, based on qualifications, licensing and experience, the impact on the sector will be transformative and irreversible.