

# Strengthening Human Capacity Development to Improve RMNCH Outcomes

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## Legacy

By capturing and sharing lessons learned from MCSP country efforts and global evidence on efforts to strengthen human capacity development, MCSP will contribute to learning and produce recommendations for evidence based approaches for strengthening human capacity development (HCD) to achieve sustained quality and coverage of high-impact Reproductive, maternal, newborn and child health (RMNCH) interventions.

## Definition

There are a range of definitions for capacity development. As noted by the United Nations Development Programme (UNDP): “For some, capacity development can be any effort to teach someone to do something, or to do it better<sup>1</sup>” MCSP defines our work in human capacity development as the processes used to develop individual and team abilities to set goals and to strengthen and maintain capabilities to perform the competencies required for individual and team roles.

## Why is HCD important?

USAID’s vision for Health Systems Strengthening includes human resources for health as a primary area of focus and a core function of the health system. One of the key strategic outcomes of this vision is the provision of *essential services*. MCSP’s approach to human capacity development builds the capacity of individuals and teams to deliver high impact RMNCH essential services. Within human resources for health, one of the USAID priorities is to “conceive and adapt effective models for transformative education and maintenance of skills/competence.<sup>2</sup>” In line with this USAID priority, MCSP is applying evidence based approaches to human capacity development and seeking to transform traditional approaches that have not had the desired outcomes. MCSP’s approach to human capacity development focuses on building individual health worker knowledge and skills through experience and practice, alongside improving both individual and team processes and performance. MCSP prioritizes four primary components in its human capacity development approach:

1. Pre-service Education
2. In-Service Training
3. Mentoring
4. Supervision

MCSP employs varying combinations of these components across country programs. Design and implementation of education, training, mentoring and coaching, and supervision vary based on the country context. MCSP-supported human capacity development efforts may target a range of competencies important for health workers and managers including:

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<sup>1</sup> United Nations Development Programme. Capacity Development: A UNDP Primer. UNDP, 2009. <http://www.undp.org/content/undp/en/home/librarypage/capacity-building/capacity-development-a-undp-primer/>

<sup>2</sup> United States Agency for International Development, Vision for Health Systems Strengthening. <https://www.usaid.gov/what-we-do/global-health/health-systems/usaid-vision-health-systems-strengthening>

- Service delivery and clinical competencies (both community and facility)
- Quality Improvement competencies
- Management competencies

Sustained improvement of RMNCH outcomes cannot be achieved without investing in human capacity development. High-impact interventions can only be sustained at scale if health workers are supported and strengthened to deliver these interventions.

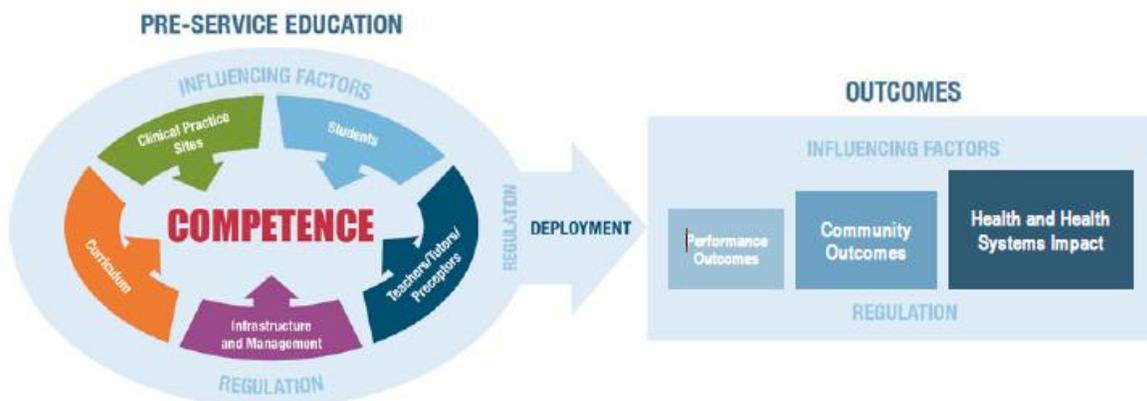
## What do we hope to achieve?

MCSP aims to ensure that our country programs implement the most efficient and effective mechanisms to promote human capacity development. Currently MCSP countries implement various components to strengthen human capacity development based upon the country priorities. MCSP follows the continuum from the basic preparation of a healthcare provider for service, to supporting continual professional development through in-service training and mentoring, and leveraging existing supervisory systems to support health care provider performance in the workplace. Below is a short summary of MCSP key definitions and approaches used.

## Pre-Service Education

Pre-Service education is the *preparatory education to develop knowledge, skills and behaviors of health care providers prior to deployment, or before “entering service”*. MCSP’s pre-service education programs apply a systems-strengthening approach to ensure competence upon graduation. Rather than focusing on isolated interventions, such as curriculum revision, or faculty development, MCSP utilizes a rapid needs assessment tool to identify gaps within the pre-service education system and to prioritize activities based on identified gaps. Used to strengthen the pre-service education system, this assessment applies the conceptual framework developed by Jhpiego<sup>3</sup> based on an integrative review of the literature (see Figure 2). The conceptual model identifies direct and indirect factors that influence graduate competence, and points to expected outcomes of producing competent graduates that are deployed and supported. Country programs select interventions from the direct factors in the conceptual model, e.g, clinical practice sites, students, teachers/tutors/preceptors, infrastructure and management and curriculum, to strengthen the pre-service education system based on the professional board or council and Ministry of Health priorities. While some country programs emphasize certain components over others based on national priorities and gaps, a systems approach is used to assess and determine the combination of interventions that will result in maximum impact on graduate competence.

**Figure 1. Conceptual Model: The Health Impacts of Pre-Service Education**



<sup>3</sup> Conceptual model based an integrative review of the literature: The Health Impacts of Pre-Service Education, ©Jhpiego Corporation, 2012. Accessed at: <http://reprolineplus.org/resources/health-impacts-pre-service-education-integrative-review-and-evidence-based-conceptual>

## In-Service Training

MCSP seeks to apply the evidence to transform in-service training, which continues to receive significant levels of funding despite evidence that training alone is not sufficient for producing desired results. In-Service Training is a *structured and formal training approach for health care workers and managers (after completion of pre-service education) to reinforce existing competencies or develop new ones*. In-service training is often an important component of continuing professional development. MCSP programs advocate that in-service training should be linked to quality improvement efforts and combined with mentoring or formal supervision. It should be selected as an approach if there is a documented gap in knowledge and skills and delivering as an isolated intervention should be avoided. If selected, evidence-based techniques should be applied in the appropriate settings, with the right frequency, to ensure they are as effective and efficient as possible. MCSP seeks to link any in-service training provided to continuing professional development processes existing in country.

## Mentoring

MCSP programs primarily combine mentoring with in-service training and quality improvement efforts. MCSP use of mentoring most closely aligns with the definition of clinical mentoring below. This description of mentoring is commonly referred to in human resource management literature as ‘coaching’<sup>4</sup>. Most low and middle-income (LMIC) countries use the term “clinical mentoring” or “mentoring.” Mentoring may focus on other or additional competencies-such as management, implementing quality improvement efforts or using data for decision making.

“Clinical mentoring is a system of practical training and consultation that fosters ongoing professional development of mentees to deliver sustainable high-quality clinical care. Clinical mentoring should be seen as part of continued professional development required to create and maintain competent care providers. Driven by the learning needs of mentees [based on expected job performance and desired skills], it occurs in face-to-face consultation, as well as through ongoing phone and e-mail consultations.”<sup>5</sup>

This approach to mentoring differs from the commonly used human resource management terminology ‘professional mentoring’ or ‘mentoring’. Professional mentoring is a process applied in work, training or education settings in which a respected, experienced person (the mentor) partners with a less experienced person (the mentee) to support and nurture personal and professional development to cultivate a specific skill set. Unlike clinical mentoring, mentees *determine their learning goals*, which often focus on ‘soft skills’ such as communication, managing conflict, etc., and *select their mentor*. It is always 1:1, whereas coaching or clinical mentoring often pairs a mentor with a team or small group of individuals.<sup>6</sup> Unlike formal supervision, management and reporting structures, mentoring, as defined and implemented by MCSP, leverages peers or other individuals rather than hierarchical supervisory relationships.

## Supervision

MCSP program efforts consistently include supervision related activities, seek to reinforce supportive supervision, and increase the use of data to drive decisions and improve quality. Supervision is formally defined as “management by overseeing the performance or operation of a person or group.” Supervision is a formal process and emphasizes health facility management and captures certain key indicators and statistics. It is often more hierarchical and managerially oriented. Supervision is key in many

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<sup>4</sup>A “coach” is a person who works closely with one or more individuals to support development of a specific skill or set of skills. Coaching is more task oriented while [professional] mentoring is more relationship oriented. Mentors often provide coaching. Refer to: Coaching vs. Mentoring: 25 Ways They’re Different, Thought Paper, Management Mentors, Winter 2013.

<sup>5</sup> Clinical Mentorship Manual for Integrated Services, 2011. Department of Health, Republic of South Africa.

organizational settings, and the goals are pre-determined by the health system. It may be more critical and evaluative than the more non-judgmental approach associated with mentorship. MCSP efforts in supervision recognize a multi-dimensional approach to supervision is important given the traditional, visiting supervisor model is associated with minimal improvements in health care provider performance<sup>7</sup>. Multi-dimensional supervision includes strategies such as reinforcing and assessing standards, developing partnerships between provider and client and community, using client feedback to improve quality and engaging individual health workers in the process.<sup>8</sup>

## What do we want to learn?

At the global level, MCSP programs are implementing a combination of the four components based on national priorities. The USAID vision for health systems strengthening urges implementing partners to evaluate the outcomes and impact of our work and interventions. As countries seek to implement new approaches to capacity development, gathering and sharing program learning is critical. MCSP is gathering formal and informal program learning from our human capacity development efforts, with a focus on alternative learning and mentoring approaches, and will disseminate learning to contribute to the global body of evidence. Currently MCSP program learning questions related to human capacity development are summarized in the table below.

### Human Capacity Development Learning Questions

Ethiopia and Zambia NB, MH	Do training activities that integrate basic newborn care with basic emergency obstetric care effectively ensure providers' competencies in basic newborn care in Ethiopia and Zambia? Country/Countries: Ethiopia, Zambia
Ethiopia MH (BEmONC)	Evaluation of blended approach for basic emergency obstetric and newborn care (BEmONC): Are the gains of knowledge through the blended BEmONC training similar to or better than those gains through the conventional BEmONC training approach?
Ghana PSE/Community-based Health and Planning Services (CHPS)	How do different methods of scaling up Community Health Officer training impact Community Health Officers' confidence and competence in implementing the complete CHPS model, especially in terms of community engagement?
Kenya	What is the change in perceptions, knowledge, and skills of graduates in EPI following implementation of the revised EPI content in the pre-service curriculum?
Madagascar MH, NB, FP	Can a mentorship program improve the mastery of MNH and FP clinical skills post-provider training?
Nigeria MH, NB	Is a low-dose, high frequency/m-mentoring a better approach than group-based training in improving the competencies of birth attendants in Kogi and Ebonyi states?
Rwanda NB	Can a set of post-training follow-up activities (low-dose, high frequency training, mentoring, and data review) improve provider performance of ENC/HBB?

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<sup>7</sup> Rowe, Alex. Health Care Provider Performance Review. Presentation for World Bank, September 5, 2014. Accessed at: <http://www.worldbank.org/content/dam/Worldbank/Event/SIEF/20140905-quality-of-health-care-services-products/01-Health-care-provider-performance-review-Alexander-Rowe.pdf>

<sup>8</sup> Multidimensional Supervision. Necochea, E., Kols, A.J., Bossemeyer, D., ©Jhpiego Corporation, 2010.

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