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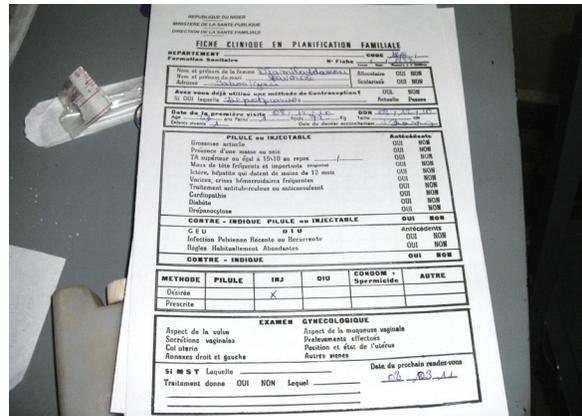
HEALTH CARE  
IMPROVEMENT  
PROJECT



TECHNICAL REPORT

**ALIGNING AND CLARIFYING HEALTH  
WORKER TASKS TO IMPROVE MATERNAL  
CARE IN NIGER**

**The Tahoua Region Human Resources Quality  
Improvement Collaborative**



AUGUST 2011

This report was prepared by University Research Co., LLC (URC) for review by the United States Agency for International Development (USAID). It was authored by Lauren Crigler of Initiatives Inc. and Maina Boucar, Alison Wittcoff, Whitney Isehower, and Tana Wuliji of URC. The Tahoua Human Resources Quality Improvement Collaborative is implemented by the USAID Health Care Improvement Project, which is made possible by the generous support of the American people through USAID. Funding for this work was provided by the U.S. President's Emergency Plan for AIDS Relief through USAID.

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**Front cover:**

*Top left:* Dr. Karimou Sani, left, and Dr. Sani Abdou of URC during the December 2010 coaches' meeting in Niamey, Niger. *Photo by Whitney Isenhower, URC.*

*Top right:* Family planning record as redesigned at Konni District Hospital as part of its improvement activities. *Photo by Karimou Sani, URC.*

*Bottom left:* Women at the Dogueraoua Health Center who participate in the improvement effort by cleaning birthing rooms and the health center, contributing to facility hygiene and cleanliness. *Photo by Karimou Sani, URC.*

*Bottom right:* Tsernaoua Health Center in Niger's Tahoua region, a site participating in the collaborative. *Photo by Karimou Sani, URC.*

TECHNICAL REPORT

# **Aligning and Clarifying Health Worker Tasks to Improve Maternal Care in Niger**

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Improvement Collaborative**

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**DISCLAIMER**

The views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.

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The USAID Health Care Improvement Project provides technical leadership and assistance for improving health care delivery and health workforce management to more than 30 USAID-assisted countries in Africa, Asia, Europe, and Latin America. The project works with Ministries of Health to develop community, facility, and management quality improvement (QI) teams that carry out and test changes to improve care and health outcomes to better meet the needs of underserved populations. HCI builds on 20 years of USAID-supported experience and innovation to adapt QI approaches—including continuous QI, improvement collaboratives, job aids and reminders, self-assessment, and performance-based incentives—originally successful in industrialized countries.

URC’s subcontractors for the project include EnCompass LLC; Family Health International; Health Research, Inc.; Initiatives Inc.; Institute for Healthcare Improvement; Johns Hopkins University Center for Communication Programs; and Management Systems International. Initiatives is the lead organization for HCI’s health workforce development activities.

To learn more about HCI’s work on human resources and workforce development, please contact [healthworkforce@urc-chs.com](mailto:healthworkforce@urc-chs.com) or visit [www.hciproject.org/healthworkforce](http://www.hciproject.org/healthworkforce).

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## ABBREVIATIONS

ANC	Antenatal care
CHR	<i>Centre Hospitalier Régional</i> (Regional Hospital Center)
CSI	<i>Centre de santé intégré</i> (Health center)
DH	District hospital
DHMT	District health management team
DRSP	<i>Direction régionale de la santé publique</i> (Regional directorate of public health)
ENC	Essential newborn care
EONC	Essential obstetric and newborn care
FP	Family planning
HCI	USAID Health Care Improvement Project
HR	Human resources
HRH	Human resources for health
HW	Health worker
MDG	Millennium Development Goal
MOPH	Ministry of Public Health
PDSA	Plan-Do-Study-Act cycle
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PPH	Postpartum hemorrhage
QI	Quality improvement
UN	United Nations
URC	University Research Co., LLC
USAID	United States Agency for International Development

## EXECUTIVE SUMMARY



A Tahoua Region maternity quality improvement team. The USAID Health Care Improvement Project supports the team's work to realign human resources to improve maternal care in Niger. *Photo by Lauren Crigler, Initiatives Inc.*

The human resources crisis affecting public health systems throughout Africa is one of the biggest challenges in attaining the Millennium Development Goals (MDGs). Facing difficult working environments and inadequate support, health workers are often unprepared and unable to meet their demanding workloads; their failures, despite good intentions, cause them to lose motivation, become disengaged, and even vacate their posts altogether.

This report describes pioneering work where quality improvement methods are being applied to strengthen human resources management and performance at the facility, district, and regional management levels to improve maternal care in Niger's Tahoua Region. The project is a collaboration between the Ministry of Public Health of Niger (MOPH) and the USAID Health Care Improvement Project (HCI), which seeks to build the capacity of health systems to better respond to the health needs of underserved populations; improve efficiency and reduce costs; and improve health worker engagement, productivity, and performance.

With the support of the MOPH and HCI, 11 district-level management and 15 health facility quality improvement (QI) teams have worked together since mid-2009 to improve maternal and newborn care. Regional and district health teams have implemented system changes while facility teams have focused on improving performance support and health worker engagement. These teams use the QI collaborative approach to develop, test, implement, and spread feasible strategies targeting specific human resources improvement objectives to improve maternal care services.

As part of this strategic approach to improving human resources management, teams first aligned maternal health goals and objectives from the central to facility levels, and clarified and defined tasks and competencies for clinical staff in maternity units. They then developed peer learning and feedback strategies to increase the number of safe deliveries and designed team-based reward and recognition mechanisms for improved performance.

Improvements made by these teams resulted in significant clinical, performance, and efficiency gains between May 2009 and December 2010: six of Tahoua's eight districts have met the national target for the percentage of births delivered in a health facility (i.e., more than 25%); postpartum hemorrhage fell by half in participating sites; adherence to essential newborn care standards rose from 72% to 98%; and the average waiting time for pre-natal consultations was reduced by 50–98%. When the Tahoua Human Resources Collaborative started, none of the health workers had job descriptions, whereas now, almost all health workers have specific, written job descriptions and clear roles and responsibilities outlined for their work.

Results from this collaborative demonstrate that by building the capacity of health workers and district managers to work in teams to solve problems that deter their ability to provide maternal care, their performance, productivity, efficiency, quality of care, and clinical indicators are sustainably improved in 18 months or less.

Having addressed human resource problems, participating facilities also have more competent health workers to help women deliver; fewer women are bleeding to death after childbirth; and women receive quicker, more-efficient maternal care.

Following on the collaborative's achievements in improving maternal care, the Niger Ministry of Public Health has decided to scale up the human resource management improvements nationally to all health facilities and to introduce an internal quality improvement process within the Ministry's central level management departments.

## I. INTRODUCTION

The human resources for health (HRH) crisis affects 57 countries worldwide, 36 of them in sub-Saharan Africa (WHO 2006). The health worker shortage has been identified as a significant barrier to attaining the health-related Millennium Development Goals (MDGs) (Joint Learning Initiative 2004; Dreesch et al. 2005). Despite growing demand for health services, investments in health workforce development in many crisis countries have stagnated or declined (WHO 2006). The United Nations estimates that by 2015, an additional 3.5 million health workers will be required (UN 2010).

Many of Africa's health workers face difficult workloads each day, for which they are inadequately compensated, and must labor in challenging environments with little recognition for their efforts. Additionally, HRH systems are often weak, and the overall capacity to manage HRH is low. As a result, health workers are frequently unprepared and unable to meet the high demands placed on them; they lose motivation, become disengaged, or vacate their posts altogether as a result.

The human resource challenge in the Tahoua Region of Niger is severe. The ratio of skilled health workers to the population is extremely low: 2010 data show that the ratio of doctors is approximately 1 per 35,000 population; the ratio is only slightly better for nurses and midwives: 1 per 5,000 population (Africa Health Workforce Observatory). The ratios are worse in rural zones, where 60% of Tahoua's providers deliver care to 80% of the region's population. The acute shortage of skilled health workers is one factor in Niger's extremely high maternal mortality rate of more than 600 maternal deaths per 100,000 live births.

Niger's 2005-2010 National Health Development Plan sets goals to reduce gaps in care quality and increase the number of health care workers capable of delivering services. To meet these goals while addressing Niger's HRH challenges, Niger's MOPH requested HCI assistance to strengthen human resources (HR) systems and processes at all levels of the health system, starting in the Tahoua Region.

Following previous successes in improving maternal and newborn care in Niger through a pediatric hospital care improvement collaborative, implemented from 2003 to 2005, and an essential obstetric and newborn care improvement collaborative, implemented from 2006 to 2008, HCI proposed using the collaborative improvement approach to help address HRH problems impeding the delivery of quality maternal care in Tahoua. The previous collaboratives were implemented in the district hospitals in Tahoua's eight districts. As a result of keen interest in developing and field-testing effective approaches for addressing Africa's HR crisis, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) agreed to provide support for the Tahoua HR Collaborative.

The new collaborative would be limited, at least at first, to the Tahoua Region, with the goal of improving maternal and newborn care through better HR management and health worker productivity and engagement. By clarifying and defining tasks and competencies for clinical staff in maternity units and introducing peer learning and feedback strategies, teams have increased the number of safe deliveries and improved performance on other clinical measures.

This report describes the basis of and first step in this landmark initiative. Although the collaborative addresses all seven steps in the human resources performance cycle, the foundation for all of the changes introduced through the collaborative was laid during work on the first improvement objective:

### Section summary:

- Data from Niger's Ministry of Public Health (MOPH) show that the country's health workforce crisis is severe.
- The USAID Health Care Improvement Project (HCI) and Niger MOPH have implemented a landmark program to improve maternal care by applying quality improvement methods to human resources management.
- Tahoua had previous successes with USAID-supported improvement interventions, which made it an ideal location to start the human resource improvement collaborative.
- This effort increased the performance of health workers and quality of maternal care services.

aligning objectives from the central Ministry down to each individual health worker, clarifying and specifying tasks for health workers based on those objectives, streamlining workload to improve performance on these tasks, increasing compliance with clinical norms, and reducing client wait time in participating sites. A full report detailing the experiences across all objectives will be published upon completion of the collaborative.

## II. APPLYING QI METHODS TO HUMAN RESOURCES MANAGEMENT

### A. Framework for the HR Improvement Collaborative

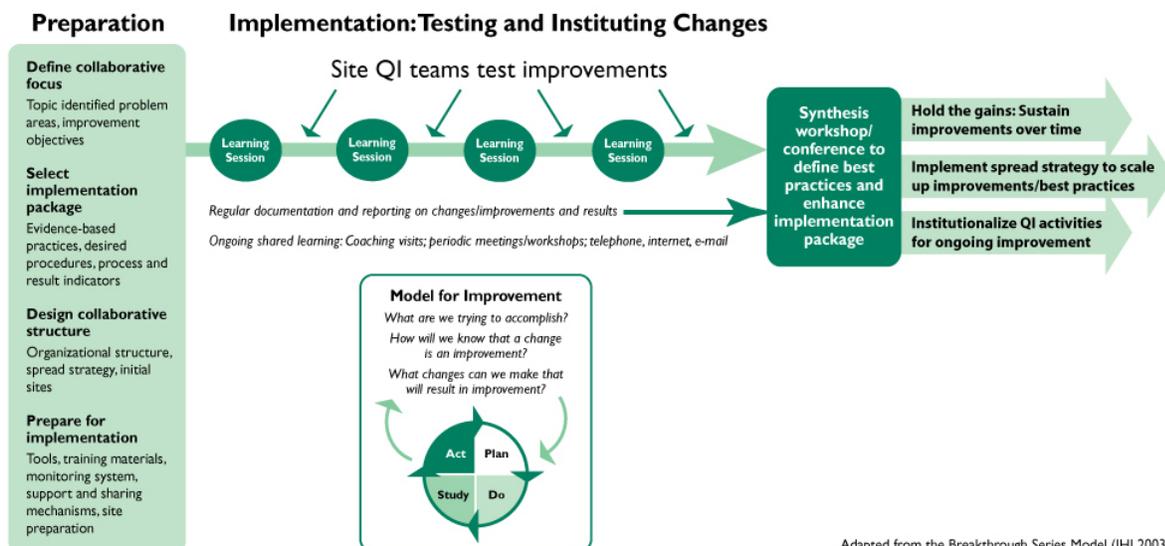
In health care quality improvement (QI) work, facility-based teams analyze their own system and processes of care, identify and test changes in the organization of care that may result in improved quality and efficiency, and use data to document the effect of their changes. Engaging teams of providers in improving care helps foster a culture of quality that contributes to health worker motivation, as well as improvements in the flow and organization of care. Participating on a well-managed QI team also affects individuals by encouraging them to engage in decision making and problem solving, to contribute to a whole larger than themselves, and to build skills and competencies related to improving the quality of care.

#### Section summary:

- The improvement collaborative approach mobilizes teams of health providers in different sites to make changes in care processes using the Model for Improvement.
- Teams in a collaborative share what they learn with other teams, to rapidly spread effective changes.
- HCI applied the improvement collaborative approach to address the key drivers of health worker engagement through changes to the performance management process.

Improvement collaboratives combine the basic practices of QI (sharing best practices, training workers, using job aids, and supportive supervision) with modern improvement strategies (team work, client focus, process analysis, making changes, and monitoring results). In addition, the collaborative approach provides that all teams participating in the collaborative focus on the same objective(s) so they can share their likenesses and differences and benefit all participating facilities. Participating facility staff form QI teams that identify, test, and measure the results of realistic solutions to basic problems the staff encounter in their work. The work empowers these staff to improve their work processes, and the collaborative approach enables them to share their experiences and solutions with fellow collaborative participants and Ministry officials. The Ministry can then expand useful innovations to other sites. Figure 1 sets out the collaborative improvement process, highlighting key stages and activities.

Figure 1: USAID HCI Project improvement collaborative model



Adapted from the Breakthrough Series Model (IHI 2003)

In Niger, as in many developing countries, HR systems of supervision and performance evaluation are weak and rife with problems: Supervisors lack supervisory skills, transportation funds, time, and experience. Health workers might be supervised by a facility manager or a regional supervisor, but the interaction is often short and administrative in nature. Compensation and career progression are divorced from any measure of performance and received, if at all and then only rarely. Workers become demoralized and non-productive.

In addition, most efforts to strengthen HR systems are implemented from the top down—from the central level of the Ministry of Health or Public Service down the layers of the health system—and all too often, the results fail to reach the health workers who ultimately determine the quality of care.

The Tahoua HR Collaborative pioneers the use of this improvement strategy to improve performance management, health worker productivity, and engagement from the bottom up, ultimately improving the quality of care. It enables health workers and managers themselves to design and implement a performance management process, or performance cycle, that works for them. Together they set objectives, build skills, provide feedback, and establish a fair process for evaluating and rewarding performance, as well as consequences for poor performance.

The HR Collaborative Framework (Figure 2) illustrates the hypothesis that if employees have performance support, they will be more engaged in their jobs. If they are more engaged in their jobs, they will stay longer, be more productive, and perform better. When health workers are engaged and perform better, health care will improve. This framework formed the basis for the HR change package that collaborative teams implemented.

**Figure 2: The HR Improvement Collaborative Framework**

Addressing the Performance Cycle	Better Health Worker Engagement	Expected Results
<ul style="list-style-type: none"> <li>▪ Clear expectations</li> <li>▪ Performance feedback</li> <li>▪ Capacity development</li> <li>▪ Fair evaluation</li> <li>▪ Reward and consequences</li> <li>▪ Career path</li> <li>▪ Adequate environment</li> </ul>	<ul style="list-style-type: none"> <li>▪ Belief in job</li> <li>▪ Belief in one's ability</li> <li>▪ Relationships with team</li> <li>▪ Future path</li> <li>▪ Recognition and support</li> <li>▪ Influence in decisions</li> </ul>	<ul style="list-style-type: none"> <li>▪ Improved retention of health workers</li> <li>▪ Improved workforce productivity</li> <li>▪ Improved quality of care</li> </ul>

## B. Engaging Health Workers for Better Performance

As noted, Africa’s undersized, ill-prepared, and often demoralized health workforce is a major global challenge in health care. To improve the quality of care, health workers need to be engaged in the process and in the work. And yet, engaging workers is frequently considered the black box in improvement: “Health workers are not motivated” is commonly heard, with no explanation of the cause of or possible solution to this lack of motivation. Many approaches to motivating and retaining health workers, such as paying slightly higher salaries or providing occasional training, have failed to close the motivational gap—in both developed and developing countries. For decades, industrial psychologists, business managers, and development organizations have struggled to identify causes and implement solutions to sub-par performance, low motivation, and high turnover.

In the past decade, the concept of “engaging” workers in the design, management, and results of their work has taken hold in the United States and in international businesses and non-profit organizations. Such engagement seems, by many accounts, to provide a new way of thinking about managing employees. “Engagement” describes the worker’s state of mind when he or she is not only satisfied

with the job, but is also motivated to do the work and committed to doing it well. Put simply, engagement is the extent to which people enjoy and believe in what they do and feel valued for doing it.

In the health care industry specifically, research by the Gallup and other organizations in more than 334 health care business units with 13, 675 health care workers in developed countries showed that increased engagement among nurses resulted in increased patient satisfaction, nurse retention, and morale; lowered complications; and improved clinical measures such as reduced infections and medication errors (Harter, Schmidt, and Hayes, 2002). Other data show that organizations with high physician engagement receive higher revenue and earnings per admission and per patient day, reduce physician recruiting costs, and sustain significant growth and profitability.

Across this research, six drivers surface consistently as keys to increasing worker engagement (Box 1) and are used by the HR Collaborative to guide improvement work in human resources. Since engagement is described as “the extent to which people enjoy and believe in what they do and feel valued for doing it,” influencing these drivers is important.

HCI has adapted the concept of “employee engagement” and incorporated it into the HR Collaborative. Health worker engagement is measured using a 26-item confidential survey and a five-point agreement scale, which were adapted from a Gallup instrument. Health workers respond to items relating to the six drivers. Although a direct link between improved performance management and increased employee engagement cannot yet be made, interviews with stakeholders and collaborative teams indicate that as the collaborative work progresses, health workers are becoming more engaged in the outcomes of their work.

#### **Box 1: The six drivers of worker engagement**

1. I believe in my job and organization.
2. I believe in my ability to succeed.
3. I have good relations with my colleagues and/or my supervisor.
4. I have the possibility of professional advancement.
5. I feel supported and recognized.
6. I can influence decisions about my work.

### **III. HR COLLABORATIVE DESIGN**

#### **A. Collaborative Goals**

In October 2008, HCI and the Niger MOPH began work on the HR Collaborative by conducting a rapid situational analysis of key HRH systems and a baseline assessment at selected sites to identify priority HRH challenges. The assessment gathered a wide range of perspectives from stakeholders at the central, regional, district, and facility levels about the status of Niger’s HR systems. The situational analysis was followed in March 2009 by an in-depth baseline assessment at 20 health facilities in three regions: Tahoua (15 sites), Maradi (3 sites), and Tillabery (2 sites).<sup>1</sup>

Key findings from the baseline were:

- Four of the 53 interviewed health workers (8%) said they had a written job description.

#### **Section summary:**

- The HR Improvement Collaborative responds to issues identified with the MOPH based on a situational analysis of HRH systems in Niger and baseline data collected in 15 sites in Tahoua.
- Three goals set for the collaborative are: 1) Improve health worker performance through team-based performance management, 2) improve the quality of maternal and newborn care, and 3) improve supervision and clinical coordination.
- The HR collaborative change package addresses the seven steps in a human resources management Performance Cycle. This report addresses the changes made and results obtained from work on the first step in the cycle, to align and clarify health worker tasks.

<sup>1</sup> See Crigler et al. 2011. Assessment of the Human Resources System in Niger. *Technical Report*. Published by the USAID Health Care Improvement Project. Bethesda, MD: URC. Available at: <http://www.hciproject.org/node/2792>.

However, no one could produce them. Only 48 of the 86 interviewed managerial staff (56%) claimed to have a written job description. Again, none were available.

- Twenty-five of the 53 health workers interviewed (47%) had received a supervisory visit in the last six months, and most of them had received only one such visit during the period. District-level officials were unclear on the protocol for supervision visits: Some thought one was required per year and others two.
- Three of the 53 health workers (6%) thought a performance evaluation system was in place, although none had ever been evaluated. Five of the 86 managerial staff (6%) said a formal evaluation system existed.
- Even though bonuses for rural and difficult assignments were an official part of the compensation system, few health workers know about them: 13 of the 53 health workers (25%) knew that regular bonuses existed, but only seven (13%) had received a bonus or other incentive.
- Health workers were asked about their workplace conditions: 56% said the space was inadequate, and 48% said the comfort level was insufficient. When asked about the availability of supplies and materials, 47% said they lacked equipment, and 40% said that available medication was insufficient.
- Thirty-three health workers were observed to enable an assessment of their productivity. Average productive time for doctors was 77%, midwives 63%, technicians 55%, nurses 44%, social workers 29%, and auxiliary workers 19%.
- Clients spent a disproportionate amount of time waiting in light of the contact time they had with health workers. In the district hospital, the average waiting time for a medical consultation was 12 hours for a contact time averaging 20 minutes.
- Health workers, regardless of their cadre or the site where they worked, were not very engaged in their work (scores ranged from 3.4 to 4.2 out of 5); illiterate health workers tended to have higher engagement scores than their literate colleagues.

These findings highlighted the gaps in basic HR management systems, including the absence of job descriptions, lack of a performance appraisal system, lack of health worker awareness of incentives that were available to them in rural settings, infrequent supervision, and poor workplace conditions. These findings informed the design of the collaborative and helped decision makers refine the collaborative's overall goals.

The MOPH and HCI defined three main goals for the HR Collaborative:

- Improve health worker performance through team-based performance management,
- Improve the quality of maternal, newborn and child care, and
- Improve supervision and clinical coordination.

The first of these goals, improving health worker performance through team-based management, is accomplished through the implementation of the seven steps of the Performance Management Cycle (see Figure 3). Each of the seven steps includes a specific improvement objective with an independent set of measurement indicators. The implementation of the first of these steps is the focus of this report.

The second goal of improving the quality of maternal, newborn and child care focuses on four clinical objectives identified by stakeholders:

- Increase rates for assisted deliveries,
- Reduce postpartum hemorrhage (PPH) rates and improve management of PPH,
- Increase family planning (FP) coverage in health facilities, and
- Improve treatment of severe malaria for children under five.

These objectives defined the clinical service areas within which the collaborative would function.

The third goal, to improve supervision and clinical coordination, includes two specific objectives:

- Increase the frequency of and improve the quality of supervision visits, and
- Improve clinical coordination meetings between regional and district management teams.

## B. The Human Resources Improvement Change Package

The implementation package, or *change package*, describes the series of improvements, or changes, that teams will implement to reach a stated collaborative objective. These changes are generally based on international best practices and are intended to guide teams as they test ways to improve work processes. These tests are performed by conducting Plan-Do-Study-Act cycles (PDSAs), part of the Model for Improvement used in HCI's improvement collaborative model, which was shown in Figure 1. To determine whether the changes result in improvement or not, teams use frequent measurements of key indicators that are linked to the expected effects of the changes introduced. In some instances, change packages are intended to be implemented in stepwise fashion, with one change enabling the next.

The HR collaborative change package was based on the seven steps in a human resources management Performance Cycle (Figure 3). Each step includes a performance objective, a change concept, specific changes, and ideas for PDSAs that teams might test in order to implement each specific change. The change package is based on international best practices in human resources and was adapted to the Niger context by local experts and stakeholders.

**Figure 3: The seven steps of the HR Performance Cycle**



Work on *Step 1: Aligning and clarifying tasks* requires defining performance expectations for each health worker, in line with the overall goals and objectives of the health system, and results in clear and meaningful job descriptions for each individual. Such job descriptions provide the foundation for work

on the remaining six steps in the cycle, which will all ultimately be addressed by the Tahoua HR Collaborative. Because of the foundational nature of the work on this first step in the cycle and because it took the longest time to complete, this report discusses only the Tahoua QI teams' work on this first improvement objective defined for the collaborative. Table I details the change package introduced in Tahoua for the first step in the Performance Cycle, Aligning and clarifying tasks.

**Table I: Niger HR Collaborative change package for Performance Cycle step I, Aligning and clarifying tasks**

<b>Improvement Objective:</b> Ensure that all workers have an <u>achievable workload</u> with <u>clear expectations and measurable objectives</u> that are in <u>line with the organizational goals</u> and are <u>kept current through review and discussion</u> .		
<b>Change concept</b>	<b>Specific changes</b>	<b>Examples and ideas for changes/PDSAs</b>
<p><b>Clarify expectations and set objectives</b></p> <p><b>Operational definition</b></p> <p>The health worker (HW) and organization (or team, supervisor) agree on exactly what is to be achieved to be successful and review and update those expectations on a quarterly basis.</p> <p><b>Best practices/ lessons learned</b></p> <p>HW participates in the process of articulating expectations in a written document and providing feedback. A cyclical process is built in for frequent updates, changes, and feedback. The document establishes the basis for capacity development, evaluation, and career advancement.</p>	<p><b>Articulate and align goals</b></p> <p>Articulate and agree upon the goals of the Ministry and the region and the specific goals as they relate to each district</p> <p>Articulate and agree upon each facility's specific and measurable goals</p>	<p>Interview those responsible at the MOPH and regional and district health management teams regarding goals of Ministry, the Region, and health facilities.</p> <p>Facility directors and staff meet to discuss health requirements or gaps within each facility's catchment area to identify local health priorities and needs.</p> <p>Communicate (disseminate, post, and hold periodic meetings) to health workers and clients what the goals of each level (central MOPH, regional and district offices, and health facilities) are and how they contribute to the overall national goals.</p>
	<p><b>Design jobs (include performance objectives)</b></p> <p>Identify and describe job roles of the Regional Directorate of Public Health (DRSP), district office, and health facilities</p> <p>Define/select performance objectives with measurable indicators</p> <ul style="list-style-type: none"> <li>• Team objectives</li> <li>• Individuals objectives</li> </ul> <p>Design an achievable workload by analyzing current work and process to identify and reduce redundancy</p>	<p>Each level (region, district, facility) identifies and describes its existing/planned roles. Present them to QI team and coach for feedback.</p> <p>Two HWs with the same duties (e.g., two nurses) together write out what they think are the objectives of their daily job and present results to rest of the team or the supervisor for feedback. Run PDSA to determine if objectives are consistent. Redesign if needed.</p> <p>QI team interviews HWs to describe the existing roles and compares to needs identified to meet MOPH goals. In sites with many people, sampling by cadre is used.</p> <p>Examine current processes, roles and tasks using the Cross-Functional Flow Chart and Matrix. Implement tools first with current tasks in a certain activity. Analyze to see if tasks can be streamlined and improved to achieve objective. Redesign tasks and test in a PDSA cycle.</p> <p>Two people in each team record all tasks each day. Identify redundancy and wasted time. Eliminate unneeded tasks. Run PDSA to test.</p>
	<p><b>Establish a process to review and update</b></p> <p>Establish a regular process to discuss and review objectives of facility, team, and individual.</p>	<p>Hold a team meeting weekly to discuss objectives, provide feedback, and problem solve. Record results.</p> <p>Two HWs (peers) meet weekly to discuss objectives, coaching/feedback, and problem-solve. Record results.</p>

## IV. IMPLEMENTATION OF THE HR COLLABORATIVE

### A. Launching the HR Collaborative in Tahoua

The collaborative was launched with an Expert Meeting in Niamey in April 2009, during which stakeholders from the MOPH, Ministry of the Public Sector and Labor, Ministry of Finance, Ministry of Population and Social Affairs, Tahoua health managers, and representatives of Niger's seven labor unions reviewed MOPH national health priorities and findings from the baseline assessment. They also reviewed and discussed the draft change package and modified it based on their discussions.

Implementation of the first Performance Cycle step "aligning and clarifying tasks," began at the first learning session, which was held in the city of Tahoua the week after the Expert Meeting.

For each of the three main collaborative goals, stakeholders defined improvement objectives and key indicators to measure achievements. These are listed in Table 2.

#### Section summary:

- Stakeholders and teams defined improvement objectives for the collaborative and key indicators to measure achievements in three areas: human resources, clinical care, and management strategies.
- Eleven management and 15 clinical teams implement the collaborative in all eight of Tahoua's districts.
- Coaches (district-level team members) guide and monitor the facility-based improvement work through regular site visits. They also lead coaching visits and learning sessions where teams come together to discuss best practices, lessons learned, and solutions to overcoming challenges.
- Involving HWs workers in creating their own job descriptions both clarifies tasks and motivates workers.

**Table 2: Collaborative goals, improvement objectives, and measurement indicators**

Collaborative Goal	Improvement objective	Measurement Indicators
1) Improve health worker performance through team based performance management.	Step 1 of Performance Cycle: Aligning goals, clarifying health worker tasks and developing job descriptions	% of sites with aligned organizational goals % of HWs with specific and clearly defined job descriptions Rate of performance objective review and planning meetings held
2) Improve quality of maternal, newborn and child care	Increase rates for assisted deliveries	Number of new antenatal care (ANC) patients enrolled % of facility deliveries % of skilled deliveries by qualified staff % compliance to essential newborn care (ENC) norms % compliance to pre-eclampsia and eclampsia norms
	Reduce postpartum hemorrhage (PPH) rates and improve management of PPH	PPH rate
	Increase family planning coverage in health facilities	Contraceptive prevalence Number of newly enrolled women for family planning (FP) services
	Improve treatment of severe malaria for children under five	% of compliance to severe malaria case management norms Hospital malaria case fatality rate
3) Improve supervision and clinical coordination	Strengthen clinical supervision from the regional management team (DRSP) to the district hospital (DH) and from the to the CSI	Increase the completion rate of supervision by DRSP from 50% to 80% Increase the number of districts with at least 80% of supervision trips completed
	Improve coordination meetings at the regional level (DRSP and HD) and at the district levels (district health management team)	Improve the % of district coordination meetings held

## B. Sites Participating in the Collaborative

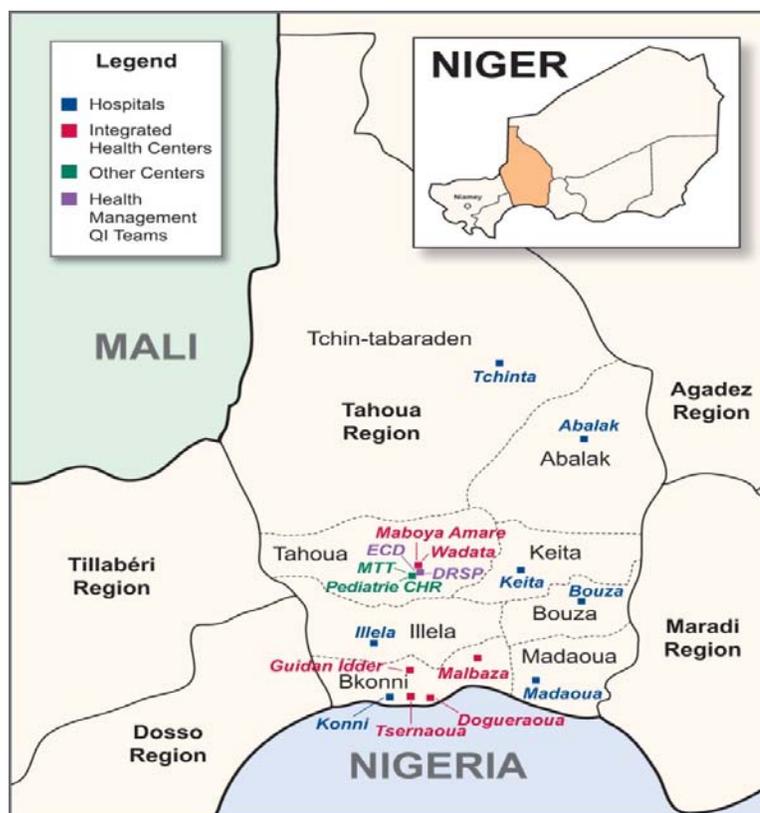
During the Expert Meeting, stakeholders agreed that although site-level teams could implement much of the change package, they would also need the support and collaboration of management teams.

Twenty-six QI teams formed at the regional, district, and facility levels to implement the collaborative:

- Fifteen clinical teams: the one regional hospital, the one regional maternity center, all seven district hospitals, and six of the Region’s 128 primary care centers (“Centres de Santé Intégré,” or CSIs). (See Figure 4 for identification of districts and selected sites.)
- Eleven management teams were also formed to support the improvements gained at the facility level. The management teams included three teams at the regional level and Tahoua’s eight district management teams.

Table 3 shows the selection of sites for the baseline assessment: 15 sites in Tahoua that included referral facilities, all seven district hospitals, and six CSIs, plus five facilities in neighboring regions of Maradi (three) and Tillabéri (two), which serve as control sites.

**Figure 4: Map of Tahoua Region and sites**



**Table 3: Health facilities in Tahoua and health workers sampled in the three regions**

Type of facility	Total number in the Tahoua Region	Sites participating in the HR Collaborative (Tahoua)	Control sites		Tahoua management teams participating in HR Collaborative
			Maradi Region	Tillabéri Region	
Regional hospital	1	1	1	0	1 (Tahoua Regional Management Team)
					1 (Regional Hospital Management Team)
Regional maternity	1	1	0	0	1
District hospital	7	7	2	2	1 (Tahoua District Management Team)
					7 (district hospital management teams in the other seven districts in the region)
Integrated health center	128	6	0	0	

Site selection was based on two considerations:

- 1) Representation of the regional health system: It was important to select a “slice” of the regional health system with management and clinical (health facility) structures in order to incorporate every level of the health system.
- 2) Experience in QI: Five of Tahoua’s nine hospitals had previously participated in an improvement collaborative, gaining experience that would foster implementation of this collaborative.

Management teams included all facility-based management teams as well as the Tahoua district and regional health authorities.

## C. Addressing Performance Cycle Step 1: Aligning and Clarifying Health Worker Tasks

The change package implemented by QI teams in Tahoua and described in the previous section provides technical guidance in HR that teams use in order to achieve each objective. As a pilot, however, the change package does not give specific instructions on how to accomplish each objective. Teams therefore were required to test multiple ways to accomplish each task, and some tasks were more difficult and complex than others.

Step 1 of the Performance Cycle is a complex task. Aligning goals from top to bottom—from the national level to the region, the region to the district, the district to the facility, and finally to the individual—is a challenge in even the most mature organization. The ultimate goal is for each level to understand and contribute to the objectives of the whole so that each individual understands his or her contribution to success or failure of goal achievement.

Figure 5 illustrates the alignment process. The objectives of the national health plan are aligned first with the regional objectives, which include all regional level facilities (Regional Maternity Hospital and Regional Hospital Center), and the Regional Health Management Team. These objectives are then rolled down to each district, which includes each district hospital and the District Health Management Team. Finally, the health centers’ objectives are developed. This first phase of alignment allows individual objectives and job descriptions to be developed that are meaningful to health workers and managers working to achieve their goals. The alignment process consists of three main steps:

### 1) Formulate the objectives of each organizational level

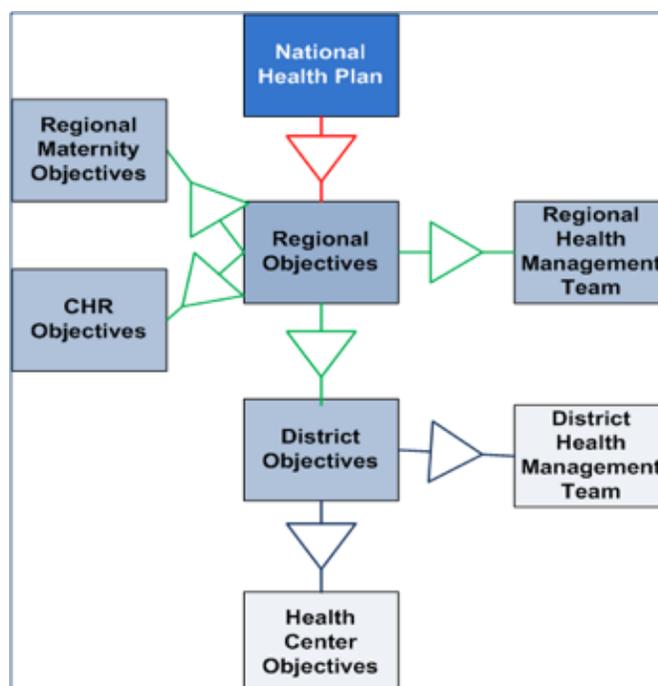
To begin, management teams worked together to articulate and agree upon:

- The goals of the MOPH and the Region and the specific goals as they relate to each district, and
- Specific and measurable goals for each facility.

### 2) List the tasks with clear performance targets

Once objectives were clear, tasks were analyzed and performance targets were set. Specific steps included:

**Figure 5: Tahoua process for aligning objectives**



- List all jobs in the service areas selected for intervention,
- Describe the functions of each position and profiles of different cadres (nurse, physician, nursing aid, etc.),
- Set performance targets for the whole service, jobs within each service, and each health worker for each position,
- List all the tasks currently carried out by each health worker for each position,
- Analyze tasks determine consistency across health worker allocation, performance objective, specific objective, and cadre profile,
- Amend and compile the final list of tasks expected by job and individual,
- Analyze the workload per health worker to determine if it is feasible (that is, analyze the relationship between the time necessary to perform the tasks and the time available), and
- Develop job descriptions based on this final analysis and verification.

### 3) Develop a process/mechanism to review goals

In order to keep job descriptions current, management teams and health workers review and revise job descriptions periodically. Having a written, detailed document to guide objectives and set goals has helped health workers focus on their tasks and create their own job descriptions. Interviews with workers and managers indicated better understanding and organization and a more satisfied workforce. “With the definition of tasks, the tasks are clear,” said Ibrahim Maikaka of the Tassigui Maternity Hospital in Tahoua of the collaborative’s effects and his impression of its beginning stages. “We do the work better,” he noted.

Health workers participated in the process of creating their own job descriptions and as well as those of colleagues. HCI coaches and MOPH district and regional coaches supported the process, and results were shared with other teams at learning sessions.

*“I feel more useful.”*  
 - Ibrahim Maikaka of the Tassigui Maternity Hospital on how having a written job description improved and motivated him in his work.

Organization of coaching visits and learning sessions—both fundamental activities in an improvement collaborative—are described in the following sections.

## D. Learning Sessions

The collaborative approach incorporates learning sessions which bring together QI teams from participating facilities to share results and challenges, learn from one another, and receive training and technical feedback to support implementation of the change package. HCI staff and coaches facilitated learning sessions that included not only QI team members, but also officials from the Ministries of Public Health and Public Works and health worker union representatives.

The first learning session, held in the city of Tahoua in May 2009, featured an overview of HR management issues in Tahoua Region by the MOPH Regional Director. Participants also received an introduction to key HR concepts, including performance and HR management, retention, and employee engagement. Also presented were the results of the March 2009 baseline assessment. Lastly, participants were introduced to how collaboratives function, the quality improvement process, and the HR change package.

*“I was impressed by the participation of all invited. I realize that at each meeting, we encounter new ideas that the participants want to master. And I realize that for the essential things, you need a certain mastery of the subject but above all the methodology. However, the emphasis has to be placed more on internal and external coaching.”*  
 - Head, MOPH Administrative Division of Personnel, Learning Session 3

At the second and third learning sessions, QI teams presented the results from changes implemented since the previous learning session and shared successful changes, challenges, and priorities.

Examples of successful changes made during work on the first improvement objective on aligning and clarifying tasks, by level of the collaborative, include:

- **Maternity:** Transferred prenatal consultation, formerly done at the maternity ward, to the health center to reduce congestion and waiting time at the maternity ward.
- **District hospital:** 1) Transferred FP activities from the cashier to a midwife: The team realized it was important to have a qualified person delivering these services. 2) Reduced the number of weekly ANC sessions, ensuring that when such sessions are held, they are full.
- **District management team:** Nominated an FP point person as part of the team to ensure the timeliness of quarterly reports on contraceptive rates. This resulted in an improvement in the percentage of on-time reports from 60% to 96%.

Figure 6 summarizes key events and processes in the development of the HR Collaborative and the implementation of the first step in the Performance Cycle.

## E. Monitoring and Evaluation

The March 2009 baseline assessment measured health worker productivity, engagement, and client flow (waiting time) for selected services. Data were also gathered on existing job descriptions, frequency of supervision visits and of performance evaluations, etc.

During the implementation of the collaborative, data have been collected monthly on clinical indicators, quarterly on indicators for supervision and coordination, and at baseline and midterm on productivity, engagement and client flow.

Although changes tested and implemented by teams have focused on implementing steps in the Performance Cycle, results to date show that addressing performance management can lead to improved clinical outcomes. Engaged in their jobs and tasks, health workers are able to more efficiently and passionately carry out their tasks of counseling pregnant women, addressing women's needs both before and after childbirth, and properly managing the maternity wards so women are seen in the timeliest manner possible.

HCI also developed an Excel-based database and team journal template to assist QI teams to monitor indicators, document changes tested, and determine what changes actually yielded improvements.

## F. Coaching and Supporting QI Teams

Coaching QI teams is intended to both build MOPH and DRSP capacity as well as support site-level teams in their improvement efforts through site visits and remote support. Both internal and external coaches review results with teams and help them problem solve to reduce obstacles to implementing HR changes. Two types of coaches are involved in the collaborative:

1. **Internal coaches:** These coaches are part of the QI team, such as DHMT supervisors, chief nurses, or midwives. They are selected based on their availability, QI knowledge, and reliability. They conduct QI team meetings at least monthly.
2. **External coaches:** These coaches are from the DRSP, HCI, the DHMT, or the district health QI team. They are not directly involved in implementing improvement activities at individual facilities. They visit sites every six–nine weeks to provide support to strengthen documentation processes, build QI teams' skills, validate indicators, and support teams to use the results from changes to inform further improvements. HCI staff coach MOPH, DRSP, and DHMT staff who serve as coaches to QI teams.

**Figure 6: Milestones in the implementation of the Niger HR Collaborative, 2008-2010**

<p><b>October 2008: Rapid assessment of HRH systems</b></p> <ul style="list-style-type: none"><li>• Key informant interviews in Niamey, Tahoua, with stakeholders from central, regional, district, and facility levels</li></ul>
<p><b>March 2009: Baseline assessment conducted</b></p> <ul style="list-style-type: none"><li>• 20 facilities participated in the assessment</li></ul>
<p><b>April 2009: Expert meeting held and first improvement objective introduced</b></p> <ul style="list-style-type: none"><li>• Engaged key national stakeholders</li><li>• Introduced key HR concepts that would be advanced by the Collaborative</li><li>• Introduced the Model for Improvement and collaborative approach</li><li>• Presented baseline assessment results</li></ul>
<p><b>April 2009: Learning Session I</b></p> <ul style="list-style-type: none"><li>• Engaged facility and district management teams</li><li>• Introduced key HR concepts that would be advanced by the collaborative</li><li>• Introduced the Model for Improvement and collaborative approach</li></ul>
<p><b>May 2009: HR Collaborative established</b></p> <ul style="list-style-type: none"><li>• Seven district hospitals, a referral maternity center and DH, and six CSIs, and 11 district management offices participate</li></ul>
<p><b>July 2009: Learning Session 2 held and implementation support was provided for the first improvement objective</b></p> <ul style="list-style-type: none"><li>• Continued to engage facility and district management teams</li><li>• QI teams shared challenges and successes in aligning/rationalizing their jobs with MOPH priorities</li><li>• Prioritized goals to form focus of improvement activities</li></ul>
<p><b>November 2009: Assessed selected facilities using midline tools</b></p> <ul style="list-style-type: none"><li>• 12 facilities participated in the midline</li></ul>
<p><b>December 2009: Learning Session 3 held and implementation support was provided for the first improvement objective</b></p> <ul style="list-style-type: none"><li>• Continued to engaged QI team members, officials from the Ministries of Public Health and Public Works, and union representatives (60 participants)</li><li>• QI teams presented tested changes and results</li></ul>
<p><b>October 2010: Assessed selected facilities using midline tools</b></p> <ul style="list-style-type: none"><li>• HCI headquarters and Niger staff visited facilities to interview HWs and others regarding the collaborative's progress during its 18 months</li><li>• Field-tested data collection tools at four different sites</li></ul>
<p><b>December 2010: Coaches conduct meeting</b></p> <ul style="list-style-type: none"><li>• Teams and facilities met in Niamey to discuss achievements and challenges in carrying out the first improvement objective</li></ul>

**Note:** The MOPH and HCI have conducted coaching visits to each QI team every other month since the first learning session in April 2009 to the present.

## G. Ensuring Sustainability of Improvement

For teams to be able to independently carry out this innovative initiative of applying QI to performance management, it was necessary to support implementation at the pace of each individual team and facility to ensure its success and sustainability. For example, work on the first improvement objective (aligning and clarifying tasks) took up to a year for some sites to fully implement due to the challenges associated with this process and an approach that was entirely new to them; other facilities were faster in achieving this objective.

Working with facilities also ensures that the improvement work can function in an existing health system that will continue after the collaborative ends. Helping teams utilize the resources and capabilities they already have (e.g., motivated leaders, journals to document and monitor progress, and workers who can survey clients for feedback) increases a collaborative's chances of improving efficiency and care despite high staff turnover.

One facility that experienced improvements despite high staff turnover and constant system changes is the Madaoua District Hospital: A case study describing its improvement experience is in Box 2.

## V. COLLABORATIVE RESULTS TO DATE

### Section summary:

- Improvement occurred in all four clinical indicators: Assisted deliveries with a qualified personnel increased from 12.4% to 31%; contraceptive prevalence rose from 9.6% to 15%; compliance with ENC standards increased from 74% to 94%, and the PPH incidence fell from 2% to 1%.
- Productivity increased dramatically for nurses, somewhat for doctors, and stayed the same for midwives.
- Sites reported that more supervision visits were conducted at CSIs (increased from 25% to 50%), coordination meetings were taking place (in 33% of participating sites), and coaching visits were occurring (in 50% of participating sites).
- Almost all HWs (97%) working in a site participating in the collaborative now have job descriptions.
- Results from work on Improvement Objective I show that by improving HR systems, health outcomes and the quality of care can also be improved.

In November 2009, HCI and MOPH coaches conducted an assessment to measure the collaborative's overarching indicators and determine whether QI teams were improving in clinical, human resources, and management areas. The assessment evaluated indicators the teams had chosen. Table 4 compares the March 2009 baseline assessment results with those from the later assessment.

**Table 4: Progress in selected indicators, March 2009 and November 2009**

	Measurement Indicators	March 2009 (Baseline)	November 2009
Human Resources	Employee has a job description	8% (4 of 53)	95% (89 of 94)
	HW engagement (measured on a five-point scale)	3.2 (n=153)	3.7 (n=69)
	% of time utilized for productive (client-related) activities	Physicians 73% Midwives 63% Nurses 44%	Physicians 83% Midwives 63% Nurses 91%
Clinical	Assisted deliveries by qualified personnel	12.4%	31%
	Contraceptive prevalence	9.6%	15%
	Postpartum hemorrhage rate	2%	1%
Mgmt	% of planned supervision visits that were completed	50% of DHs 25% of CSIs	50% of DHs 50% of CSIs
	% of planned coordination meetings that were held	0%	33%

## Box 2: Case study of Madaoua District Hospital

### Statistics

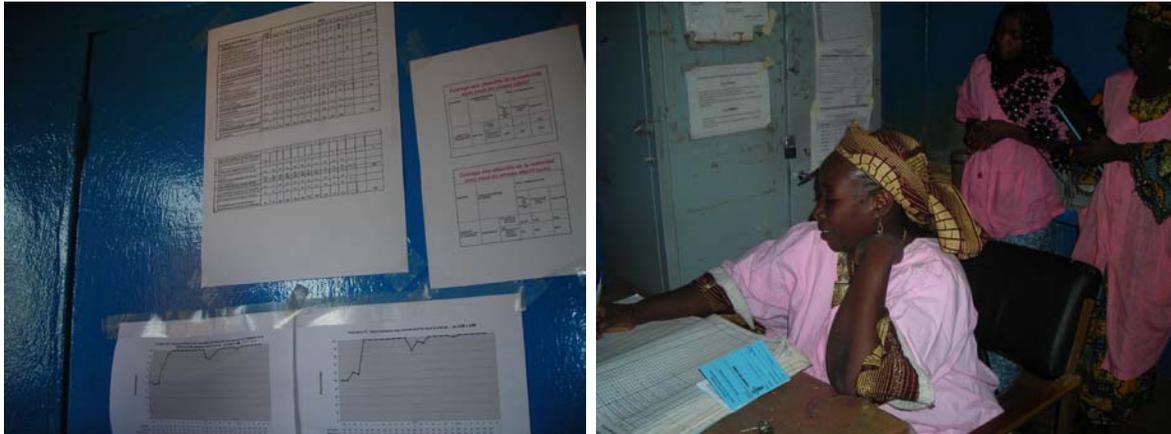
- 57 hospital personnel, including in the maternity, psychiatry, and laboratory wards
- 2 QI teams:
  1. Clinical maternity team with eight members
  2. Managerial team with eight members
- Population the hospital serves: about 445,000

(Data obtained in Madaoua and Niamey, Niger, in December 2010.)

A successful project that relies on support from multiple members and levels recognizes that all involved players are crucial in affecting change and achieving positive outcomes. The QI teams of the Niger HR Collaborative exemplify this idea. At the Madaoua District Hospital, the clinical team's eight members work in maternity care, and everyone from the head doctor to the cleaning staff are part of the team and its efforts to improve care.

Despite frequent staff turnover (the team formed in June 2009 with nine members, lost three, and added two by December 2010), team members have written their own job descriptions, which also serve as job aids to remind staff of care procedures and daily tasks. Staff members now hold nearly regular weekly meetings to sort out difficulties in delivering quality care.

Staff members continually collaborate and assist each other, contributing to a more open, motivating work environment. Overall, the workload is distributed more evenly, and when the workload shifts, staff members seek to balance it without outside assistance.



Left: Job descriptions and reminders guide staff members in their tasks of providing patient care. Right: A midwife fills in a patient's record. Photos by Karimou Sani, URC.

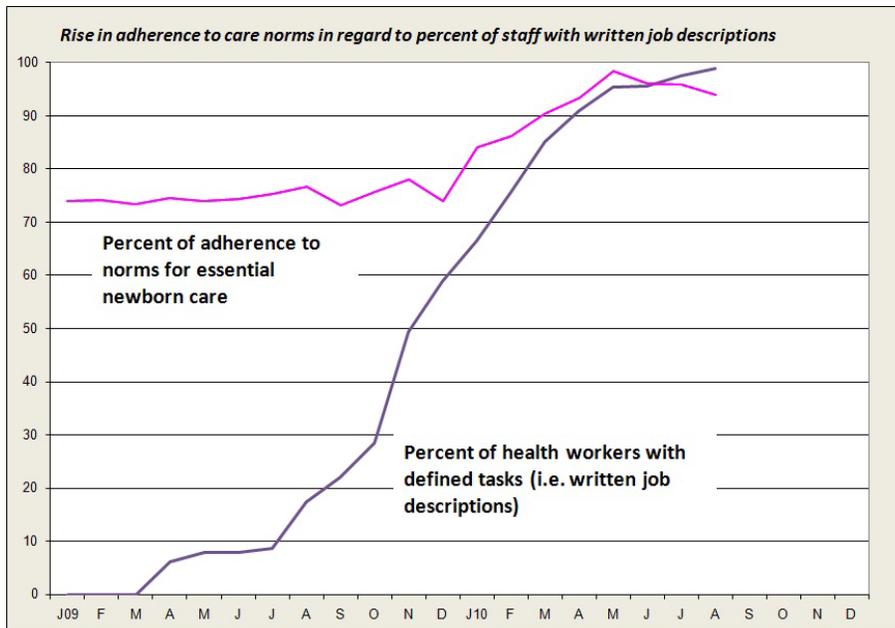
“If I don't have a lot of work and another does, I can assist her,” said Fatima Boubacar, a midwife participating in the Collaborative.

For team members, seeing their work's results—or lack thereof—also spurred their motivation. Boubacar said that staff needed time to adjust and adhere to the improvement goals, reading the results of a March 2010 client feedback survey made them more engaged in the work. Of the 10 patients surveyed, some found the wait times to be too long, and health workers immediately sought to perform their tasks more efficiently and ensure that patients are seen in a timely manner. Client waiting times have been reduced from more than two hours to at most 40 minutes, and often less.

Through providing better management, involving health workers in developing their own tasks and work objectives, and showing these workers the direct outcomes of their efforts, the collaborative helped increase workers' efficiency and motivation, thus providing more supportive and attentive care.

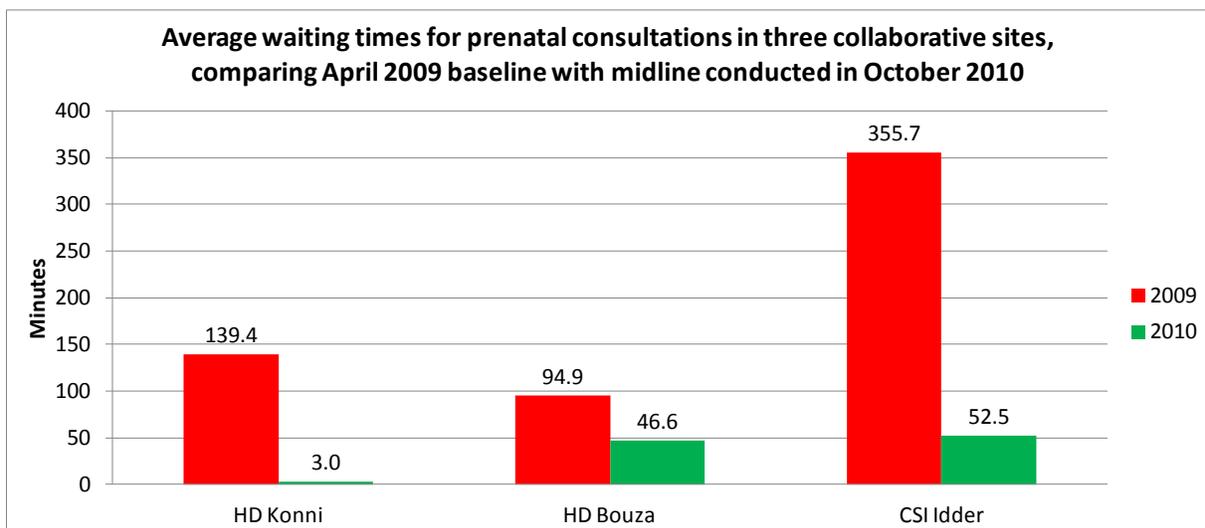
A key outcome of work on the first improvement objective was for facility QI teams to develop written job descriptions with clearly defined tasks for health workers. Over time, the number of written job descriptions increased at all sites, as did those for management teams. As of January 2010, 65% of health workers had a written job description. By November 2009, 95% of them did, although some fluctuation is inevitable as new staff join and others leave. By August 2010, workers could see that as health workers had written job descriptions with defined tasks, the adherence to national norms for essential newborn care also increased (Figure 7).

**Figure 7: Percentage of staff with written job descriptions and increase in adherence to norms**



When workers realigned tasks that improved their performance, they could also improve their facility's care efficiency by reducing client waiting times. When clients wait less for their appointments, their satisfaction and trust in the center's ability to provide effective, quality care also increases. Figure 8 shows reductions achieved in clients' waiting times.

**Figure 8: Prenatal consultation waiting times, three collaborative sites, 2009 and 2010**



In addition to reduced client waiting times and more effective worker performance, clients have also noticed other changes at CSIs, such as a cleaner space and more attentive staff; these changes have increased their trust in the care they receive.

“The hospital is tidier these past two years,” said Salamatou Arzika, a QI collaborative team member of the Konni District Hospital, in December 2010.

*“I prefer to come here because I am looked after better here.”*

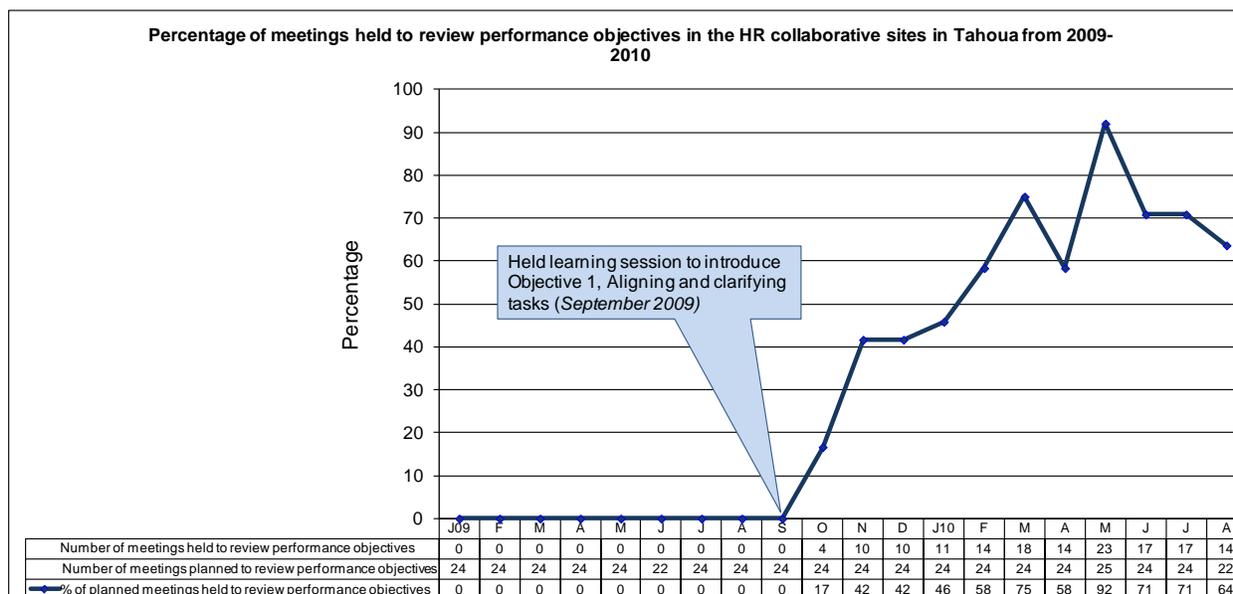
-Abou Illa, a client who visits the Konni DH rather than her CSI because the hospital’s staff members, who participate in the Collaborative, provide more attentive care.

One woman, Abou Illa, said she travels from her village, which has a CSI, to the Konni DH because the care she receives there is better. She has been coming to the hospital for 27 years and commented, “The workers are more knowledgeable than before.”

Figure 9 shows the percentage of meetings that were held by the collaborative sites from January 2009– May 2010. These meeting enable team members to

discuss and review performance objectives. Of the 24 sites (two referral hospitals, seven district hospitals, six health centers and nine management offices) reporting for most months, each site had planned to hold one meeting a month to review performance objectives. However, the graph shows that meetings were not conducted until October 2009 after the HR Collaborative began. Since October 2009, there also has been a steady upward trend showing that every month, more collaborative sites are meeting monthly to review performance objectives. In May 2010, 96% of sites had held a monthly meeting to review performance objectives.

**Figure 9: Percentage of meetings held to review performance objectives**

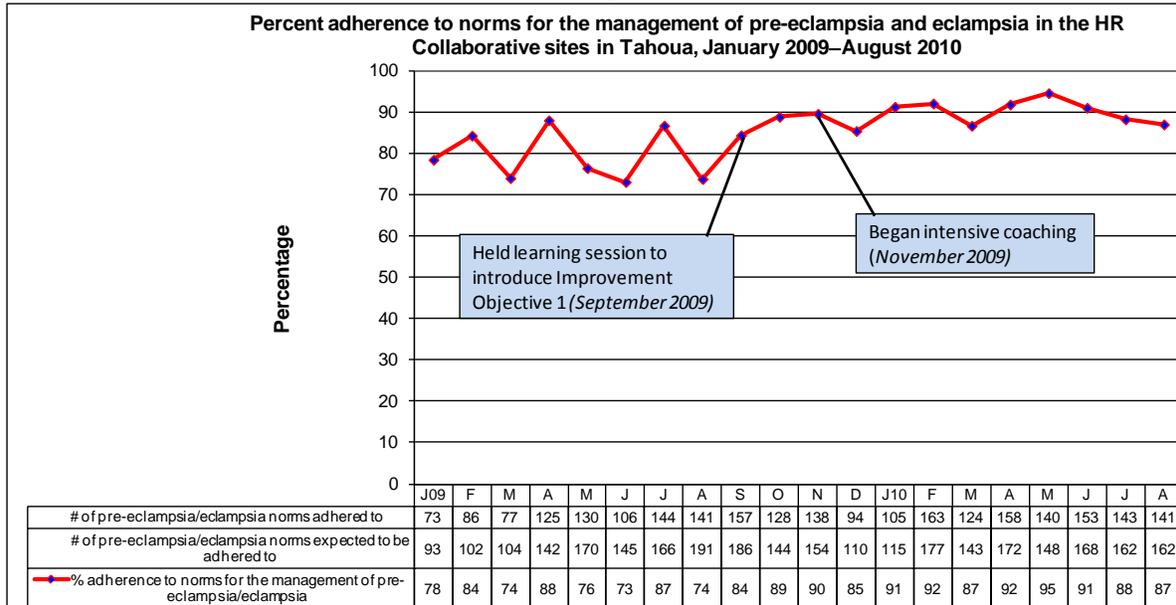


While teams could sometimes hold only one or two meetings a month and it was more difficult to keep the meetings regular in the beginning, some sites, such as the Wadata Health Center, increased the number of meetings to as many as four per month.

The increase in the number of sites holding meetings to review performance objectives led to an improvement in adherence to norms for the management of pre-eclampsia/eclampsia and essential newborn care in collaborative sites (Figures 10 and 11). Through these meetings, health workers have become aware of what their responsibilities are and what tasks they must complete, as well as how to complete these tasks following the highest standards. This shows that HR activities can positively impact

the quality of care delivered by health workers. For example, Figure 10 shows that in May 2009, when the collaborative began, the level of adherence to norms for the management of eclampsia in participating sites was 76%. Figure 10 shows that from January to August 2009, adherence to norms for the management of pre-eclampsia and eclampsia in participating sites ranged from 73% to 88%; in October 2009 to August 2010, adherence ranged from 85% to 96%.

**Figure 10: Percentage of adherence to norms in the management of pre-eclampsia and eclampsia**



Adherence to norms for essential newborn care (ENC) has also improved, shown in Figure 11. Before intensive coaching to the collaborative sites began in November 2009, adherence to ENC norms was stuck between 70% and 80%. After this change, a steady rise occurred in adherence, exceeding 85% and holding there for four months. As of May 2010, the level of adherence to these norms was 98%, a notable increase from the 74% level found at the beginning of the HR Collaborative in May 2009.

**Figure 11: Percentage adherence to essential newborn care norms**

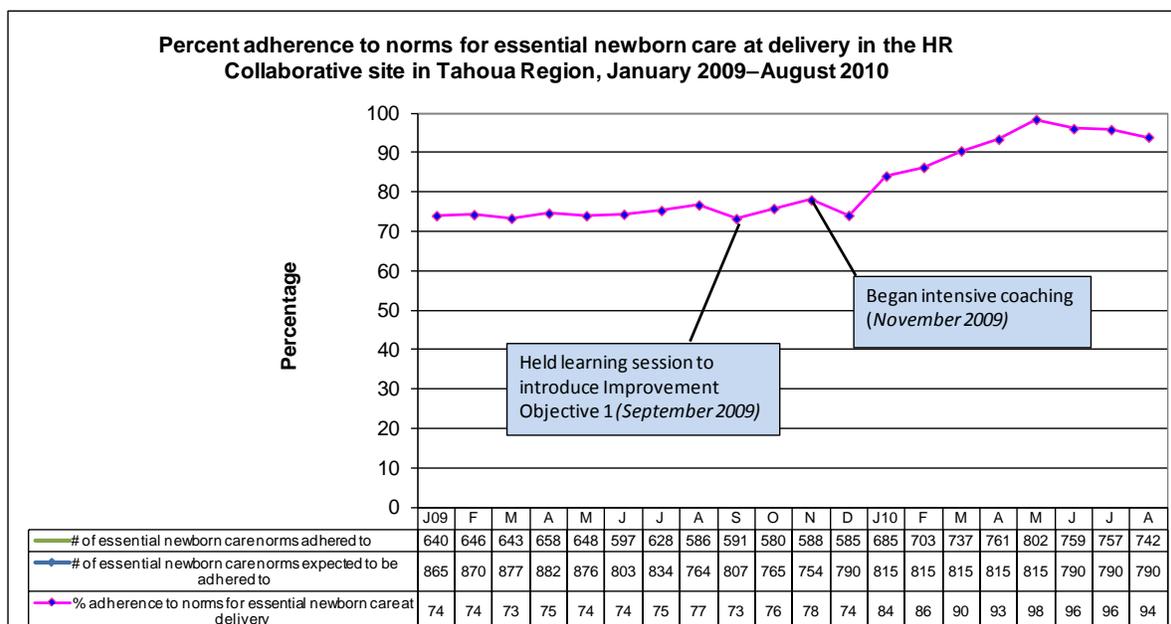
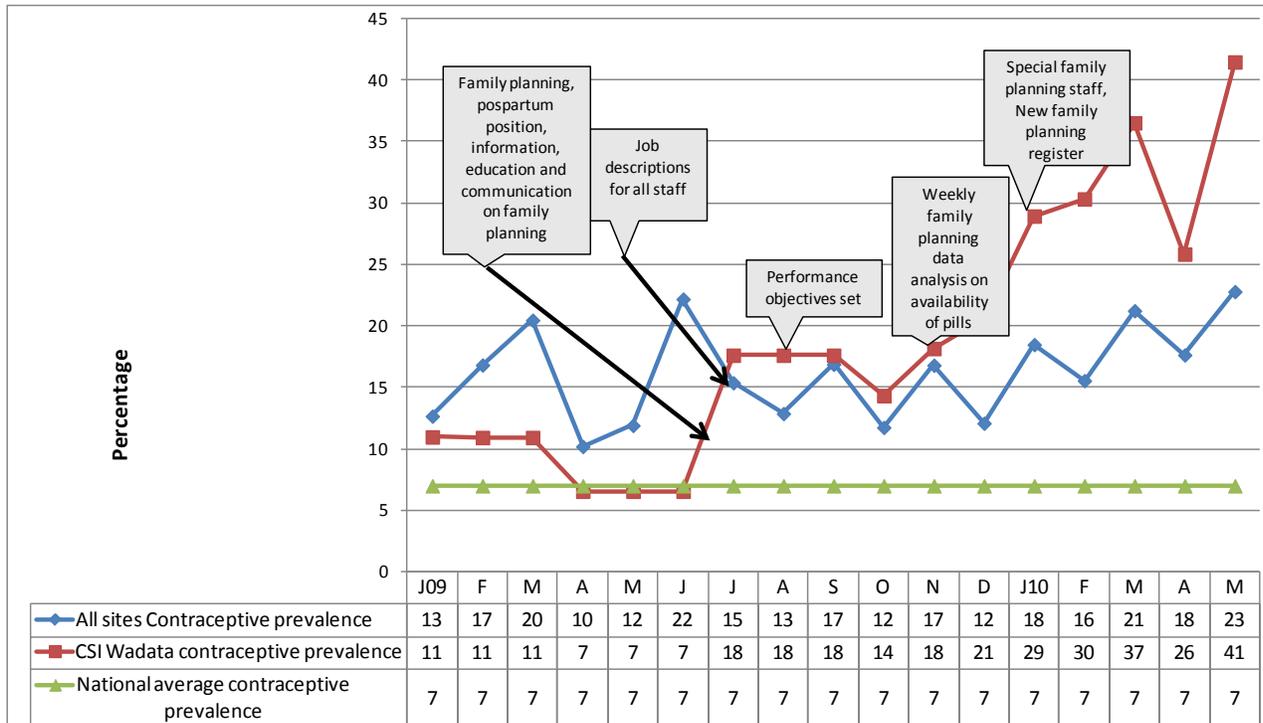


Figure 12 also illustrates how HR activities can positively impact performance objectives and goals. One objective that facilities set for themselves, based on national goals, was to increase the use of contraceptives. As shown, the national average for contraceptive use is only 7%, whereas at collaborative sites it is overall significantly higher. Figure 12 also shows examples of specific changes that the Wadata site implemented: health workers created a specific position to focus on family planning (FP) information, education, and communication; they increased the frequency of data gathering and analysis on uptake by new clients; and they implemented new registers for FP clients. More information about the Wadata health center’s improvement journey is in Box 3.

**Figure 12: Contraceptive prevalence in all collaborative sites combined, Wadata CSI, and national level, January 2009–May 2010**



### Box 3: Case study of the Wadata Integrated Health Center

#### Statistics

- 17 personnel
- 1 QI team: a clinical maternity team with 11 members
- Population the health center serves: about 41,000

(Data obtained in Konni and Niamey, Niger, in December 2010.)

*Salli Yarchiloum and Adama Albachir Mohamed attend a learning session with other sites' QI teams at the Konni District Hospital in December 2010. Photo by Karimou Sani, URC.*



Proper pacing and understanding team members' needs helped the Wadata CSI workers successfully implement significant changes in maternal care. Instituting and maintaining meetings where QI team members could discuss and write employees' job descriptions enabled them to make changes needed to improve care.

QI team member Adama Albachir Mohamed said it took about three months after the team started participating in the Collaborative for team leaders to fully understand and engage in the work. It had been difficult for team members to fully understand the meetings' value. However, meetings soon were held as often as weekly, with members attending and involving themselves in the discussions and work. It was through these meetings that changes were decided, such as listing tasks by room (e.g., the birth room) that had to be completed to ensure proper, safe births and posting the lists on appropriate walls so workers could read them as needed. Team member Salli Yarchiloum said she and other team members also had a clearer idea of what to do as a result.

"More meetings were needed at the beginning," Mohamed said. Two meetings per month would not have sufficed at the start.

As the improvement work progressed and workers became more engaged, fewer meetings were held and workers could complete tasks and responsibilities more independently.

Other changes this team introduced were to create a specific position to focus on family planning, increase how often they gathered information on new clients and analyzed it, and implement a new registers for FP clients. This work contributed to a contraceptive prevalence rate of 41% in May 2010, well above the average 23% rate in other Collaborative sites and significantly greater than the 7% national average rate.

What these team members learned from their improvement work is that when implementing any new initiative, it can be difficult for workers to engage themselves and quickly take on the work, but with leaders who are competent, patient, and understanding, team members and other staff can become better motivated and involved in the work. It is the kind of dedication exhibited by the Wadata QI team leaders that led this small CSI to see great results in worker performance and client care in a short period.

## VI. LESSONS TO DATE AND NEXT STEPS

### A. Lessons Learned

The experience of the facility teams participating in the collaborative has shown that improving human resource management systems and processes can positively impact clinical indicators and the quality of care delivered to patients. This collaborative has allowed teams to clearly see the link between HR inputs and clinical outcomes and the value of aligning their tasks with those of the goals and objectives of the district and the region. The analysis of tasks has allowed health workers and facilities to prioritize roles and responsibilities while improving the quality of care provided to patients.

#### Section summary:

- It is important to engage workers at all levels (doctors, nurses, midwives, drivers, cleaners, etc.) to make everyone feel part of a team.
- A new initiative, such as the Niger HR Collaborative, can take time for workers to understand, value, and feel engaged in, thus patience and flexibility were important when carrying out and implementing this new concept.
- By monitoring the impact of improvement changes, clinical, and HR management indicators simultaneously, QI teams are better able to see the link and results of their work and be motivated to continue carrying out improvements.

Now that health workers have clearly defined tasks, they are able to concentrate their efforts on the key tasks and priorities of their position, allowing them to use their time more effectively. This has been observed in both sites with and without prior QI and essential obstetric and newborn care (EONC) experience. Ten of the 15 sites in the Niger HR collaborative had previously participated in an EONC improvement collaborative that was completed in 2008. However, the other five sites had never received formal training in EONC and had never practiced EONC in their sites before the start of the HR collaborative. After learning sessions and coaching visits, these new sites are now able to perform EONC at their own facilities and perform at a level comparable to the sites that previously implemented the work.

In addition, through this process, district health management teams have realized how important supervision and support are to the facilities and that providing this support needs to occur on a regular basis to maintain worker engagement and efficient performance. Supervision now focuses on helping facilities to achieve organizational objectives by clarifying tasks, adjusting workload with work initiatives, and involving workers in these processes. Analysis of tasks has also helped teams to realize where capacity needs to be developed and that feedback and performance support are essential for health workers to build their skills.

While there were many challenges in implementing the first phase of the collaborative (ensuring health workers arrived at meetings, making the change package and collaborative's goals understandable and easy to follow for all involved, engaging all health workers, etc.), it was viewed as a critical first step. An important lesson learned was the value of shared learning. Facilitating the transfer of knowledge across sites was important for bringing less experienced sites up to the level of more experienced sites. Health workers and managers with experience in QI were also effectively utilized to help orient and spread improvements to newer QI teams.

### B. Next Steps

Results in the Tahoua Region already have been nationally recognized in Niger. While teams continue to implement improvements relating to the remaining HR objectives in the change package, as a result of the collaborative's success, the MOPH is including this approach as part of its five-year national health plan launched in 2011. Quality improvement approaches from the collaborative also will be applied to two internal MOPH departments: human resources and maternal and child health.

In July 2010, the MOPH invited the HR Collaborative teams from Tahoua to present their results to an assembly of 400 MOPH officials from across Niger, at the end of which they decided to include the HR and QI collaborative process in their five-year national health plan and in subsequent annual work plans. Participants included all MOPH unit heads from all National Directorates, all national directors, all national program directors, all national and regional referral hospitals and maternities directors, all regional directors, a sample of DHMTs from each of the eight regions (medical officers and administrative/financial managers), the General Secretariat members, and the Minister's Cabinet members. The daylong meeting consisted of an overview of the collaborative process and the HR Collaborative's objectives and included presentations from some of the QI teams highlighting their achievements. Presentations given were from all levels of the health system (i.e., Regional Directorate, DHMT, district hospital, and a peripheral facility) with results shared and discussed. In addition to making this process part of the MOPH's five-year plan, an outcome of this meeting also was to integrate QI in all strategic MOPH reference documents.

Primarily, workers' efforts with and results seen from the first Improvement Objective have shown that while it may take some time to implement a new initiative with a different approach, teams and health workers can comprehend and successfully carry it out if they are properly coached, shown patience, and continually engaged. Workers also are willing to work toward something new, despite possible increased efforts on their part, if they can see the link between the work they are doing and the results it produces. The Niger HR Collaborative achieved this visible link by connecting clinical and HR indicators simultaneously. In this kind of work, it also is important to engage each individual worker and make him or her realize the significance his or her work can have on health outcomes.

Using lessons and results from Niger, the USAID Health Care Improvement Project has been working since November 2010 to support the Ministry of Health and Social Welfare and implementing partners to apply improvement approaches to HRH in Tanzania, with the aim of improving health worker performance and the quality of HIV services.

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